The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	27 July 2023						
Title	Guardian of Safe Working Hours Annual Report						
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 a consolidated annual report on rota gaps, and the plan for improvement to reduce these gaps to be included in the Trust's Quality Account. This report addresses the requirement for the year from April 2022 to March 2023 for consideration by the Trust Board.						
Recommendation	The Board is asked to note the content of this report for inclusion in the Trust's Quality Account.						
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
	☒	☐	☐	☐	☐	☐	☐
Link to Board Assurance Framework [BAF]	No direct link. 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	Annual Report of the Guardian of Safe Working Hours.						

GUARDIAN OF SAFE WORKING ANNUAL REPORT

1. EXECUTIVE SUMMARY

The purpose of this annual report is to highlight the vacancies in junior doctor rotas and steps taken to resolve these during the year from April 2022 to March 2023.

Rota gaps on actual working rotas are also influenced by sickness absence, individualised working requirements, and changes in working patterns due to changes in educational and rest requirements. These additional factors influencing the gaps in service coverage are not outlined in this report.

Where vacancies exist, the gaps in service coverage are mainly addressed by rewriting work schedules, redeployment of doctors to areas of greatest clinical need and the use of locums, mainly from the internal locum bank. In some areas we are seeing trainee shifts being covered by consultants, or shifts being left uncovered, and other members of the team picking up the extra work.

The main areas of persistent or recurrent concern for vacancies are:

- Haematology Oncology – due to an increase in the number of posts on the rota, but challenges in the recruitment of suitable candidates.
- Cardiothoracic anaesthesia – due to challenges in the recruitment of suitable candidates, a temporary pausing of the medical training initiative overseas recruitment path by Health Education England (HEE) North East (NE) (now resolved), and delays in the visa process.
- Paediatric surgery – due to the small number of doctors on the rota, any vacancy has a large impact on workload.
- Neonatal medicine – due to delays in overseas doctors recruited via the medical training initiative route being established in post.
- Paediatric oncology – due to the small number of doctors on the rota and locally employed doctors' contracts ending.

The Trust takes a proactive role in recruiting to vacancies where funding is identified. Delays from recruitment to the appointment of overseas candidates were experienced due to visa issues, being a recurrent theme. In addition, there has been an increase in candidates being appointed but not taking up their roles due to discrepancies in pay between the Locally Employed Doctor contract and the 2016 contract. Approval has just been given for alignment of the two contracts.

The current issues, obstacles, and actions taken to resolve the issues for these and other areas with high vacancies are outlined below.

2. INTRODUCTION / BACKGROUND

The 2016 New Junior Doctor Contract came into effect on 3rd August 2016. The terms and conditions of service of the new junior doctor contract (2016) require a consolidated annual

report on rota gaps, and the plan for improvement to reduce these gaps to be included in the Trust's Quality Account.

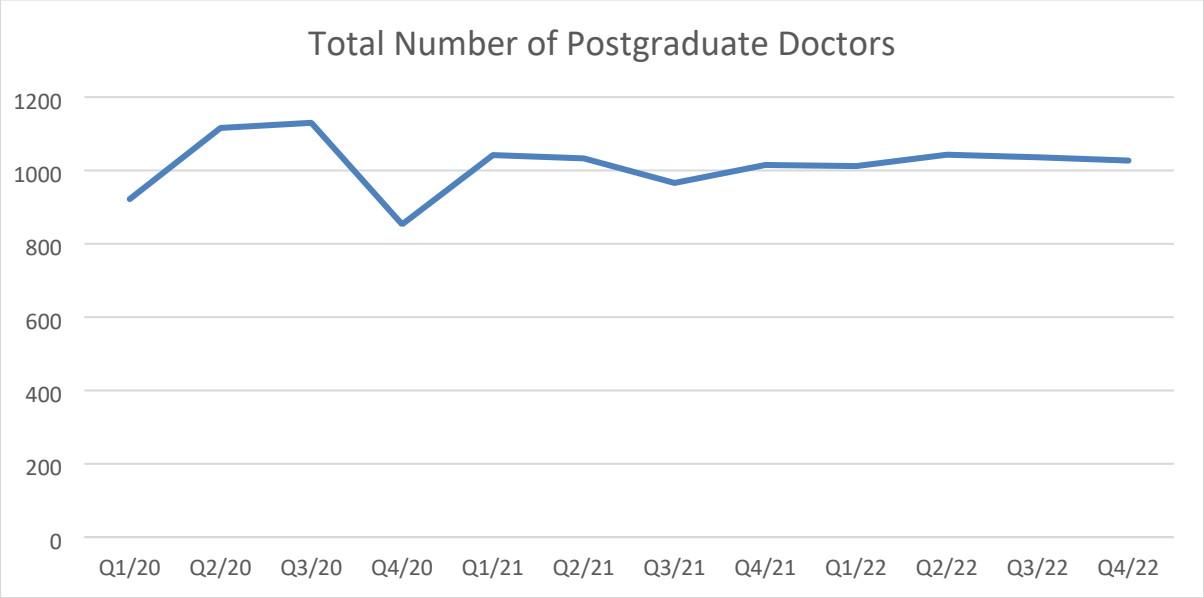
3. HIGH LEVEL DATA

Number of postgraduate doctors / dentists in training on 2016 TCS: 824

Number of postgraduate doctors on 2002 TCS: 203

Total number of postgraduate doctors / dentists: 1,027

3.1 Trend of Number of Postgraduate doctors by quarter:



This data shows a stable number of postgraduate doctors within the Trust.

4. ANNUAL VACANCIES DATA SUMMARY BY SPECIALTY AND GRADE PER QUARTER

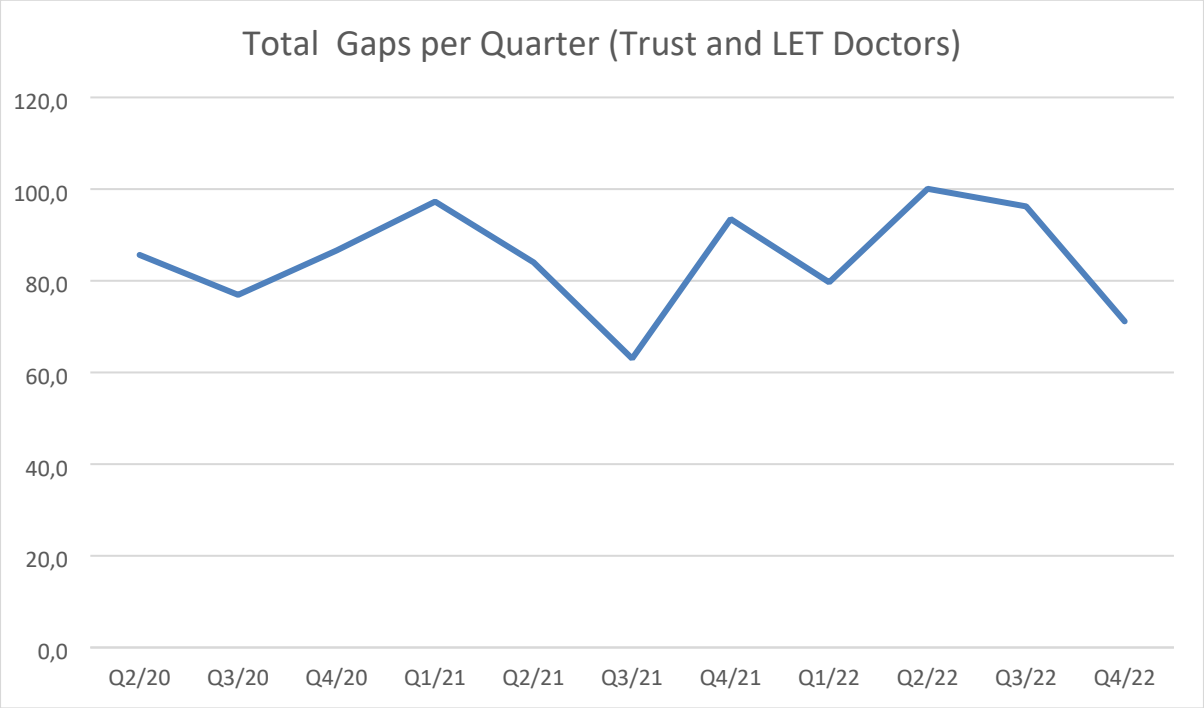
Site	Specialty/Sub Specialty	Grade	No required on rota (at full complement)	Q4	Q3	Q2	Q1
	Cancer Services						
FH	Oncology	ST3+	14	2	3.8	2.3	1.3
FH	Palliative Medicine	F2/ST1+	13	1.2	1.3	1.7	1.8
FH	Haematology / Oncology	F2/ST1/ST2	10	3	2.3	2	1.7
FH	Haematology / Oncology	CMT	3	0.9	0.5	0.3	0.3
FH	Haematology	ST3+	10	0.8	1.3	2	1.5
	Cardiothoracic Services			0			
FH	Cardiology	F2/ST1-2	5	0.7	0.2	1.2	1

Site	Specialty/Sub Specialty	Grade	No required on rota (at full complement)	Q4	Q3	Q2	Q1
FH	Cardiology	CMT	3 (from Dec 2022)	0.6	1	1	0
FH	Cardiothoracic Anaesthesia	ST3+	9	0	3	3.7	2
FH	Cardiothoracic Surgery	F2/ST1-2	2	0	0	0.7	1
FH	Cardiothoracic Surgery	ST3+	11	2	4	3	4
FH	Cardiothoracic Transplant	ST3+	3	1	1	1	1
FH	PICU	ST3+	8	0.2	2.4	0.7	0.2
FH	Paediatric Cardiology 1st	F2/ST1/ST2	7	1	1.3	1.3	1
FH	Paediatric Cardiology 2nd	ST3+	9	0.5	0.4	0.2	0
FH	Respiratory Medicine	CMT/ST1-2	6 (from Jan 2023)	0.6	1	1	0
FH	Respiratory Medicine	ST3+	11 (rotate with RVI)	0.5	1.1	0.7	0.2
	Children's Services			0			
RVI	Paediatric Surgery 2nd	ST3+	8	1.2	1.4	2.1	1.4
RVI	Paediatrics 1st - ST1/ST2 (now inc Paeds Surgery)	F2/ST1/ST2	25 (from Sept 2022)	2.1	2.7	2.4	2.4
RVI	General Paediatrics	ST3+	21	1.2	1.6	2	2.6
RVI	Paediatric Oncology	ST3+	6	2	3	2	0.7
RVI	Paediatric ICU (PICU)	ST3+	8	1	1.1	1.8	1.4
	Dental			0			
RVI	Maxillofacial Surgery	ST1/ST2	8	1	1	1.7	1.3
RVI	Dental Core Training	DCT	12	0	0	0.7	1
	EPOD			0			
FH	ENT	F2 / CST / ST1-2	5 (from Jan 2023)	0.9	1.1	0.7	0.2
FH	ENT	ST3+	9	0.4	0.4	1.1	0.4
RVI	Plastic Surgery	F2/ST1/ST2	8 (from Jan 2023)	0	0.3	1.7	0.7
RVI	Plastic Surgery	ST3+	13	0	0	0.3	1
RVI	Ophthalmology	F2/ST1/ST2	6	0.9	1.8	1.7	1.4
RVI	Ophthalmology	ST3+	25 (from Dec 2022)	2.7	1.9	1.1	0.9
RVI	Dermatology	F2	1	0	0	0	0
RVI	Dermatology	ST3+	7 (from Sept 2022)	1	0.7	0.9	0.7
RVI	Dermatology	CMT	2	0	1	1	2
RVI	Dermatology	GPSTR	1	0.4	0.4	0.4	0
	Integrated Lab Medicine			0			
RVI	Histopathology	ST3+	16 (from Jan 2023)	0.95	0.8	1.5	2.5
RVI	Forensic Histopathology	ST3+	2	2	2	2	2
RVI	Histopathology	ST1/2	8	1.6	2	2	0.6
C4L	Genetics	ST3+	4	1	0.8	0.4	0.4

Site	Specialty/Sub Specialty	Grade	No required on rota (at full complement)	Q4	Q3	Q2	Q1
RVI	Medical Microbiology rota integrated with Infectious diseases, virology and general internal medicine	ST1+	21	1	1	0.9	0.8
	Medicine			0			
FH	General Internal Medicine	F2/GPVTS/CMT/TF	21	2.6	2.2	1.3	2
RVI	CMT BOH and FOH Combined (August 2019)	CMT	11	1.1	1	1	1.7
RVI	CMT Acute- ACU (August 2019)	CMT	2	0	1	1.3	2
RVI	ACCS on Assessment Suite Only	ACCS	2	0	0	0.1	0.2
RVI	General Internal Medicine	ST3+	25	2	2.9	2.9	3.1
FH	Care of the Elderly	ST3+	5	0.7	1.2	0.9	0.2
RVI	Accident & Emergency 1st	ACCS/ST1-2/CT1-2	20	2.6	4	4.5	2.2
RVI	Accident & Emergency 2nd	ST3+	15	1.45	2.3	4.2	4.8
	Musculoskeletal			0			
FH	Rheumatology	ST3+	5	0	0.1	1.7	1.4
FH	Rheumatology	CMT1-2	4	1	1	1.3	2
FH	Orthopaedics	F2/ST1/ST2	6	0	0.7	1	0
RVI	Orthopaedics	F2/ST1/ST2	5	1	0.3	0.3	0.3
RVI/FRH	Orthopaedics	ST3+	19	1.6	1.3	0.9	0
	Neurosciences			0			
RVI	Neurosurgery	F2/ST1/ST2	5	0.5	0.7	0.7	0
RVI	Neurosurgery	ST3+	13	0	1	0.7	0.4
RVI	Neurology	ST3+	13	1.1	1.1	1.6	0.2
RVI	Neurology	F2/ST1/ST2	2	0	0	0.1	0.2
RVI	Neurology	IMT/CMT	3	0.5	1	0	0
RVI	Neurophysiology	All grades	3	0	0	0.2	0
	Peri-operative FH			0			
FH	Critical Care	F2 ST1-7	11	1.2	1.6	2.5	1.2
FH	Anaesthetics General	ST1-7 CT1-2	29	2.2	2	1.9	1.8
	Peri-operative RVI			0	0		
RVI	Critical Care	ST1+	14 (from Aug 2022)	1.7	1.9	1.8	3.7
RVI	Anaesthetics	ST1-2 / ST3 +	40 (from Aug 2022)	2.4	2.5	3.4	3.1
	Radiology			0			
RVI / FH	Radiology On Call	ST2 / ST3+	33	1	1.3	1.4	1.2
RVI / FH	Neuroradiology	All grades	4	0.2	0.2	0.7	0.9
	Surgical Services			0			
FH	General Surgery	F2/ST1/ST2/ST3+	7	1.1	2.1	1.7	1
FH	Vascular	ST3+	10	1	2	1.3	0.3
RVI	General Surgery	F2/ST1/ST2	7	0.4	1	0.7	0.7
RVI	General Surgery	ST3+	17	2.1	3.3	2.6	1.5

Site	Specialty/Sub Specialty	Grade	No required on rota (at full complement)	Q4	Q3	Q2	Q1
FH	IoT - NSR & Teaching Fellows	ST1-2 NSR TFs	4	1	1	0.7	0
	Urology & Renal			0			
FH	Renal Medicine	F2/ST1/ST2	5	0.5	0.7	0.3	0.7
FH	Renal Medicine	ST3+	7 (from Aug 2022)	0.4	0.4	0.6	1
FH	Urology	F2/ST1/ST2	7	0	0.1	0.1	0.4
	Women's Services			0			
RVI	Obstetrics & Gynaecology	F2/ST1/ST2	14	1	0	0.3	0
RVI	Obstetrics & Gynaecology	ST3+	22	1.5	2	1.3	0.3
RVI	Neonates	F2/ST1/ST2	7	0.2	0.4	1.4	0
RVI	Neonates	ST3+	13	0.8	2.1	1.4	0

4.1 Trends in rota gaps



5. ISSUES ARISING

The purpose of this report is to highlight any current issues or concerns, including the reasons for the gaps, obstacles in resolving this and actions taken to resolve the issues.

Key:
LED = Locally Employed Doctor
LET = Lead Employer Trust
ACCP = Advanced Critical Care Practitioner

MTI = Medical Training Initiative – a UK scheme allowing a fixed number of international graduates to work and train within NHS for a maximum of 24 months
LTFT = Less Than Full Time

Site	Specialty/Sub Specialty	Reason for Gap	Obstacles to Recruitment	Actions taken to overcome obstacles
	Cancer Services			
FH	Oncology	Extra training posts created	Lack of LET doctors to fill gaps	Accommodating workload within workforce
FH	Haematology/ Oncology	Extra posts created	Short lead time for recruitment	Jobs readvertised with longer lead time to recruit
	Cardiothoracic Services			
FH	Cardiothoracic anaesthesia	LEDs not recruited	Challenges to MTI recruitment and visa issues. MTI route temporarily paused by HEE NE	Pause by HEE NE overcome by agreement to take a further anaesthesia training post. Trust looking to become an MTI sponsor to avoid future pauses by HEE NE
FH	Cardiothoracic surgery/ transplant	Postgraduate trainees removed by LET	Overseas candidates – visa issues	Use of Agency locum
FH	Paediatric Cardiology	LEDs leaving	Overseas candidates – visa issues Candidates withdrawing after offer of posts	
	Children's Services			
RVI	Paediatric Surgery	LTFT doctors in full time slots, extra post created but not recruited to. Small number of gaps have large impact on workload	Late recruitment	Creation of further post by recycling of training gap funding
RVI	Paediatrics	LTFT doctors in full time slots		Temporary posts created to fill gaps
RVI	Paediatric Oncology	Small Rota – LED contracts expired		Further recruitment
RVI	PICU	Unknown		Accommodating workload within workforce
	Plastic Surgery &			

Site	Specialty/Sub Specialty	Reason for Gap	Obstacles to Recruitment	Actions taken to overcome obstacles
	Ophthalmology			
RVI	Ophthalmology	LEDs leaving (contract expired) /Natural turnover	High numbers required	LED posts advertised
	Laboratory Medicine			
RVI	Histopathology/ Forensic Histopathology	Unknown	Unable to recruit suitable candidates	LED posts advertised
RVI	Genetics	Unknown		Accommodating workload within current workforce
	General Internal Medicine			
RVI /FH	General Internal Medicine/Care of the Elderly	LEDs leaving, LET gaps, GP training gaps		Teaching fellows, working with available workforce to cover workload, locums and 'as and when' contracts for doctors
	Accident & Emergency			
RVI	Accident & Emergency	New jobs approved, not yet recruited, LET gaps, natural turnover		Further Trust Grade and fellow posts advertised. Plan for recruitment of Advanced Care Practitioners
	Musculoskeletal			
FH	Orthopaedics	LEDs leaving prior to end of contract	High drop out in recruitment and after commencing job	'Rebadging' of posts to general surgery, with same out of hours commitment
	Perioperative			
RVI	Critical Care	LEDs leaving		LEDs recruited. Accommodating workload within current workforce. Use of internal locums
RVI	Anaesthetics	LTFT and LET gaps		Use of internal locums
FH	Critical Care	LEDs leaving		LEDs recruited. Accommodating workload within current workforce. Use of internal locums
FH	Anaesthetics	LTFT and LET gaps		Use of internal locums

Site	Specialty/Sub Specialty	Reason for Gap	Obstacles to Recruitment	Actions taken to overcome obstacles
	Surgical Services			
FH	General Surgery	Unknown		Accommodating workload within current workforce
FH	IoT - NSR & Teaching Fellows	Unknown		Accommodating workload within current workforce
FH	Vascular	LEDs leaving		Overseas fellow appointed
RVI	General Surgery	LET and LEDs leaving		Teaching fellows, Specialty fellows and Newcastle surgical rotation appointments
	Women's Services			
RVI	Obstetrics & Gynaecology	LTFT in full time slots		Accommodating workload within current workforce
	Neonates	LTFT in full time slots	Overseas candidates – delays in recruitment via the MTI route	

Personal communication with the recruitment team suggests that the main barriers to recruitment are issues with visas for overseas doctors and the fact that locally employed doctors are employed on the 2002 contract. This has different pay scales and often results in a significant pay drop. I cannot comment on whether this acts as a deterrent to application, but there have been several examples where candidates have been appointed but have withdrawn after they have realised this.

Although this does not always result in a gap in the rota, as other candidates have been appointed, on some occasions it has been a barrier to recruitment of high calibre candidates.

5.1 Actions taken to resolve these issues

The Trust takes a proactive role in the management of vacancies through the work of the Junior Doctor Recruitment and Education Group (JDREG). Members of this group include the Director of Medical Education, Finance Team representative and Medical Staffing personnel.

In addition to recruitment to postgraduate doctor posts, the Trust runs several successful Trust based training fellowships and a teaching fellow programme to fill anticipated gaps in the rota. These are 12-month posts aimed to maintain doctors in post and avoid the problem of staff retention.

A proposal to align the Locally Employed Doctor contract with the 2016 TCS has recently been approved. Plans to implement this are currently being worked out.

Other actions to resolve the issues are rewriting work schedules to reflect the number of available doctors, employing physician associates and advanced care practitioners to assist with junior doctor workload, redeployment of doctors to areas of clinical need, and the use of locums.

5.2 Locum Spend 01.04.22 – 31.03.23

Lead Employer Trust:	£2,063,973
NUTH:	£2,925,476
Total:	£4,989,449

Locum Spend 01.04.21 – 31.03.22

Lead Employer Trust:	£1,572,158
NUTH:	£2,605,543
Total:	£4,177,701

Additional information from the finance department regarding breakdown of locum spend is supplied in the appendix.

6. SUMMARY

Vacancies are present on a number of rotas. This is due to both gaps in the regional training rotations, partial gaps created by less than full time doctors in a full-time training slot, and lack of recruitment of suitable locally employed doctors.

Overseas recruitment often results in a delay between recruitment and appointment due to delays in the medical training initiative process and delays in issuing visas.

Locally Employed Doctor recruitment is also impacted by discrepancies of pay between the LED contract and the training contract. Plans to resolve this are in progress.

The Trust takes a proactive approach to minimising the impact of vacancies by active recruitment, with a clear focus on staff retention to attract the best candidates, use of advanced nurse practitioners and physician associates, and by rewriting work schedules to ensure that key areas are covered.

Gaps on actual working rotas are also impacted by short term sickness and changes in working patterns. These gaps are not highlighted in this report.

Locum use is high in many areas, and many directorates reported consultants covering junior doctor shifts, and shifts going uncovered.

7. RECOMMENDATIONS

The Board is asked to (i) note the content of this report for inclusion in the Trust's Annual Quality Account; (ii) to encourage pro-active recruitment of doctors to reduce vacancies and to continue to consider the impact of changes to working patterns on the workforce workload balance.

Report of Henrietta Dawson
Consultant Anaesthetist
Trust Guardian of Safe Working Hours
6 June 2023

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	27 July 2023						
Title	Guardian of Safe Working Quarterly Report (Q4 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 from 27 December 2022 to 26 March 2023 for consideration by the Trust People Committee, prior to submission to 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
	☒	☐	☐	☒	☐	☐	☐
Link to Board Assurance Framework [BAF]	No direct link. In order to maintain quality and safety, we must have a junior doctor workforce who can work within safe hours and receive excellent training.						
Reports previously considered by	Quarterly report of the Guardian of Safe Working Hours.						

GUARDIAN OF SAFE WORKING QUARTERLY REPORT

1. EXECUTIVE SUMMARY

This quarterly report covers the period from 27 December 2022 to 26 March 2023.

There are now 824 postgraduate doctors in training on the New Junior Doctor Contract and a total of 1,027 postgraduate doctors in the Trust.

There were 148 exception reports in this period. This compares to 124 exception reports in the previous quarter.

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

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	824	(836)
Total Number of Junior Doctors	1,027	(1,036)
Number of Exception reports	148	(124)
Number of Exception reports for Hours Breaches	142	(122)
Number of Exception reports for Educational Breaches	15	(7)
Fines	16	(2)
Admin Support for Role	Good	
Job Planned time for supervisors	Variable	

4. EXCEPTION REPORTS

4.1 Exception Report by Speciality (Top 3)

		(Previous quarter for comparison)
General Surgery	73	(56)
General Medicine	26	(42)
Paediatric Surgery	21	(0)

4.2 Exception Report by Rota/Grade

General Surgery		
FH (F1)		72
FH (ST3+)		1
General Medicine		
FH		
F1	Older person's medicine	15
CT/F2	Older person's medicine	2
RVI		
F1	Back of House	9
Paediatric Surgery ST3+		21

4.3 Example Themes from Exception Reports

General Surgery FH

"2 F1s covering general surgery; minimum staffing of 5. Multiple complicated patients."

The high workload and staffing issues within general surgery F1 at Freeman are well known and have been escalated to the Executive Team. There are plans for an additional F1 from August 2023 for a 2-year period.

General Medicine RVI/FH

"Less than minimum staffing in the morning (8:30-1300) - only 2 doctors. Less than minimum staffing in the afternoon (1300-1630) - only 1 doctor. Discussion with the rota coordinator to get an extra member of staff to cover the ward which was unsuccessful."

Paediatric Surgery RVI

"24 Hour NROC (non-resident on call). Shift started 8am 16/02/23. Became non-resident at 4.45am on 17/02/2023. This was due to multiple patients to review in A&E; on the wards

and theatre cases; including a theatre case which finished in the early hours followed by patients on the ward to review following this. I then attended handover; virtually; in the morning for approximately 30 minutes (including telephone handover with SHO prior)."

The high workload and imbalance of workforce/workload in this department has recently been highlighted through exception reports. Solutions are being explored by the department, with support from Medical Staffing and myself.

5. EXCEPTION REPORT OUTCOMES

5.1 Work Schedule Reviews

A work schedule review is currently being undertaken for paediatric surgery.

5.2 Fines

15 fines are being calculated for paediatric surgery: Total fine £6,916.73 (1 fine still to be calculated.)
Rule breached: "Unable to achieve minimum overnight continuous rest of five hours between 22:00 and 07:00 during a non-resident on-call (NROC)."

1 fine for ophthalmology: £24.18
Rule breached: "Unable to achieve minimum overnight continuous rest of five hours between 22:00 and 07:00 during a non-resident on-call (NROC)."

6. ISSUES ARISING

6.1 Workforce and workload

The recurring theme as to when exception reports are raised is when there is a reduction of doctor numbers on the ward or high workloads. As in previous reports, exception reports often mention staffing levels on the wards below the minimum prescribed staffing levels.

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

These are covered in the Annual Report.

7.1 Locum Spend

Lead Employer Trust (LET) Locum Spend

January to March (Q4 2022-23)	£566,045
October to December (Q3 2022-23)	£367,761
July to September (Q2 2022-23)	£683,260

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. The increase of £198k from Q3 to Q4 was as a result of Internal Medicine increasing by £95k , Women's by £90k, Cardiothoracic by 35k and Peri-Op by £27k offset by a £53k reduction in Children and £26k reduction in Dental."

Trust Locum Spend

January to March (Q4 2022-23)	£1,122,608
October to December (Q3 2022-23)	£646,204
July to September (Q2 2022-23)	£673,665

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. Junior Doctor industrial action was briefly discussed.

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

10 May 2023

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	27 July 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
	☐	☐	☐	☒	☐	☐	☐
Link to Board Assurance Framework [BAF]	Strategic Risk SO2.2 [Staffing]						
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 16 May 2023 and interviewed 1 candidate for 1 Consultant in Emergency Medicine post.

By unanimous resolution, the Committee was in favour of appointing Dr Annie Lumb.

Dr Lumb holds MBBS (University of Newcastle) 2014, and FRCEM (UK) 2023. Dr Lumb is currently employed as a Specialty Trainee in Emergency Medicine on behalf of the Lead Employer Trust, at the Royal Victoria Infirmary.

Dr Lumb is expected to take up the post of Consultant in Emergency Medicine in October 2023.

1.2 An Appointments Committee was held on 19 May 2023 and interviewed 3 candidates for 1 Consultant Urologist (Laparoscopic/Robotic Renal Surgery) post.

By unanimous resolution, the Committee was in favour of appointing Mr Anthony Emmanuel.

Mr Emmanuel holds MBBS (University of London) 2011, MD (University of London) 2017, MRCS (England) 2017, and FRCS (England) 2022. Mr Emmanuel is currently employed as Specialty Trainee in Urology on behalf of the Lead Employer Trust, at the Freeman Hospital.

Mr Emmanuel is expected to take up the post of Consultant Urologist (Laparoscopic/Robotic Renal Surgery) post in September 2024.

1.3 An Appointments Committee was held on 19 May 2023 and interviewed 3 candidates for 1 Consultant Urologist (Pelvic Robotic Surgery) post.

By unanimous resolution, the Committee was in favour of appointing Mr Nnaemeka Eli.

Mr Eli holds MBBS (University of Nigeria Nsukka) 2008, MRCS (Edinburgh) 2016, and FRCS (Edinburgh) 2021. Mr Eli is currently employed as a Post CCT Robotic Fellow at the Freeman Hospital.

Mr Eli is expected to take up the post of Consultant Urologist (Pelvic Robotic Surgery) in October 2023.

1.4 An Appointments Committee was held on 14 June 2023 and interviewed 3 candidates for 3 Consultant Ophthalmologist posts.

By unanimous resolution, the Committee was in favour of appointing Miss Joanna DaCosta, Mr Hani Hasan, and Mr Salman Sadiq.

Miss DaCosta holds MBBS (University of London) 1999, MSc (University of Manchester) 2005, MRCOhth (UK) 2006, and FRCOphth (UK) 2012. Miss DaCosta is currently employed as a Fellow in Ophthalmology at Liverpool University Hospitals NHS Foundation Trust.

Miss DaCosta is expected to take up the post of Consultant Ophthalmologist post in September 2023.

Mr Hasan holds MBBS (University of Khartoum) 2010, FRCOphth (UK) 2018, and ChM (University of Edinburgh) 2019. Mr Hasan is currently employed as a Locum Consultant Ophthalmologist at Great Western Hospitals NHS Foundation Trust.

Mr Hasan is expected to take up the post of Consultant Ophthalmologist in September 2023.

Mr Sadiq holds MBBS (University of Health Sciences Lahore, Pakistan) 2012, and FRCOphth (UK) 2021. Mr Sadiq is currently employed as a Specialty Trainee in Ophthalmology on behalf of the Lead Employer Trust, at Sunderland Royal Hospital.

Mr Sadiq is expected to take up the post of Consultant Ophthalmologist in February 2024.

1.5 An Appointments Committee was held on 5 July 2023 and interviewed 2 candidates for 1 Consultant in Infectious Diseases post.

By unanimous resolution, the Committee was in favour of appointing Dr Bhahimi Puvaneswaran.

Dr Puvaneswaran holds MBBS (University of London) 2009, MRCP (UK) 2014, and FRCPath (UK) 2021. Dr Puvaneswaran was most recently employed as a Specialty Trainee in Infectious Diseases and Medical Microbiology on behalf of the Lead Employer Trust, at Royal Victoria Infirmary.

Dr Puvaneswaran is expected to take up the post of Consultant in Infectious Diseases in October 2023.

1.6 An Appointments Committee was held on 7 July 2023 and interviewed 1 candidate for 1 Consultant Rheumatologist post.

By unanimous resolution, the Committee was in favour of appointing Dr Fiona Rayner.

Dr Rayner holds MBBS (University of Newcastle) 2008, MRCP (UK) 2011, and PhD (University of Newcastle) 2023. Dr Rayner is currently employed as a Specialty Trainee in Rheumatology on behalf of the Lead Employer Trust, at South Tyneside and Sunderland NHS Foundation Trust.

Dr Rayner is expected to take up the post of Consultant Rheumatologist in November 2023.

1.7 An Appointments Committee was held on 10 July 2023 and interviewed 1 candidate for 1 Consultant in Diabetes and Endocrinology post.

By unanimous resolution, the Committee was in favour of appointing Dr Owain Leng.

Dr Leng holds MBChB (University of Glasgow) 2010, MRCP (UK) 2013, and FRCP (UK) 2021. Dr Leng is currently employed as a Consultant Physician (Diabetes and Endocrinology) at Northumbria Healthcare NHS Foundation Trust.

Dr Leng is expected to take up the post of Consultant in Diabetes and Endocrinology post in December 2023.

2. RECOMMENDATION

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

Report of Andy Welch
Medical Director
27 July 2023

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	27 July 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 the Safety Assessment Ward Compliance dashboard • Freedom to Speak Up (F2SU) • Nursing and Midwifery Safer Staffing • Professional Nurse Advocate • Newcastle Improvement (NI)						
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 standardfocusing on safety and quality. • We will be an effective partner, developing and delivering integrated care and playing ourpart 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
	☒	☒	☒	☐	☒	☐	☐
Link to Board Assurance Framework [BAF]	Strategic Objective One Putting patients at the heart of everything we do. Providing care of the highest standard focussing on safety and quality. Strategic Risk Description i) SO1.1 [Capacity and Demand] ii) SO1.4 [NHS core standards - patient safety and quality of care]						
Reports previously considered by	The ECN Update is a regular comprehensive report bringing together a range of issues to theTrust 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: Safety Assessment Ward Compliance Dashboard

This month's 'Spotlight' section provides an overview of the work to develop a near 'real time' Ward Compliance Safety Assessment dashboard.

Assessing patients' needs and ensuring their care is individualised and personalised is fundamental to high quality care and professional nursing practice. One of the ways this is achieved is by ensuring on admission to hospital and regularly throughout an in-patient stay, safety assessments are completed, and appropriate actions put into place to minimise risk and optimise individualised care.

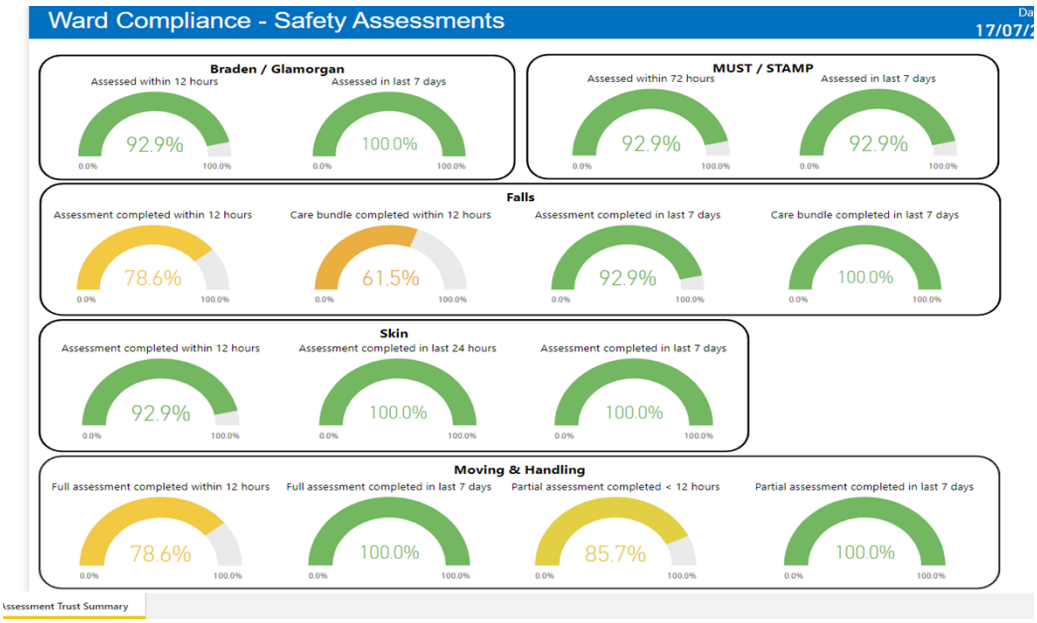
Current compliance and assurance frameworks such as the Clinical Assurance Toolkit (CAT) are already well established and actively used to measure and monitor nurse sensitive indicators. However, the development of the electronic patient record (EPR) provides a significant opportunity to enhance this work further providing data in real time for ward to board assurance. The ECN and senior nursing team are keen to take advantage of the opportunity that the EPR provides to enhance patient experience and improve outcomes for care.

The Chief Nursing Information Officer (CNIO) has led the Digital Health Team, in collaboration with colleagues from Information Management and Technology (IM&T) to develop a dashboard which captures safety assessment compliance across a range of areas in near real time to help improve compliance and assurance but most importantly to ensure safe and high quality care. Work has focused intially on building a platform which will display compliance over a number of key risk assessments such as:

- Nutrition and hydration
- Skin assessment
- Falls risk assessment
- Moving and handling risk assessment

After building, testing and receiving feedback from key stakeholders, the Ward Compliance Safety Assessment Dashboard was launched on the 5 June 2023. The dashboard is accessed via the intranet reporting hub, with the data refreshed four times per day.

The picture below is a screenshot of the landing page for the dashboard and shows which areas of compliance are measured. This can then be broken down by ward and matron portfolio and also drill down to invididual patient data, outlining where an assessment is required.



Over the first month of the dashboard being live there has been an improvement in compliance in all domains from day one. As this is a dynamic dashboard which changes four times per day, percentage compliance will change multiple times per day. Early learning recognises it will not be possible to ensure 100% compliance across all domains and the timing of assessments, depending upon route of admission, play a factor in compliance particularly for assessments within the first twenty-four hours. We are already working on how we can set realistic but ambitious targets for compliance and best practice based on this very early work.

This is just the first iteration of the dashboard and further work is planned to include compliance with other clinical checks or assessments such as intravenous line, catheter and drain checks. These will be developed over this year and included once appropriate testing has been completed.

What is exciting to see, is how the EPR can be utilised to improve care and inform professional practice in real time and not just be utilised to provide data for retrospective audit where the opportunity to improve for that patient may have been missed.

Further updates to the Trust Board on this work will be provided in future reports.

Section 2: Freedom Two Speak Up (FTSU)

Section two provides a high-level overview of the work of the FTSU service within the Trust.

The FTSU service continues to receive an increasing number of contacts from staff as a result of the active promotional work, consistency of message regarding speaking up generally and, essentially, the increased number of staff-to-staff recommendations. Between June 2022 and March 2023, the Freedom to Speak Up Guardian (FTSUG) has managed 73 cases which required intervention beyond advice and support being given to the complainant. The increasing level of activity, and the greater number of concerns being raised with a degree of seriousness which required significant intervention, reflects the growing credibility of the service and the >200% service growth over the last 3 years.

The vast majority of concerns raised continue to relate to interpersonal relationships, particularly between line managers (or Human Resources (HR)) and staff. These do not necessarily equate to bullying allegations but perceptions of mismanagement, ineffective or unfair HR processes or inequity.

Staff satisfaction with the service they receive remains consistently high with excellent responses in feedback questionnaires. All staff who accessed the service were given the opportunity to feedback via a questionnaire; of those who responded, 100% said that they would recommend the service to a colleague and 100% rated it as 5 out of 5.

A comprehensive update was provided to the People Committee in April 2023 (included within the Public Board Reference Pack for information).

Section 3: Nursing and Midwifery Safer Staffing

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

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

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:

- Four wards in total have required high-level support over the last three months. All wards have action plans in place, overseen by the Nurse Staffing and Clinical Outcomes Group and by the ECN Team. An overview of these wards including current nurse sensitive indicators, as well as current performance and actions in place, have been discussed and presented to the Trust's Quality Committee.
- Where beds have been closed due to staffing concerns, a weekly documented review with the ECN 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 and are reported daily into the ECN Team. In the last three months, 535 red flags have been generated across the Trust. The highest numbers are from across Medical Wards (n=151), Cardiothoracic Wards (n=110) and Childrens Wards (n=105).
- All staffing related DATIX reports have been reviewed and were graded no harm, low/minor or moderate. In the last quarter the number of DATIX had substantially reduced from the previous quarter where there was an average of 20 per month. The last three months are noted below.
    - March: 10
    - April: 8
    - May: 13

Recruitment and Retention remain a priority workstream and the report provides an update on the current pipeline of Registered Nurses and Healthcare Support Workers (HCSWs). International Recruitment (IR) remains an important focus and an overview of progress with the current and future IR pipeline is included in the report.

The following key points are contained within the report:

- The current total Registered Nursing (RN) and Midwifery workforce combined turnover is 9.61%. This is based on Month 2 data and demonstrates a reduction from 11.18% previously reported. Its compares favourably with the national median of 12.45% and improving the retention figure remains a key priority.
- The Band 5 RN vacancy rate is 4.66% based on the financial ledger at Month 2 and relates to current substantive staff in post. This is a favourable position when compared to the 2022 Month 2 vacancy rate of 8.4%. It does not include those nurses currently in the recruitment process, where there is a pipeline of 133 (head count and not including international recruitment) staff across adult and paediatrics.
- The Trust had an ambitious plan supported with NHS England (NHSE) funding through international recruitment for the deployment of 300 nurses and 5 midwives for 2022/23 and have successfully completed this recruitment plan.
- Additional NHSE funding has been made available for 2023/24 with a bid that has been secured for a further 150 nurses to be deployed by the end of November 2023.
- The Trust have also agreed to 'go further' to recruit an additional 74 nurses to be deployed by the end of March 2024 bringing the additional total of international recruits to 224 nurses.
- The large-scale HCSW community event based at the Beacon Centre in the west of the city funded by the NHSE 'Widening Access Transformational project' has taken place in May 2023. The aim of the event was to test innovative recruitment solutions and work with community partners to recruit a representative workforce which impacts health inequalities. The day saw an unprecedented response from the community with 1,000 people attending. 294 candidates were interviewed on the day and more than 700 people who we were unable to see on the day left their details via a QR code. The first follow up interviews will be held at the Beacon Centre in July 2023.

Whilst there is a 'lead in' time for all new recruits, this combined with domestic recruitment will place the Trust in a strong position ahead of the forthcoming winter.

Section 4: Professional Nurse Advocate

Section four provides an update on the development and deployment of the Professional Nurse Advocate (PNA) model since the last update provided to the Trust Board in July 2022.

The Professional Nurse Advocate (PNA) model was launched in 2021 by the Chief Nursing Officer for England. The specific remit of the PNA model is to facilitate restorative clinical supervision to colleagues and teams in nursing and beyond. The training equips the PNA to listen and to understand the challenges and demands of colleagues and to lead, support and deliver quality improvement initiatives in response which will encourage the development of a supportive and nurturing working environment.

The Trust currently has 43 qualified PNAs with a number in training. There is also a significant number of Trust staff wanting to complete the 20-credit level 7 academic module and are awaiting a place. If successful, this would take the total number of trained PNAs to 83. Whilst this is encouraging this is still significantly below the national aspiration of ensuring there is a PNA to nurse ratio of 1:20 which would require in the region of 250 PNA within the Trust.

At present, the entry point to the PNA programme is through regional teams and managed centrally which is impacting on progress. This process is under review.

The Trust is contractually obliged to report PNA activity monthly via the Provider Workforce Report (PWR). This report shows an overall increase in activity over the last year as the number of PNAs increases. It has been encouraging to see through the data that there has been substantial increase in the provision of restorative clinical supervision and career conversations, with approximately 60 of each being offered monthly by Trust PNAs.

To support and expand this work further, the Associate Director of Nursing/PNA Lead has been working with local Higher Education Institutions to develop an accreditation agreement, which could see a co-delivered programme in collaboration with University of Sunderland and Northumbria Healthcare NHS Foundation Trust. It is anticipated this will provide better access to a PNA programmes and can support the programme with a co-delivered curriculum, which can draw upon existing Trust teams.

The Trust is also developing a PNA webpage to support nurses interested in becoming or accessing PNA services and to support existing PNAs with resources to support the wider dissemination of the role.

Section 5: Newcastle Improvement

Section five of the report provides an overview of the work of Newcastle Improvement (NI).

NI continue to support the Trust aim to embed a culture of continuous quality improvement (QI) across Newcastle Hospitals by 2025.

From a capability and capacity perspective, NI are building resilience and financial sustainability through the in-house delivery of cohort three of Improvement for Teams (ITP) and Improvement Coach (ICP) programmes. These programmes were formerly delivered by our strategic partners, the Institute for Healthcare Improvement (IHI) and are designed to equip individuals and teams with the skills, knowledge, experience, and confidence to lead improvement initiatives in their own area of work and to support others in developing improvement initiatives.

NI have further been delivering training to a range of colleagues from across the Trust through QI essentials, enhanced induction, preceptorship, and Leo programmes as well as refining a QI workbook to support individuals working on improvement initiatives.

NI, through Newcastle Change Programme, have been working to align the complementary skills of NI and the Trust's Programme Management Office (PMO) to support priority transformational programmes. NI improvement facilitators are more frequently working

with ICP-graduated coaches to support teams to deliver small-scale improvement initiatives, whilst increasing the confidence of ICP-graduated coaches to be self-sufficient in supporting other teams.

Through the remainder of 2023/24, NI will develop links with the Clinical Boards through the NI partner role, aimed at offering improvement expertise, providing strategic support for defining improvement priorities and aligning QI work with Patient Safety and Quality Assurance. Work will continue to embed environmental sustainability metrics into QI projects and there will be an increased focus on patient engagement across all supported initiatives.

RECOMMENDATION

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

Report of Maurya Cushlow
Executive Chief Nurse
27 July 2023

EXECUTIVE CHIEF NURSE REPORT

1. SPOTLIGHT – SAFETY ASSESSMENT WARD COMPLIANCE DASHBOARD

Assessing patients' needs and ensuring their care is individualised and personalised is fundamental to high quality care and professional nursing practice. One of the ways this is achieved is by ensuring on admission to hospital and regularly throughout an in-patient stay, safety assessments are completed, and appropriate actions put into place to minimise risk and optimise individualised care.

Current compliance and assurance frameworks such as the CAT are already well established and actively used to measure and monitor nurse sensitive indicators. However, the development of the EPR provides a significant opportunity to enhance this work further providing data in real time for ward to board assurance. The ECN and senior nursing team are keen to take advantage of the opportunity that the EPR provides to enhance patient experience improve outcomes for care.

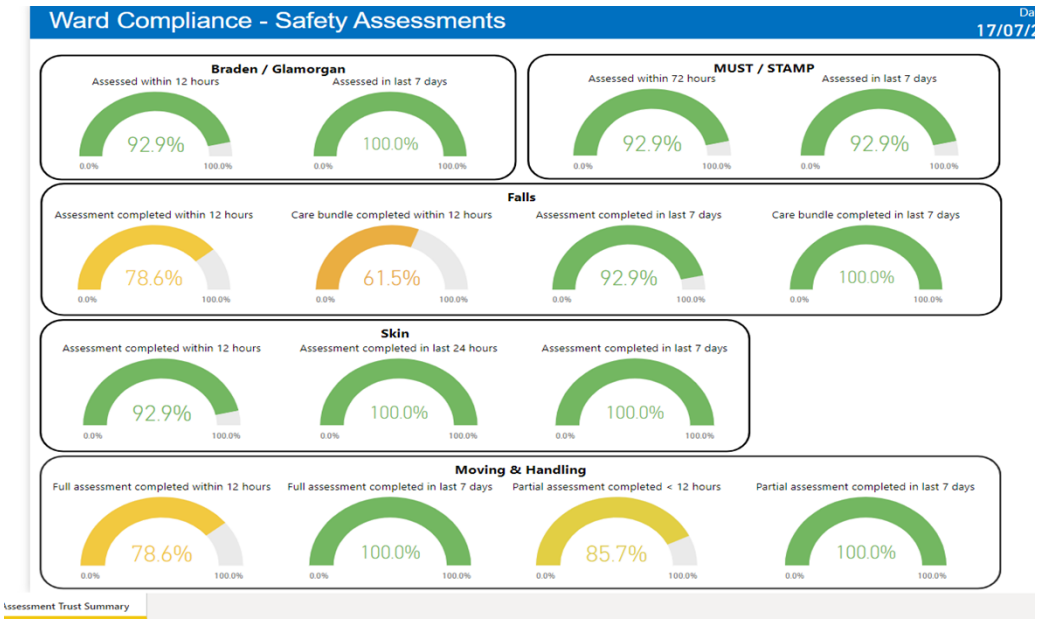
1.1 Progress and implementaion

The CNIO has led the Digital Health Team, in collaboration with colleagues from IM&T to develop a dashboard which captures safety assessment compliance across a range of areas in near real time to help improve compliance and assurance but most importantly to ensure safe and high quality care. Work has focused intially on building a platform which will display compliance over a number of key risk assessments such as:

- Nutrition and hydration
- Skin assessment
- Falls risk assessment
- Moving and handling risk assessment

The aim was to display this information in an easy format which front line staff would find useful and valauble but also ensure that data could be provided at a Trust, Matron, Ward and individual patient basis. After building, testing and feedback from key stakeholders, the Ward Complianece Safety Assessment dashbaord was launched on the 5 June 2023. The dashboard is accessed via the intranet reporting hub, with the data refreshed four times per day.

The picture below is a screenshot of the landing page for the dashboard and shows which areas of compliance are measured. This can then be broken down by ward and matron portfolio and when the compliance percentage is clicked, this can be drilled down to invididual patient data, outlining where an assessment is required.



1.2 Compliance improvement

Feedback from front line leaders and Matrons has been extremely positive. Staff have shared with the digital health teams where changes need to be made or where there are concerns regarding data accuracy and these have been addressed. It has also provided an opportunity for staff to gain a deeper understanding of the safety assessments in practice. It is important that we foster this discussion, learning and education as we must guard against this becoming a 'tick box' exercise but ensure it supports high quality professional decision making in practice leading to the delivery of high-quality personalised care.

Over the first month of the dashboard being live there has been an improvement in compliance in all domains from day one. As this is a dynamic dashboard which changes four times per day, percentage compliance will change multiple times per day. Early learning recognises it will not be possible to ensure 100% compliance across all domains and the timing of assessments, depending upon route of admission, play a factor in compliance particularly for assessments within the first twenty-four hours. We are already working on how we can set realistic but ambitious targets for compliance and best practice based on this very early work.

The senior nursing team along with the digital health team will be reviewing three months' worth of data and using this, alongside feedback from front line staff and clinical leaders to agree a process of monitoring and audit moving forward and what our thresholds of compliance should be. In the interim, our CAT remains in place for additional audit and assurance.

1.3 Next Steps

This is just the first iteration of the dashboard and further work is planned to include compliance with other clinical checks or assessments such as intravenous line, catheter and drain checks. These will be developed over this year and included once appropriate testing has been completed.

What is exciting to see, is how the EPR can be utilised to improve care and inform professional practice in real time and not just be utilised to provide data for retrospective audit where the opportunity to improve for that patient may have been missed.

2. FREEDOM TO SPEAK UP (FTSU)

The FTSU service continues to receive an increasing number of contacts from staff as a result of the active promotional work, consistency of message regarding speaking up generally and, essentially, the increased number of staff-to-staff recommendations. Between June 2022 and March 2023, the FTSUG has managed 73 cases which required intervention beyond advice and support being given to the complainant. The increasing level of activity, and the greater number of concerns being raised with a degree of seriousness which required significant intervention, reflects the growing credibility of the service and the >200% service growth over the last 3 years.

The vast majority of concerns raised continue to relate to interpersonal relationships, particularly between line managers (or HR) and staff. These do not necessarily equate to bullying allegations but perceptions of mismanagement, ineffective or unfair HR processes or inequity.

Staff satisfaction with the service they receive remains consistently high with excellent responses in feedback questionnaires. All staff who accessed the service were given the opportunity to feedback via a questionnaire; of those who responded, 100% said that they would recommend the service to a colleague and 100% rated it as 5 out of 5.

A comprehensive update was provided to the People Committee in April 2023 (included within the Public Board Reference Pack for information).

3. NURSING AND MIDWIFERY SAFER STAFFING UPDATE

3.1 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. These guidelines are currently under review to ensure the learning from the pandemic, strikes and winter pressures regarding staffing in exceptional circumstances is built into the long-term framework for safe staffing management.

Although nurse staffing levels have improved overall, there are still 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.

Additional actions continue which include:

- A daily staffing review of planned, actual, and required demand by the Senior Nursing Team and is reported to the ECN and Silver command daily.
- 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.

There is a monthly review by the ECN Team with confirmation to remain in Level 2 escalation until the de-escalation criteria has been met.

Despite all mitigations remaining in place, the increasing requirement for enhanced care observation continues and whilst robust oversight remains in place, it is recognised that this cannot be met on all occasions with acuity and dependency remaining high across all service areas.

Staffing and bed capacity remains closely monitored by the senior nursing team with weekly support in place for clinical areas where staffing levels continue to impact on the ability to maintain commissioned bed activity.

3.2 Nurse Staffing and Clinical Outcomes

As we remain in staffing escalation level 2, it is important to ensure 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.

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
March	17	x2 Musculoskeletal Services x6 Internal Medicine x2 Cardiothoracic Services x2 Urology and Renal Services x5 Children's Services	5	4	6	2	0
April	20	x2 Musculoskeletal Services x6 Internal Medicine x2 Cardiothoracic Services x2 Urology and Renal Services x5 Children's Services x3 Neurosurgical Services	8	4	5	3	0
May	16	x2 Musculoskeletal Services x5 Internal Medicine x2 Cardiothoracic Services x2 Urology and Renal Services x5 Children's Services	2	4	4	2	4

- Four wards in total have required high-level support over the last three months. All wards have action plans in place, overseen by the Nurse Staffing and Clinical

Outcomes Group and by the ECN Team. An overview of these wards including current nurse sensitive indicators, as well as current performance and actions in place, have been discussed and presented to the Trust's Quality Committee.

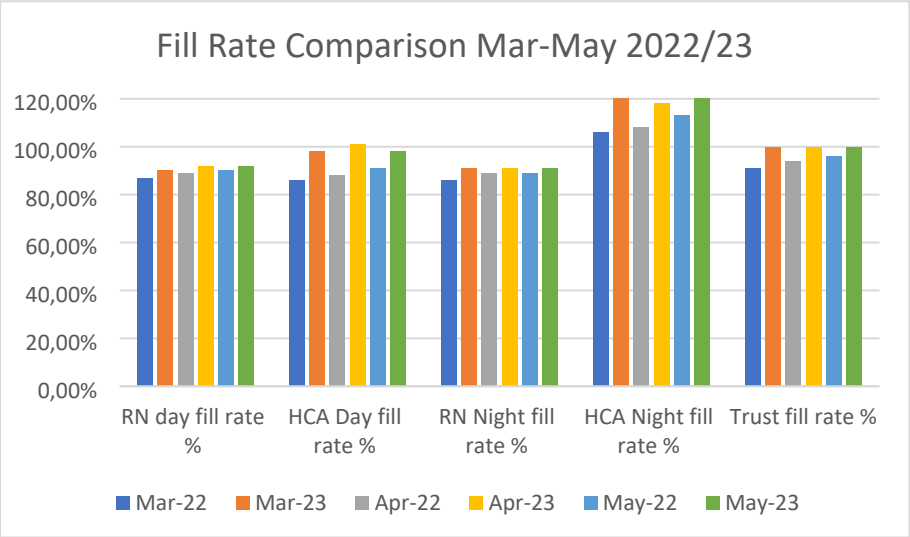
- Where beds have been closed due to staffing concerns, a weekly documented review with the ECN Team remains in place and will continue until all commissioned bed capacity is safely opened.
- Red flags generated within the SafeCare module by the nursing staff in conjunction with professional judgement 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 and are reported daily into the ECN Team. In the last three months, 535 red flags have been generated across the Trust. The highest numbers are from across Medical Wards (n=151), Cardiothoracic Wards (n=110) and Childrens Wards (n=105).
- All staffing related DATIX reports have been reviewed and were graded no harm, low/minor or moderate. In the last quarter the number of DATIX had substantially reduced from the previous quarter where there was an average of 20 per month. The last three months are noted below.
  - March: 10
  - April: 8
  - May: 13

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

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

The Trust level fill rates and CHPPD date are detailed below. This data is produced monthly by ward, submitted nationally and included on the Trust website.

Month	CHPPD	RN day fill rate %	HCA Day fill rate %	RN Night fill rate %	HCA Night fill rate %	Trust fill rate %
March 2023	8.1	90%	98%	91%	123%	100%
April 2023	8.5	92%	101%	91%	118%	100%
May 2023	8.7	92%	98%	91%	121%	100%



Key points to note:

- The fill rate across all domains has improved from the same period last year.
- There continues to be an improvement in fill rates for registered nurses on days due to an improved vacancy position.
- The Healthcare Assistant (HCA) fill rate on nights is above planned due to the need to support enhanced care observation based on acuity and dependency. This is being closely monitored to understand if additional mitigating actions needs to be considered.
- The gap in RN fill rate of 8% on days and 9% on nights whilst an improvement, continues to be challenging on wards and departments when trying to provide the highest possible standard of care.

3.4 Recruitment and International Recruitment

3.4.1 Registered Nurse Recruitment

The current total Registered Nursing and Midwifery workforce combined turnover is 9.61%. This is based on Month 2 data and demonstrates a reduction from 11.18% previously reported. Its compares favourably with the national median of 12.45% and improving the retention figure remains a key priority.

In July 2023 the Trust will see its first Legacy Mentor posts being advertised. The legacy mentors will be experienced nurses who can provide support to new registrants through coaching, mentoring and pastoral support. They are intended to be professional points of contact for staff wellbeing and career progression. The aim is that by appointing Legacy Mentors we can retain both our experienced staff late in career and support our new staff in practice.

The Band 5 RN vacancy rate is 4.66% based on the financial ledger at Month 2 and relates to current substantive staff in post. This is a favourable position when compared to the 2022 Month 2 vacancy rate of 8.4%. It does not include those nurses currently in the recruitment process, where there is a pipeline of 133 (head count and not including international recruitment) staff across adult and paediatrics. The centralised and bespoke recruitment of Band 5 registered nurses continues with the next interviews taking place in July 2023. The Nursing, Midwifery and Allied Health Professions (AHP) Recruitment and Retention Group

continue to provide oversight and analysis of the staffing data to identify further requirements in the short, medium and longer term.

3.5 International Recruitment

The Trust had an ambitious plan supported with NHSE funding through international recruitment for the deployment of 300 nurses and 5 midwives for 2022/23 and have successfully completed this recruitment plan.

Additional NHSE funding has been made available for 2023/24 with a bid that has been secured for a further 150 nurses to be deployed by the end of November 2023. The Trust have also agreed to 'go further' to recruit an additional 74 nurses to be deployed by the end of March 2024 bringing the additional total of international recruits to 224 nurses.

As part of national governance and oversight, a review of our international recruitment progress was carried out by the regional NHSE team on 7 June 2023. This was used to inform the national team on Trust progress prior to releasing the second tranche of funding. The Trust received positive feedback from the regional team regarding progress in exceeding our recruitment plan to date.

3.6 Healthcare Support Workers (HCSW)

The Trust continues to be part of the national HCSW programme which has a target to achieve a consistent zero-vacancy HCSW position. Due to staff turnover and service innovations, maintaining a zero position is challenging and retention work including career conversations and proactive recruitment remain a priority. There are currently 29 (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 HCSW across the organisation. This includes the provision of a career conversation for all HCSWs and high-quality induction and training.

The large-scale community event based at the Beacon Centre in the west of the city funded by the NHSE 'Widening Access Transformational project' has taken place in May 2023. The aim of the event was to test innovative recruitment solutions and work with community partners to recruit a representative workforce which impacts health inequalities. The day saw an unprecedented response from the community with 1,000 people attending. 294 candidates were interviewed on the day and more than 700 people who we were unable to see on the day left their details via a QR code. The first follow up interviews will be held at the Beacon Centre in July 2023.

As part of our commitment to develop the HCSW pipeline, we have applied and been selected for the 'Altogether Better' programme, as one of only eight Trusts in the region. This programme looks at ideas, practices, tools, and support to deliver a more diverse workforce. It encourages the exploration of bias in the recruitment process and in how people gain promotion. The aim of the programme is to deliver a more diverse HCSW workforce that meets the needs of our organisation. The hope is by looking at HCSW we can scale up the learning across the whole Trust.

4. PROFESSIONAL NURSE ADVOCATE (PNA)

As previously reported to the Trust Board in July 2022, the PNA model was launched in 2021 by the Chief Nursing Officer. The specific remit of the PNA model is to facilitate restorative clinical supervision to colleagues and teams in nursing and beyond. The training equips the PNA to listen and to understand the challenges and demands of colleagues and to then lead, support and deliver quality improvement initiatives in response.

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

4.1 Current Trust Position

The Trust currently has 43 qualified PNAs with a number of PNAs who have completed their programme and are awaiting confirmation of progression. There is also a significant number of Trust staff wanting to complete the 20-credit level 7 academic module and are awaiting a place. If all staff gain a place and complete this would take the total number of trained PNAs to 83.

This is still significantly below the national aspiration of ensuring there is a PNA to nurse ratio of 1:20 which would require in the region of 250 PNA to be training within the Trust.

In early 2023, a national evaluation took place to review the process of supporting PNA training as issues regarding inconsistency of programme, delay in confirmation of award or difficulty in accessing programmes were raised by Trusts. This has led to a tender process for the PNA programme where it was anticipated that some of the issues raised would be addressed though this is still in progress. At present, the only way to access a PNA programme is through expressions of interest into the regional teams and managed centrally which is impacting on progress.

4.2 Trust Reporting

Over the last 12 months, the Trust as part of its contract, has been required to report PNA activity monthly via the PWR. Currently the activity is requested of each PNA via email from the Trust PNA Lead.

The PWR report does indicate an overall increase in activity over the last year as the number of PNAs increases. It has been encouraging to see through the data that there has been substantial increase in the provision of restorative clinical supervision and career conversations, with approximately 60 of each being offered on a monthly basis by Trust PNAs. PNAs are also being supported with coaching or advice on how to get started with restorative supervision to steadily increase the activity.

The Technology Enhanced Learning (TEL) team are also supporting effective reporting via the Learning Lab platform to encourage a better standard of reporting via the PWR.

4.3 Next Steps

There is a requirement to significantly increase the number of PNAs in the Trust. The Trust PNA Lead has been working with local Higher Education Institutions to develop an accreditation agreement, which would see a co-delivered programme in collaboration with University of Sunderland and Northumbria Healthcare NHS Foundation Trust. It is anticipated that we can have better access to a PNA programmes and can support the programme with a co-delivered curriculum, which can draw upon existing Trust teams.

The Trust is also developing a PNA webpage to support nurses interested in becoming, or accessing PNA services, to support existing PNAs with resources and support the wider dissemination of the role.

It is anticipated that these steps will lead to greater understanding and recognition of role, improved consistency and experience of PNA's on programme and a more consistent support to the wider nursing workforce.

5. NEWCASTLE IMPROVEMENT (NI)

NI continue to support the Trust aim to embed a culture of continuous QI across Newcastle Hospitals by 2025.

From a capability and capacity perspective, NI are building resilience and financial sustainability through the in-house delivery of cohort three of ITP and ICP programmes. These programmes, that were formerly delivered by our strategic partners – IHI, are designed to equip individuals and teams with the skills, knowledge, experience, and confidence to lead improvement initiatives in their own area of work and to support others in developing improvement initiatives. NI have further been delivering training to a range of colleagues from across the Trust through QI essentials, enhanced induction, preceptorship, and Leo programmes as well as refining a QI workbook to support individuals working on improvement initiatives.

NI, through Newcastle Change Programme, have been working to align the complementary skills of NI and the Trust's PMO to support priority transformational programmes. Within the Outpatient transformation programme, the primary initiative relating to implementation of Patient Initiated Follow-Up (PIFU) has now
seen more than 12,000 patients added to a PIFU pathway. 3,000 patients have now seen their PIFU period expire, avoiding the need for a follow-up appointment, and delivering added value to the Trust if circa £225,000. From a surgical transformation perspective, the Trust continues to benefit from an increase in day case rates and resultant release of overnight bed capacity and the programme is focussed on the implementation of Care Co-ordination System (CCS) across surgical specialties to support improved theatre utilisation. This programme is also benefitting from the addition of a formal patient partner role. NI improvement facilitators are more frequently working with ICP-graduated coaches to support teams to deliver small-scale improvement initiatives, whilst increasing the confidence of ICP-graduated coaches to be self-sufficient in supporting other teams.

Through the remainder of 2023/24, NI will develop links with Clinical Boards through the NI partner role, aimed at offering improvement expertise, providing strategic support for defining improvement priorities and aligning QI work with Patient Safety and Quality

Assurance. Work will continue to embed environmental sustainability metrics into QI projects and there will be an increased focus on patient engagement across all supported initiatives.

6. RECOMMENDATION

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

Report of Maurya Cushlow
Executive Chief Nurse
27 July 2023

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	27 July 2023		
Title	Maternity 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 purpose of this paper is to provide members of the Trust Board with an update against the national drivers and priorities for maternity services. This paper provides members of the Trust Board with an update of actions in response to the findings from the Care Quality Commission (CQC) inspection of the Newcastle Upon Tyne NHS Hospitals Maternity Service in January 2023, published in May 2023. The domains of 'well-led' and 'safe' were focused upon as part of their national maternity inspection programme. The maternity service was graded 'requires improvement' and this paper details the work that has been implemented and is ongoing as part of an action plan to ensure those areas highlighted by the inspection as breaches in regulation, and those areas identified for improvement, are achieved. This paper references the Ockenden report, with a more detailed paper planned for September. The Ockenden Report (30 March 2022) can be found at: https://www.gov.uk/government/publications/final-report-ofthe-ockenden-review The 'Three-year delivery plan for maternity and neonatal services' was published by NHS England (NHSE) in March 2023 and previously presented to Trust Board in May 2023. The plan was developed in response to the Ockenden and East Kent reports which highlighted failures in maternity care and the need for nationwide learning and improvement. The 'Three-year delivery plan' has four key themes divided into twelve priority actions/objectives working toward the ambition of providing safer, more personalised, and more equitable care for families. Work has commenced to benchmark current Trust position against those objectives identified by the plan where responsibility is held at Trust level. Key stakeholders within the Trust maternity services have also undertaken collaborative work as part of the Local Maternity and Neonatal System (LMNS) in a regional workshop to develop and co-produce solutions to the plan. The NHSE three year delivery plan for maternity and neonatal services can be found at: https://www.england.nhs.uk/long-read/three-year-delivery-plan-for-maternity-and-neonatal-services/		

<table>
<tr><td>Recommendation</td><td colspan="7">The Trust Board is asked to:
i) Receive and discuss the report;
ii) Note the findings of the final report of the CQC inspection and the actions taken and ongoing in response to this;
iii) Note the current level of assurance against the interim and final Ockenden recommendations;
iv) Note the initial benchmarking of maternity services against the ‘Three year delivery plan for maternity and neonatal services’ and that further detailed work is required to identify outstanding actions required to ensure full compliance; and
v) 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>Link to Board Assurance Framework [BAF]</td><td colspan="7">No direct link.</td></tr>
<tr><td>Reports previously considered by Trust Board</td><td colspan="7">Previous reports have been presented to members of the Trust Board on Ockenden, The Kirkup Report, and The Maternity Incentive Scheme (CNST).</td></tr>
</table>

MATERNITY SERVICES UPDATE

EXECUTIVE SUMMARY

This paper provides the Trust Board with an overview and update of the leading priorities and quality considerations for the Maternity Service. A specific focus of this paper will be on the Maternity Care Quality Commission (CQC) Inspection.

Section 2 reports on the CQC maternity inspection in January 2023 covering the two key domains of 'safe' and 'well-led'. The CQC inspection findings were published on 12 May 2023 resulting in the overall rating for the Maternity service as 'requires improvement'. A rating of 'good' was declared for 'well-led' and 'requires improvement' for safe.

This paper provides an update on the action plan (Appendix 3) implemented in response to the CQC inspection findings. An immediate response was required by the Trust to comply with legal obligations for:

- **Regulation 12(1)(2); the Trust must ensure staff complete daily check of emergency equipment. They must ensure equipment used by staff and women and birthing people is in date, checked regularly and safe for the intended purpose.**

  The Trust have implemented immediate actions to meet with this requirement. Emergency and critical equipment checks are recorded on clinical standard's checklists and monitored daily by the Matrons. An assurance framework has been implemented to include weekly oversight by the Director of Midwifery and a monthly audit programme to illustrate embedding of changes in practice.
  Trust self-assessed as compliant.

- **Regulation 18(1)(2)(a); the Trust must ensure all staff receive such appraisal as is necessary to carry out their duties.**

  This is a rolling process with a plan implemented for monthly monitoring by the Clinical Board. Current compliance within the Maternity Service is 69% with an ongoing plan in place to meet the Trust target of 95% by March 2024, which is within the expected timeframe.
  Trust self-assessed as compliant.

- **Regulation 12(1)(2)(g); the Trust must ensure the proper and safe management of medicines, ensuring out of date medicines are removed and medicines are stored securely.**

  Improvement work has been undertaken in strengthening the management of medicines, together with the implementation of an assurance framework which includes a ward level daily process for ensuring medication is secure, together with a monthly review of all stored medication and IV fluids. Self-assessed as partially compliant pending ongoing work which is underway to mitigate risk in relation to IV

and emergency drugs on the Delivery Suite. Full compliance will be made following completion of work in July 2023.
Trust self-assessed as partially compliant pending ongoing work.

In addition, although not breaching regulation, the following areas were highlighted for further improvement:

- **The Trust should ensure that all staff complete the required mandatory training, including the appropriate level of safeguarding adults and children training.**

  Mandatory Training for Maternity Services is split into two sections: Trust level mandatory training and maternity specific 'Core Competency' training. Figures currently stand at:

  - Trust level Mandatory Training: 86% against a target of 95%
  - Children's Safeguarding Level 3: 87% against a target of 95%
  - Maternity Specific Core Competency Training: 52% against a target of 90%

  All training is set against an annual rolling programme, a process is in place for monitoring trajectory against the set target with defined timeframes.

  It should be noted that additional maternity specific training has now been recommended through the nationally revised Core Competency Framework, which requires significant time resource for staff attendance. Work is currently in progress to review the impact of this for Newcastle and will be presented in a later paper.

  This cross references to the Maternity Incentive Scheme paper presented to the Trust Board in July 2023.
  Trust self-assessed as partially compliant pending further review of newly published recommendations.

- **The Trust should ensure all areas are clean and staff use control measures to prevent the spread of infection.**

  Assurance framework in place to include daily Matron presence within each area in relation to expected standards. Compliance is monitored and reported through the Trust-wide monthly Clinical Assurance Tool (CAT). Additional oversight provided by the Director of Midwifery through monthly reporting at a local level.
  Trust self-assessed as compliant.

- **The Trust should ensure sufficient midwifery staff are deployed to keep women, birthing people, and babies safe.**

  The Trust is currently 3.8% below the recommended Birthrate Plus establishment. This position will change with the commencement in post of newly appointed Midwives in September, with a projection of 4.6% over the established budget.

Recruitment will continue thereafter to further increase up to the approved 20wte over establishment.

An assurance process is in place to ensure daily monitoring and oversight of staffing versus acuity at ward level. This is overseen by Matrons and further oversight provided to the Director of Midwifery twice weekly for additional support and assurance with regard to workforce planning and mitigation of risk.

It has been identified that the strength of the documented evidence in relation to daily movement of staff and data capture can be improved, with work in progress to ensure documentary evidence of monitoring and reporting.
Trust assessed as compliant.

- **The Trust should ensure estates and facilities in the delivery suite are suitable to meet the needs of women, birthing people and families and protect their privacy and dignity.**

  It has long been recognised that improvement work to the estate is a priority. Bespoke work is currently being undertaken in refurbishment of the bereavement facilities to improve the provision of privacy and dignity for families. This work is planned for completion early in 2024. General work across the estate will continue to be a priority.

  Despite the challenges presented by the estate, staff continuously prioritise the privacy and dignity of service users at all times in the provision of care.
  Trust self-assessed as partially compliant pending continuous refurbishment.

- **The Trust should act to ensure staff fully complete all aspects of modified obstetric early warning scores in order to assess the risks to women and birthing people.**

  Moving from a paper-based Modified Early Warning Score (MEWS), e-obs has been implemented in the Maternity Service in July 2023. This will enable a continuous process of review in relation to completion of MEWS, and greater quality assurance through audit.
  Trust assessed as partially compliant pending implementation and audit of newly implemented system.

- **The Trust should continue to monitor the security of the unit continues to be reviewed in line with national guidance.**

  All security work completed; annual Baby abduction simulation planned to be undertaken in August 2023.
  Trust assessed as compliant.

- **The Trust should continue work to introduce a robust formal triage and escalation process within the maternity assessment unit.**

Work is underway in planning the implementation of a bespoke electronic Maternity Triage system (BSOTS). Training requirements currently in review with an anticipated 'go-live' date of September 2023. Interim measures include a paper based system to support triage and escalation, together with schedule of audit to inform the quality of assessment.
Trust assessed as partially compliant.

This paper reports on the work that has already been undertaken and is ongoing, to assure the Trust Board that the maternity service is working towards full compliance with these obligations and that systems are in place to ensure compliance is maintained.

Section 3 provides a brief update on the current position for the Trust in relation to the recommendations from both the interim and final Ockenden reports. Compliance with Ockenden has been reported in separate Ockenden papers to Trust Board up until May 2023. Full compliance is now demonstrated at 76.7%, partial-compliance 20.9%, and 2.3% of recommendations remain non-compliant (Appendix 1 and 2). A further full and detailed report will be provided to the Trust Board in September 2023.

Section 4 provides members of the Trust Board with a brief overview of the Trust's current position against the ambitions of the 'Three-year delivery plan for maternity and neonatal services.' The 'Three-year delivery plan for maternity and neonatal services' was published by NHSE on 30 March 2023, in response to findings and recommendations from recent maternity reports (Ockenden 2020 and 2022, East Kent 2022, and previously Morecambe Bay 2015).

The ambition of the plan is to improve maternity care so that it is safer, more personalised, and more equitable. The four key themes of the plan are divided into twelve priority actions (objectives). The maternity service has commenced benchmarking the specific actions required of providers. Regional work has already commenced through the Local Maternity and Neonatal System (LMNS) supporting key maternity leaders and stakeholders to attend a collaborative workshop exploring the themes and objectives of the plan. Achievement of the 'Three-year delivery plan' is interdependent on provision of services and support at LMNS/Integrated Care Board (ICB) level and Nationally from NHSE.

The Trust continues to benchmark existing services against the ambitions of the 'Three-year plan' and identify work that is required to fully comply with the objectives of the plan. (Appendix 4). The Trust anticipates that as benchmarking continues, any associated risks affecting compliance will be identified. Of note is that compliance will also rely on the interdependency of the ambition through National and ICB support. A further detailed update will be provided to the Trust Board in September 2023.

MATERNITY SERVICES UPDATE

1. INTRODUCTION

This paper provides the Trust Board with an overview and update for the leading priorities and quality considerations for the Maternity Service.

The Trust Board is provided with an update on the action plan implemented in response to the Care Quality Commission's (CQC) findings published in May 2023 from their inspection of maternity services in January 2023. Newcastle upon Tyne NHS Hospitals Maternity Services received a rating of 'requires improvement' following an inspection of the domains of 'well led' and 'safe.' This paper provides the Trust Board with an overview of the work that has been undertaken and is ongoing in response to those areas that 'must' and 'should' be done as highlighted by the inspection.

A brief update is provided in relation to the Maternity Services current compliance to the recommendations of both the interim and final Ockenden reports (2020 and 2022).

The Trusts position against the 12 priority actions and objectives set out by NHS England's 'Three-year delivery plan for maternity and neonatal services' published on 30 March 2023 are also referenced.

2. CARE QUALITY COMMISSION (CQC) JANUARY 2023 INSPECTION UPDATE

The CQC undertook a short notice inspection on 10 and 11 January 2023 as part of the national maternity inspection programme. The inspection focussed on the domains of 'safe' and 'well-led' and the final report was published on 12 May 2023. The Trust was rated 'requires improvement' for 'safe' and 'good' for 'well led' with an overall maternity services rating of 'requires improvement'.

The Trust has developed and implemented an action plan in response to the CQC inspection findings which identified three areas requiring immediate improvement to comply with legal obligations:

- **Regulation 12(1)(2); the Trust must ensure staff complete daily check of emergency equipment. They must ensure equipment used by staff and women and birthing people is in date, checked regularly and safe for the intended purpose.**

  The Trust have implemented immediate actions to meet with this requirement. Emergency and critical equipment checks are recorded on clinical standard's checklists and monitored daily by the Matrons. An assurance framework has been implemented to include weekly oversight by the Director of Midwifery and a monthly audit programme to illustrate embedding of changes in practice.
  Trust self-assessed as compliant.

- **Regulation 18(1)(2)(a); the Trust must ensure all staff receive such appraisal as is necessary to carry out their duties.**

  This is a rolling process with a plan implemented for monthly monitoring by the Clinical Board. Current compliance within the Maternity Service is 69% with an ongoing plan in place to meet the Trust target of 95% by March 2024, which is within the expected timeframe.
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- **Regulation 12(1)(2)(g); the Trust must ensure the proper and safe management of medicines, ensuring out of date medicines are removed and medicines are stored securely.**

  Improvement work has been undertaken in strengthening the management of medicines, together with the implementation of an assurance framework which includes a ward level daily process for ensuring medication is secure, together with a monthly review of all stored medication and IV fluids. Self-assessed as partially compliant pending ongoing work which is underway to mitigate risk in relation to IV and emergency drugs on the Delivery Suite. Full compliance will be made following completion of the work in July 2023.
  Trust self-assessed as partially compliant pending ongoing work.

In addition, although not breaching regulation, the following areas were highlighted for further improvement:

- **The Trust should ensure that all staff complete the required mandatory training, including the appropriate level of safeguarding adults and children training.**

  Mandatory Training for Maternity Services is split into two sections: Trust level mandatory training and maternity specific 'Core Competency' training. Figures currently stand at:

  - Trust level Mandatory Training: 86% against a target of 95%
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  All training is set against an annual rolling programme, a process is in place for monitoring trajectory against the set target with defined timeframes.

  It should be noted that additional maternity specific training has now been recommended through the nationally revised Core Competency Framework, which requires significant time resource for staff attendance. Work is currently in progress to review the impact of this for Newcastle and will be presented in a later paper.

  This cross references to the Maternity Incentive Scheme paper presented to the Trust Board in July 2023.

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- **The Trust should ensure all areas are clean and staff use control measures to prevent the spread of infection.**

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  The Trust is currently 3.8% below the recommended Birthrate Plus establishment. This position will change with the commencement in post of newly appointed Midwives in September, with a projection of 4.6% over the established budget. Recruitment will continue thereafter to further increase up to the approved 20wte over establishment.

  An assurance process is in place to ensure daily monitoring and oversight of staffing versus acuity at ward level. This is overseen by Matrons and further oversight provided to the Director of Midwifery twice weekly for additional support and assurance with regard to workforce planning and mitigation of risk.

  It has been identified that the strength of the documented evidence in relation to daily movement of staff and data capture can be improved, with work in progress to ensure documentary evidence of monitoring and reporting.
  Trust assessed as compliant.

- **The Trust should ensure estates and facilities in the delivery suite are suitable to meet the needs of women, birthing people and families and protect their privacy and dignity.**

  It has long been recognised that improvement work to the estate is a priority. Bespoke work is currently being undertaken in refurbishment of the bereavement facilities to improve the provision of privacy and dignity for families. This work is planned for completion early in 2024. General work across the estate will continue to be a priority.

  Despite the challenges presented by the estate, staff continuously prioritise the privacy and dignity of service users at all times in the provision of care.
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- **The Trust should act to ensure staff fully complete all aspects of modified obstetric early warning scores in order to assess the risks to women and birthing people.**

Moving from a paper-based Modified Early Warning Score (MEWS), e-obs has been implemented in the Maternity Service in July 2023. This will enable a continuous process of review in relation to completion of MEWS, and greater quality assurance through audit.
Trust assessed as partially compliant pending implementation and audit of newly implemented system.

- **The Trust should continue to monitor the security of the unit continues to be reviewed in line with national guidance.**

  All security work completed; annual Baby abduction simulation planned to be undertaken in August 2023.
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  Work is underway in planning the implementation of a bespoke electronic Maternity Triage system (BSOTS). Training requirements currently in review with an anticipated 'go-live' date of September 2023. Interim measures include a paper based system to support triage and escalation, together with schedule of audit to inform the quality of assessment.
  Trust assessed as partially compliant.

This paper reports on the work that has already been undertaken and is ongoing, to assure the Trust Board that the maternity service is working towards full compliance with these obligations and that systems are in place to ensure compliance is maintained.

3. OCKENDEN

As previously reported to the Trust Board, the final Ockenden Report published on 30 March 2022, highlighted a number of immediate and essential actions (IEAs) and recommendations to be implemented by all maternity services in England.

The Trust's position and ongoing compliance with Ockenden has been reported in separate Ockenden papers to Trust Board up until May 2023. Work continues to progress the recommendations of the combined reports; full compliance is now demonstrated at 76.7%, partial-compliance 20.9%, and 2.3% of recommendations remain non-compliant. A further detailed paper will be presented to the Trust Board in September 2023.

An item of note in relation to the outstanding non-compliant action is as follows:

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

The Director of Midwifery has commenced work in reviewing the midwifery staffing position across the previous three years. This work will now be supported by the operational and strategic Senior Midwife for Workforce who has recently commenced in post.

The Trust Board are asked to note that this work now requires consideration and inclusion of the recommendations from the new 'Core Competency Framework version 2' published on 31 May 2023. The framework recommends a significant increase in the training requirements for Midwifery staff. The Trust currently provides two full days of maternity specific training for Midwives and the new framework recommends an increase to five days.

The three-year review will require the recommended additional training to be factored into the calculated uplift for Newcastle Hospitals Maternity service. An update will be presented to the Trust Board at a later date.

4. THREE YEAR DELIVERY PLAN FOR MATERNITY AND NEONATAL SERVICES

The 'Three-year delivery plan for maternity and neonatal services' was published by NHS England (NHSE) on 30 March 2023, in response to the Ockenden (2022), East Kent (2022) and previously Morecambe Bay (2015) reports. These reports highlight continued failures and inequalities in maternity care for families.

The ambition of the Three-year plan is to improve maternity and neonatal care in England; ensuring it is safer, more personalised, and more equitable for women, babies, and families.

As reported to Trust Board in May 2023, the four key themes of the plan are split into twelve priority actions. Responsibilities for each action have been further defined at Trust, LMNS/ICB and National level.

Technical guidance from NHSE was published in May 2023 defining the measures that will be used to monitor progress and assess compliance of the key objectives at LMNS and National levels.

The Trust has commenced a benchmarking exercise on the ambitions of the twelve objectives from the Three-year plan. A detailed breakdown of compliance will be reported to the Trust Board in September 2023.

Members of the Maternity Team attended the first workshop of a regional process on 10 May hosted by the LMNS to support the implementation of the Three-year delivery plan. Trusts from the North East and North Cumbria (NENC) attended with representation from a broad range of staff and key stakeholders. The day resulted in discussion and exploration of the Three-year delivery plan, encouraging collaborative thinking and solutions for some of the key areas.

The four key themes and 12 priority actions/objectives are:

Theme 1: Listening to women and families with compassion which promotes safe care.
Objective 1: Provide care that is personalised.
Objective 2: Improve equity for mothers and babies.
Objective 3: Work with service users to improve care.

Theme 2: Supporting our workforce to develop their skills and capacity to provide high-quality care.
Objective 4: Grow our workforce.
Objective 5: Value and retain our workforce.
Objective 6: Invest in skills.

Theme 3: Developing and sustaining a culture of safety to benefit everyone.
Objective 7: Develop a positive safety culture.
Objective 8: Learning and improving.
Objective 9: Support and oversight.

Theme 4: Meeting and improving standards and structures that underpin our national ambition.
Objective 10: Standards to ensure best practice.
Objective 11: Data to inform learning**.**
Objective 12: Make better use of digital technology in maternity and neonatal services.

The Trust will continue benchmarking current services to identify gaps and actions required. The associated local risks in achieving the objectives of the Three year delivery plan will also be dependent on the timely support from the LMNS and NHSE in implementing the deliverables under their respective responsibilities. Local performance outcomes and measures must be agreed and aligned to those metrics that will be used at LMNS and National level to and monitor progress and compliance.

5. CONCLUSION

The final report following the CQC inspection of Maternity services in January was published on 12 May 2023. An action plan in response to the 3 breaches in regulation, together with the 7 advisories on improvements which should be made, highlighted in the report, has been implemented and is ongoing to ensure that the Trust meets with the regulatory requirements and service improvements as identified by the inspectors.

Progress against the interim and final Ockenden recommendations has continued, however this must now be aligned to the ambitions and objectives set out in the 'Three-year delivery plan for maternity and neonatal services.'

The Trust continue to progress benchmarking current services against the objectives of 'The Three Year Plan.' The identification of any associated risks will become more evident as the Trust progresses this work which also relies on National and ICB support. Collaborative work

has commenced within the NENC LMNS to explore regional thinking and ways of working in achieving the plans ambitions and objectives. A further update will be provided to the Trust Board in September 2023.

6. RECOMMENDATIONS

The Trust Board is asked to:

i) Receive and discuss the report;
ii) Note the findings of the final report of the CQC inspection and the actions taken and ongoing in response to this;
iii) Note the current level of assurance against the interim and final Ockenden recommendations;
iv) Note the initial benchmarking of maternity services against the 'Three year delivery plan for maternity and neonatal services' and that further detailed work is required to identify outstanding actions required to ensure full compliance; and
v) Note the associated risks involved.

Report of Maurya Cushlow
Executive Chief Nurse
27 July 2023

APPENDIX 1

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

	Q14	Bimonthly meetings with Trust safety champions (obstetrician and midwife) & Board level champions.	Compliant
	Q15	Robust mechanism working with and gathering feedback from service users through MVP to design services.	Compliant
	Q16	Identification of an Executive Director & non-executive director for oversight of maternity & neonatal services.	Compliant
IEA 3: Staff Training & Working Together	Q17	Evidence of multidisciplinary team (MDT) training and working validated by LMNS 3 times a year. All professional groups represented at all MDT and core training.	Compliant
	Q18	Twice daily (over 24hrs), 7-days a week consultant-led multidisciplinary ward rounds.	Compliant
	Q19	Trust to ensure external funding allocated for the training of maternity staff is ring-fenced.	Compliant
	Q20	Effective system of clinical workforce planning (see section 2).	Compliant
	Q21	90% attendance for each staff group attending MDT maternity emergencies training session (with LMNS oversight and validation).	Compliant
	Q22	Twice daily (over 24hrs), 7-days a week consultant-led multidisciplinary ward rounds	Compliant
	Q23	Evidence of multidisciplinary team (MDT) training and working validated by LMNS 3 times a year. All professional groups represented at all MDT and core training.	Compliant
IEA 4: Managing Complex Pregnancy	Q24	Maternal Medicine Centre (MMC) Pathway referral criteria agreed with trusts referring to NUTH for specialist input.	Compliant (regraded partial compliance due to need for audit)
	Q25	Women with complex pregnancies (whether MMC or not) must have a named consultant lead.	Partial Compliance (regraded compliant)
	Q26	Early specialist involvement and management plans must be agreed where a complex pregnancy is identified.	Compliant (regraded partial compliance due to need for audit)
	Q27	Demonstrate compliance with all five elements of the Saving Babies' Lives care bundle (SBLCBv.2)	Compliant

	Q28	Continuation of Q25: mechanisms to regularly audit compliance.	Compliant (regraded partial compliance due to need for audit)
	Q29	Trust supporting the development of maternal medicine specialist centre.	Compliant
IEA 5: Risk Assessment Throughout Pregnancy	Q30	All women must be formally risk assessed at every antenatal contact.	Partial Compliance (regraded compliant)
	Q31	Risk assessment must include ongoing review of the intended place of birth.	Compliant (regraded partial compliance due to need for audit)
	Q32	Demonstrate compliance with all five elements of the Saving Babies' Lives care bundle (V.2).	Compliant
	Q33	Regular audit mechanisms are in place to assess Personalised Care & Support Plan compliance.	Compliant (regraded partial compliance due to need for audit)
IEA 6: Monitoring Fetal Wellbeing	Q34	Dedicated Lead Midwife and Lead Obstetrician to champion best practice in fetal wellbeing.	Compliant
	Q35	Leads must be sufficiently senior with demonstrable expertise to lead on clinical practice, training, incident review and compliance of Saving Babies' Lives care bundle (V.2)	Compliant
	Q36	Demonstrate compliance with all five elements of the Saving Babies' Lives care bundle (V.2).	Compliant
	Q37	90% attendance for each staff group attending MDT maternity emergencies training session (with LMNS oversight and validation).	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

Ockenden 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 (must now incorporate Core Competency v2 recommendations)
	1.4	The feasibility and accuracy of the BirthRate Plus tool and associated methodology must be reviewed nationally by all bodies. These bodies must include as a minimum NHSE, RCOG, RCM, RCPCH.	n/a Awaiting direction from National bodies
Workforce Planning and Sustainability: Training We state that the Health and Social Care Select Committee view that a proportion of maternity budgets must be ring-fenced for training in	1.5	All trusts must implement a robust preceptorship programme for newly qualified midwives (NQM), which supports supernumerary status during their orientation period and protected learning time for professional development as per the RCM (2017) position statement for this.	Compliant
	1.6	All NQMs must remain within the hospital setting for a minimum period of one year post qualification. This timeframe will ensure there is an opportunity to develop essential skills and competencies on which to advance their clinical practice, enhance professional confidence and resilience and provide a structured period of transition from student to accountable midwife.	n/a National direction has changed since publication of Final report
	1.7	All trusts must ensure all midwives responsible for coordinating labour ward attend a fully funded and nationally recognised labour ward coordinator education module, which supports advanced decision making, learning through training in human factors, situational awareness, and psychological safety, to tackle behaviours in the workforce.	Partial compliance
	1.8	All trusts to ensure newly appointed labour ward coordinators receive an orientation package which reflects their individual needs. This must encompass opportunities to be released from clinical practice to focus on their personal and professional development.	Compliant

every maternity unit should be implemented.	1.9	All trusts must develop a core team of senior midwives who are trained in the provision of high dependency maternity care. The core team should be large enough to ensure there is at least one HDU trained midwife on each shift, 24/7.	Compliant
	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.	Compliant
	3.2	When a middle grade or trainee obstetrician (non-consultant) is managing the maternity service without direct consultant presence trusts must have an assurance mechanism to ensure the middle grade or trainee is competent for this role.	Compliant
	3.3	Trusts should aim to increase resident consultant obstetrician presence where this is achievable.	Compliant
	3.4	There must be clear local guidelines for when consultant obstetricians' attendance is mandatory within the unit.	Compliant
	3.5	There must be clear local guidelines detailing when the consultant obstetrician and the midwifery manager on-call should be informed of activity within the unit.	Compliant
4. Clinical Governance: Leadership:	4.1	Members of the Trust Board must work together with maternity departments to develop regular progress and exception reports, assurance reviews and regularly review the progress of any maternity improvement and transformation plans.	Compliant

Trust boards must have oversight of the quality and performance of their maternity services. In all maternity services the Director of Midwifery and Clinical Director for obstetrics must be jointly operationally responsible and accountable for the maternity governance systems.	4.2	All maternity service senior leadership teams must use appreciative inquiry to complete the National Maternity Self-Assessment Tool if not previously done. A comprehensive report of their self-assessment including governance structures and any remedial plans must be shared with their trust board.	Partial compliance
	4.3	Every trust must ensure they have a patient safety specialist, specifically dedicated to maternity services.	Compliant
	4.4	All clinicians with responsibility for maternity governance must be given sufficient time in their job plans to be able to engage effectively with their management responsibilities.	Partial compliance
	4.5	All trusts must ensure that those individuals leading maternity governance teams are trained in human factors, causal analysis, and family engagement.	Partial compliance
	4.6	All maternity services must ensure there are midwifery and obstetric co-leads for developing guidelines. The midwife co-lead must be of a senior level, such as a consultant midwife, who can drive the guideline agenda and have links with audit and research.	Compliant
	4.7	All maternity services must ensure they have midwifery and obstetric co-leads for audits.	Compliant
5. Clinical Governance – Incident investigation and complaints Incident investigations must be meaningful for families and staff and lessons must be learned and implemented in practice in a timely manner.	5.1	All maternity governance teams must ensure the language used in investigation reports is easy to understand for families, for example ensuring any medical terms are explained in lay terms.	Compliant
	5.2	Lessons from clinical incidents must inform delivery of the local multidisciplinary training plan.	Partial compliance
	5.3	Actions arising from a serious incident investigation which involve a change in practice must be audited to ensure a change in practice has occurred.	Partial compliance
	5.4	Change in practice arising from an SI investigation must be seen within 6 months after the incident occurred.	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. Learning from Maternal Deaths Nationally all maternal PM examinations must be conducted by a pathologist who is an expert in maternal physiology and pregnancy related pathologies. In the case of a maternal death a joint review panel/investigation of all services involved in the care must include representation from all applicable hospitals/clinical settings.	6.1	NHS England and Improvement must work together with the Royal Colleges and the Chief Coroner for England and Wales to ensure that this is provided in any case of a maternal death.	n/a
	6.2	This joint review panel/investigation must have an independent chair, must be aligned with local and regional staff, and seek external clinical expert opinion where required.	n/a
	6.3	Learning from this review must be introduced into clinical practice within 6 months of the completion of the panel. The learning must also be shared across the LMS.	To action once implemented by external stakeholder
7. Multidisciplinary Training Staff who work together must train together Staff should attend regular mandatory training. Rotas & Job planning need to ensure all staff can attend.	7.1	All members of the multidisciplinary team working within maternity should attend regular joint training, governance, and audit events. Staff should have allocated time in job plans to ensure attendance, which must be monitored.	Partial compliance
	7.2	Multidisciplinary training must integrate the local handover tools (such as SBAR) into the teaching programme at all trusts.	Compliant
	7.3	All trusts must mandate annual human factor training for all staff working in a maternity setting; this should include the principles of psychological safety and upholding civility in the workplace, ensuring staff are enabled to escalate clinical concerns. The content of human factor training must be agreed with the LMS.	Compliant
	7.4	There must be regular multidisciplinary skills drills and on-site training for the management of common obstetric emergencies including haemorrhage, hypertension and cardiac arrest and the deteriorating patient.	Compliant

Clinicians must not work on labour ward without appropriate regular CTG training and emergency skills training	7.5	There must be mechanisms in place to support the emotional and psychological needs of staff, at both an individual and team level, recognising that well supported staff teams are better able to consistently deliver kind and compassionate care.	Compliant
	7.6	Systems must be in place in all trusts to ensure that all staff are trained and up to date in CTG and emergency skills.	Compliant
	7.7	Clinicians must not work on labour wards or provide intrapartum care in any location without appropriate regular CTG training and emergency skills training. This must be mandatory.	Compliant
8. Complex Antenatal Care: Local Maternity Systems, Maternal Medicine Networks and trusts must ensure that women have access to preconception care. Trusts must provide services for women with multiple pregnancy in line with national guidance Trusts must follow national guidance for managing women with diabetes and hypertension in pregnancy	8.1	Women with pre-existing medical disorders, including cardiac disease, epilepsy, diabetes, and chronic hypertension, must have access to preconception care with a specialist familiar in managing that disorder and who understands the impact that pregnancy may have.	Compliant
	8.2	Trusts must have in place specialist antenatal clinics dedicated to 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:	9.1	Senior clinicians must be involved in counselling women at high risk of very preterm birth, especially when pregnancies are at the thresholds of viability.	Compliant

The LMNS, commissioners and trusts must work collaboratively to ensure systems are in place for the management of women at high risk of preterm birth. Trusts must implement NHS Saving Babies Lives Version 2 (2019)	9.2	Women and their partners must receive expert advice about the most appropriate fetal monitoring that should be undertaken dependent on the gestation of their pregnancies and what mode of delivery should be considered.	Compliant
	9.3	Discussions must involve the local and tertiary neonatal teams so parents understand the chances of neonatal survival and are aware of the risks of possible associated disability.	Compliant
	9.4	There must be a continuous audit process to review all in utero transfers and cases where a decision is made not to transfer to a Level 3 neonatal unit and when delivery subsequently occurs in the local unit.	Compliant
10. Labour and Birth: Women who choose birth outside a hospital setting must receive accurate advice with regards to transfer times to an obstetric unit should this be necessary. Centralised CTG monitoring systems should be mandatory in obstetric units	10.1	All women must undergo a full clinical assessment when presenting in early or established labour. This must include a review of any risk factors and consideration of whether any complicating factors have arisen which might change recommendations about place of birth. These must be shared with women to enable an informed decision re place of birth to be made	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:	11.1	Conditions that merit further follow-up include, but are not limited to, postdural puncture headache, accidental awareness during general anaesthesia, intraoperative pain, and the need for conversion to general anaesthesia during obstetric interventions, neurological injury relating to anaesthetic interventions, and significant failure of labour analgesia.	Compliant

A pathway for outpatient postnatal anaesthetic follow-up must be available in every trust to address incidences of physical and psychological harm. Documentation of patient assessments and interactions by obstetric anaesthetists must improve. The determination of core datasets that must be recorded during every obstetric anaesthetic intervention would result in record-keeping that more accurately reflects events. Staffing shortages in obstetric anaesthesia must be highlighted and updated guidance for the planning and provision of safe obstetric anaesthesia services throughout England must be developed.	11.2	Anaesthetists must be proactive in recognising situations where an explanation of events and an opportunity for questions may improve a woman's overall experience and reduce the risk of long-term psychological consequences.	Compliant
	11.3	All anaesthetic departments must review the adequacy of their documentation in maternity patient records and take steps to improve this where necessary as recommended in Good Medical Practice by the GMC	Compliant
	11.4	Resources must be made available for anaesthetic professional bodies to determine a consensus regarding contents of core datasets and what constitutes a satisfactory anaesthetic record in order to maximise national engagement and compliance.	n/a
	11.5	The role of consultants, SAS doctors and doctors-in-training in service provision, as well as the need for prospective cover, to ensure maintenance of safe services whilst allowing for staff leave.	Compliant
	11.6	The full range of obstetric anaesthesia workload including, elective caesarean lists, clinic work, labour ward cover, as well as teaching, attendance at multidisciplinary training, and governance activity.	Compliant
	11.7	The competency required for consultant staff who cover obstetric services out-of-hours, but who have no regular obstetric commitments.	n/a
	11.8	Participation by anaesthetists in the maternity multidisciplinary ward rounds as recommended in the first report.	Compliant
12. Postnatal Care: Trusts must ensure that women readmitted to a postnatal ward and all unwell postnatal women have timely consultant review. Postnatal wards must be adequately staffed at all times	12.1	All trusts must develop a system to ensure consultant review of all postnatal readmissions, and unwell postnatal women, including those requiring care on a non-maternity ward	Compliant
	12.2	Unwell postnatal women must have timely consultant involvement in their care and be seen daily as a minimum.	Compliant
	12.3	Postnatal readmissions must be seen within 14 hours of readmission or urgently if necessary.	Compliant
	12.4	Staffing levels must be appropriate for both the activity and acuity of care required on the postnatal ward both day and night, for both mothers and babies.	Compliant

13. Bereavement Care: Trusts must ensure that women who have suffered pregnancy loss have appropriate bereavement care services.	13.1	Trusts must provide bereavement care services for women and families who suffer pregnancy loss. This must be available daily, not just Monday to Friday.	Compliant
	13.2	All trusts must ensure adequate numbers of staff are trained to take post-mortem consent, so that families can be counselled about post-mortem within 48 hours of birth. They should have been trained in dealing with bereavement and in the purpose and procedures of post-mortem examinations.	Compliant
	13.3	All trusts must develop a system to ensure that all families are offered follow-up appointments after perinatal loss or poor serious neonatal outcome.	Compliant
	13.4	Compassionate, individualised, high quality bereavement care must be delivered for all families who have experienced a perinatal loss, with reference to guidance such as the National Bereavement Care Pathway.	Compliant
14. Neonatal Care: There must be clear pathways of care for provision of neonatal care. This review endorses the recommendations from the Neonatal Critical Care Review (December 2019) to expand neonatal critical care, increase neonatal cot numbers, develop the workforce, and enhance the experience of families. This work must now progress at pace.	14.1	Neonatal and maternity care providers, commissioners and networks must agree on pathways of care including the designation of each unit and on the level of neonatal care that is provided.	Compliant
	14.2	Care that is outside this agreed pathway must be monitored by exception reporting (at least quarterly) and reviewed by providers and the network. The activity and results of the reviews must be reported to commissioners and the Local Maternity Neonatal Systems (LMS/LMNS) quarterly.	Compliant
	14.3	Maternity and neonatal services must continue to work towards a position of at least 85% of births at less than 27 weeks gestation taking place at a maternity unit with an onsite NICU.	Compliant
	14.4	Neonatal Operational Delivery Networks must ensure that staff within provider units have the opportunity to share best practice and education to ensure units do not operate in isolation from their local clinical support network. For example, senior medical, ANNP and nursing staff must have the opportunity for secondment to attend other appropriate network units on an occasional basis to maintain clinical expertise and avoid working in isolation.	Compliant
	14.5	Each network must report to commissioners annually what measures are in place to prevent units from working in isolation.	n/a
	14.6	Neonatal providers must ensure that processes are defined which enable telephone advice and instructions to be given, where appropriate, during the course of neonatal resuscitations. When it is anticipated that the consultant is not immediately available (for example out of hours), there must be a mechanism that allows a real-time dialogue to take place directly between the consultant and the resuscitating team if required.	Compliant

	14.7	Neonatal practitioners must ensure that once an airway is established and other reversible causes have been excluded, appropriate early consideration is given to increasing inflation pressures to achieve adequate chest rise. Pressures above 30cmH2O in term babies, or above 25cmH2O in preterm babies may be required. The Resuscitation Council UK Newborn Life Support (NLS) Course must consider highlighting this treatment point more clearly in the NLS algorithm.	Compliant
	14.8	Neonatal providers must ensure sufficient numbers of appropriately trained consultants, tier 2 staff (middle grade doctors or ANNPs) and nurses are available in every type of neonatal unit (NICU, LNU and SCBU) to deliver safe care 24/7 in line with national service specifications.	Partial compliance
15. Supporting Families: Care and consideration of the mental health and wellbeing of mothers, their partners and the family as a whole must be integral to all aspects of maternity service provision Maternity care providers must actively engage with the local community and those with lived experience, to deliver services that are informed by what women and their families say they need from their care	15.1	There must be robust mechanisms for the identification of psychological distress, and clear pathways for women and their families to access emotional support and specialist psychological support as appropriate.	Compliant
	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	May 23	May 23	July 23	July 23
Total Number of Recommendations (interim and final report combined)	97	100%	98 *	100%	98	100%	98	100%	98	100%
Non-applicable	12	n/a	12	n/a	12	n/a	12	n/a	12	n/a
Compliant	46	54.1%	56	65.1%	61	71.0%	65	75.6%	66	76.7%
Partial Compliance	36	41.4%	27	31.4%	23	26.7%	19	22.1%	18	20.9%
Non compliance	3	3.5%	3	3.5%	2	2.3%	2	2.3%	2	2.3%

*additional IEA added following Insight Visit Feedback

APPENDIX 3 CQC Maternity inspection 2023 for 'safe' and 'well led' - Action Plan							
Date	**Areas for Improvement**	**Must/ Should**	**Action**	**Action Lead**	**Action Owner**	**Progress**	**Supporting Documents**
20/04/23	The Trust must ensure staff complete daily checks of emergency equipment. They must ensure equipment used by staff and women and birthing people is in date, checked regularly and safe for the intended purpose. Regulation 12 (1) (2) e	Must	The Trust have implemented immediate actions to meet with this requirement. Emergency and critical equipment checks are recorded on clinical standard's checklists and monitored daily by the Matrons. An assurance framework has been implemented to include weekly oversight by the Director of Midwifery (DoM) and a monthly audit programme to illustrate embedding of changes in practice.	Matrons	B7 DS Leads B7 NBC Lead B7 Ward Leads	**Compliant**	Clinical Standards checklist for each area, weekly leader's assurance checklist. Information gathered and recorded at DoM weekly meeting. Central storage of records in place.
20/04/23	The trust must ensure all staff receive such appraisal as is necessary to carry out their duties. Regulation 18 (1) (2) (a)	Must	This is a rolling process with a plan implemented for monthly monitoring by the Clinical Board. Current compliance within the Maternity Service is 69% with an ongoing plan in place to meet the Trust target of 95% by March 2024, which is within the expected timeframe.	Directorate Management Team	Matrons B7 Team Leads Appraisers/ Appraisees	**Compliant**	Designing new 'appraisal tree' for Senior Leadership Team review and sharing within the workforce.
20/04/23	The trust must ensure the proper and safe management of medicines, ensuring out of date medicines are removed and	Must	Improvement work has been undertaken in strengthening the management of medicines, together with the implementation of an assurance framework which includes a ward level daily process	Matrons	B7 DS Leads B7 NBC Lead B7 Ward Leads B7 Team Leads Community	**Partially compliant,** pending ongoing work schedule for	Monthly medication and IV Fluid checklist, Home Birth bags monthly checklist.

	medicines are stored securely. Regulation 12 (1) (2) (g)		for ensuring medication is secure, together with a monthly review of all stored medication and IV fluids. Self-assessed as partially compliant due to the complexity of having IV fluids stored in a locked room to which non-registered staff have access. Work is underway to mitigate risk and to meet with full compliance which will be completed in July 2023.			completion July 2023.	
20/04/23	The Trust should ensure that all staff complete the required mandatory training including the appropriate level of safeguarding adults and children training. (Regulation 12)	Should	Mandatory Training for Maternity Services is split into two sections: • Trust level mandatory training • Maternity specific 'Core Competency' training. All training is set against an annual rolling programme, a process is in place for monitoring trajectory against the set target with defined timeframes. Additional maternity specific training has now been recommended through the nationally revised Core Competency Framework, which requires significant time resource for staff attendance - work is currently in progress to review the impact of this for Newcastle.	Directorate Management Team	Head of Obstetrics, Matrons, B7 Team Leads, Lead Midwives Safeguarding, Quality & Clinical effectiveness Midwife, Practice Development Lead Midwife	**Partially compliant:** Trust level Mandatory Training: 86% against a target of 95% Children's Safeguarding Level 3: 87%: against a target of 95% Core Competency Training: 52% against a target of 90%	

20/04/23	The Trust should ensure all areas are clean and staff use control measures to prevent the spread of infection. (Regulation 12)	Should	Assurance framework in place to include daily Matron presence within each area in relation to expected standards. Compliance is monitored and reported through the Trust-wide monthly Clinical Assurance Tool (CAT). Additional oversight provided by the Director of Midwifery through monthly reporting at a local level.	Director of Midwifery	Matrons, B7 Leads, Trust IPC Team Hotel Services Leads	**Compliant**, to continue to monitor.	
20/04/23	The Trust should ensure sufficient midwifery staff are deployed to keep women, birthing people and babies safe. (Regulation 18)	Should	Currently 3.8% below recommended Birthrate Plus establishment. Newly appointed Midwives to commence in September, with projection of 4.6% over the established budget. Recruitment will continue thereafter to further increase up to approved 20wte over establishment. Assurance process in place ensuring daily monitoring and oversight of staffing versus acuity at ward level - overseen by Matrons and by Director of Midwifery twice weekly for additional assurance with regard to workforce planning and mitigation of risk.	Director of Midwifery	Director of Midwifery, Matrons	**Compliant**, to continue to monitor.	Evidence strengthened through documentary evidence of monitoring and reporting of Daily staffing vs Acuity and staff movement using action log.

20/04/23	The Trust should ensure estates and facilities in the delivery suite are suitable to meet the needs of women, birthing people and families and protect their privacy and dignity. (Regulation 15)	Should	Improvement work to the estate is a priority. Bespoke work is currently being undertaken in refurbishment of the bereavement facilities to improve the provision of privacy and dignity for families. This work is planned for completion early 2024. General work across the estate will continue to be a priority. Despite the challenges presented by the estate, staff continuously prioritise the privacy and dignity of service users at all times in the provision of care.	Directorate Management Team	Directorate Management Team Assistant Director of Estates	**Partially compliant** pending continuous refurbishment.	Team meeting minutes.
20/04/23	The Trust should act to ensure staff fully complete all aspects of modified obstetric early warning scores in order to assess the risks to women and birthing people.	Should	Moving from a paper-based Modified Early Warning Score (MEWS) system, e-obs is planned for go-live in July 2023. This will enable a continuous process of review in relation to completion of MEWS, and greater quality assurance through audit.	Directorate Governance Team Quality & clinical effectiveness midwife	Risk Management Midwives, Team Leads, Shift Coordinators	**Partially compliant** pending implementation and audit of newly implemented system.	On DoM monthly professional meeting agenda.
20/04/23	The Trust should continue to monitor the security of the unit continues to be reviewed in line with national guidance.	Should	All security work completed; annual Baby abduction simulation planned to be undertaken August 2023	Directorate Management Team	Head of Security PN Matron	**Compliant,** Annual simulation planned August 2023.	

20/04/23	The Trust should continue work to introduce a robust formal triage and escalation process within the maternity assessment unit.	Should	Work underway in planning the implementation of a bespoke electronic Maternity Triage system (BSOTS). Training requirements currently in review, anticipated 'go-live' date September 2023. Interim measures include paper based system to support triage and escalation, together with schedule of audit to inform the quality of assessment.	Clinical Director Director of Midwifery	Head of Obstetrics Matron for MAU B7 Team Lead MAU	**Partially compliant,** pending implementation of BSOTS.	

APPENDIX 4

Three Year Plan Guidance, Themes, Objectives and Deliverables

Objective	Ref No:	Deliverable	Trusts	Trust Benchmark Status	ICB	NHS England
Theme 1: Listening to and working with women and families with compassion **Measures: Indicators from CQC Maternity Survey / Perinatal pelvic health services in place / UNICEF BFI accreditation / Number of women accessing perinatal mental health services / CQC inspection / CNST Maternity Incentive Scheme**						
Objective 1: Care that is personalised	1.1	Empower maternity and neonatal staff to deliver personalised care so they have the time, training, tools, and information, to deliver the ambition above.	✓	Partially compliant: Progressing		
	1.2	Monitor the delivery of personalised care by undertaking regular audits and seeking feedback from women and parents.	✓	Partially compliant: Progressing		
	1.3	Consider roll out midwifery continuity of carer in line with the principles NHS England set out in September 2022	✓	Paused		
	1.4	Achieve the standard of the UNICEF UK Baby Friendly Initiative (BFI) for infant feeding, or an equivalent initiative, by March 2027.	✓	Partially compliant: Progressing		
	1.5	Commission for and monitor implementation of personalised care.			✓	
	1.6	Commission and implement by the end of March 2024, in line with national service specifications, Perinatal pelvic health services, to identify, prevent, and treat common pelvic floor problems in pregnant women and new mothers .			✓	
	1.7	Commission and implement by the end of March 2024, in line with national service specifications: Community perinatal mental health services including maternal mental health services, to improve the availability of mental health care.			✓	
	1.8	Work with service users and other partners to produce standardised information focused on priorities identified by service users: intrapartum interventions, mode of birth, induction of labour and pain relief.				✓
	1.9	Extend the national support offer to help services to achieve UNICEF BFI accreditation or an equivalent initiative.				✓

	1.10	Publish national postnatal care guidance, setting out the fundamental components of high-quality postnatal care, to support ICSs with their local improvement initiatives by the end of 2023. Information for GPs on the 6-8 week postnatal check will be published in spring 2023.				✓
	1.11	In April 2023, publish a national service specification for perinatal pelvic health services alongside associated implementation guidance.				✓
	1.12	Create a patient reported experience measure (PREM) by 2025 to help trusts and ICBs monitor and improve personalised care.				✓
	1.13	By March 2024, act on findings from the evaluation of independent senior advocate pilots, as set out in the first Ockenden report				
	1.14	Invest to ensure daily availability of bereavement services 7 days a week by the end of 2023/24. This will help trusts to provide high quality bereavement care including appropriate post-mortem consent and follow-up.				✓
Objective 2: Improve equity for mothers and babies	2.1	Provide services that meet the needs of their local populations, paying particular attention to health inequalities. This includes facilitating informed decision-making, for example choice of pain relief in labour, ensuring access to interpreter services, and adhering to the Accessible Information Standard in maternity and neonatal settings	✓	Partially compliant: Progressing		
	2.2	Collect and disaggregate local data and feedback by population groups to monitor differences in outcomes and experiences for women and babies from different backgrounds and improve care. This data should be used to make changes to services and pathways to address any inequity or inequalities identified.	✓	Partially compliant: Progressing		
	2.3	Publish and lead implementation of their LMNS equity and equality action plan alongside neonatal ODNs, including work across organisational boundaries.			✓	
	2.4	Commission MNVPs to reflect the ethnic diversity of the local population and reach out to seldom heard groups.			✓	
	2.5	Provide regional and national support for the implementation of LMNS equity and equality action plans.				✓
	2.6	Pilot and evaluate new service models built for reducing inequalities including enhanced midwifery continuity of carer and culturally sensitive genetics services for couples practising close relative marriage in high need areas.				✓
Objective 3: Work with service users to improve care	3.1	Involve services users in quality, governance and co-production when planning the design and delivery of maternity and neonatal services	✓	Compliant		
	3.2	Commission and fund MNVPs, to cover each trust within their footprint, reflecting the diversity of the local population in line with the ambition above.			✓	
	3.3	Remunerate and support MNVP leads, and ensure that an annual, fully funded workplan is agreed and signed off by the MNVP and the ICB. All MNVP members should have reasonable expenses reimbursed.			✓	

	3.4	Ensure service user representatives are members of the local maternity and neonatal system board.			✓	
	3.5	Co-produce national policy and quality improvement initiatives with national and regional service user representatives and MNVP leads.				✓
	3.6	Through operational delivery networks, support parent representation in governance of neonatal services.				✓
	3.7	Provide funding for clinical leadership and programme management of ICBs, which includes funding to support service user involvement				✓
Theme 2: Growing, retaining, and supporting our workforce **Measures: Staff surveys / education & medical training surveys / vacancy & turnover rates for staff groups / CQC inspection / CNST Maternity Incentive Scheme**						
Objective 4: Grow our workforce	4.1	Undertake regular local workforce planning, using nationally standardised tools where available, to establish the workforce required for each profession at every stage of care. Where trusts do not yet meet the staffing establishment levels set by Birthrate+ or equivalent tools, do so by 2027/28, and in future meet the expectations from nationally recognised tools for for other professions.	✓	Compliant		
	4.2	Develop and implement a local plan to fill vacancies, which should include support for newly qualified staff and midwives who wish to return to practice.	✓	Partially compliant: Progressing		
	4.3	Provide administrative support to free up pressured clinical time.	✓	Partially compliant: Progressing		
	4.4	Commission and fund safe staffing across their system			✓	
	4.5	Agree staffing levels with trusts for those professions where a nationally standardised tool has not yet been developed. National guidance should be considered when determining staffing levels (for example, Guidelines for the Provision of Anaesthesia Services for an Obstetric Population, Royal College of Anaesthetists, 2023; Implementing the Recommendations of the Neonatal Critical Care Transformation Review)			✓	
	4.6	Align commissioning of services to meet the ambitions outlined in this document with the available workforce capacity. It is envisaged that from 2024/25 ICBs will assume delegated responsibility for the commissioning of neonatal services.			✓	
	4.7	Work with trusts and higher education institutions to maximise student placement capacity, ensuring the effectiveness and quality of clinical placements.			✓	

	4.8	Assist trusts and regions with their workforce growth plans by providing direct support, including through operational delivery networks for neonatal staffing.				✓
	4.9	Boost midwifery workforce supply through undergraduate training, apprenticeships, postgraduate conversion, return to midwifery programmes, and international recruitment.				✓
	4.10	Increase medical training places across obstetrics and gynaecology and anaesthetics to expand the consultant workforce in maternity services.				✓
	4.11	Collaborate with the Royal College of Obstetricians and Gynaecologists (RCOG) to support their work developing an obstetric workforce planning tool, to be published in 2023/24. This initiative will help establish the staffing levels required to appropriately resource clinical leadership and intrapartum care.				✓
	4.12	Established midwifery posts have increased by over 2,000 WTE since March 2021, with obstetric consultant posts and maternity support worker posts each increasing by around 400 WTE since April 2021. For neonatal services, we have invested to establish over 550 new neonatal nurses, care-coordinators, and workforce and education leads, and have committed to funding 130 WTE new allied health professional and over 40 WTE new psychologist posts.				✓
Objective 5: Value and retain our workforce	5.1	Identify and address local retention issues affecting the maternity and neonatal workforce in a retention improvement action plan.	✓	Partially compliant: Progressing		
	5.2	Implement equity and equality plan actions to reduce workforce inequalities.	✓	Partially compliant: Progressing		
	5.3	Create an anti-racist workplace, acting on the principles set out in the combatting racial discrimination against minority ethnic nurses, midwives and nursing associates resource	✓	Partially compliant: Progressing		
	5.4	Identify and address issues highlighted in student and trainee feedback surveys, such as the National Education and Training Survey	✓	Partially compliant: Progressing		
	5.5	Offer a preceptorship programme to every newly registered midwife, with supernumerary time during orientation and protected development time. Newly appointed Band 7 and 8 midwives should be supported by a mentor.	✓	Compliant		
	5.6	Develop future leaders via succession planning, ensuring this pipeline reflects the ethnic background of the wider workforce.	✓	Partially compliant: Progressing		
	5.7	Share best practice for retention and staff support			✓	
	5.8	Highlight common or high-impact retention challenges to the national team to enable consideration of a national approach.			✓	

	5..9	Support retention with funding to continue a retention midwife in every maternity unit during 2023/24, with ICBs maintaining the focus on retention thereafter.				✓
	5.10	Continue to invest in neonatal operational delivery network (ODN) education and workforce leads to support the recruitment and retention of neonatal staff.				✓
	5.11	In 2023/24, provide funding to establish neonatal nurse quality and governance roles within trusts, to support cot-side clinical training and clinical governance.				
	5.12	In 2023/24, strengthen neonatal clinical leadership with a Continue to address workforce inequalities through the Workforce Race Equality Standard.national clinical director for neonatal and national neonatal nurse lead.				✓
	5.13	Continue to address workforce inequalities through the Workforce Race Equality Standard.				✓
	5.14	Provide national guidance for implementation of the A-Equip model and for the professional midwifery advocate role to provide restorative clinical supervision in local services.				✓
	5.16	By April 2024, develop a framework and models for coaching, to improve the quality of midwifery student clinical placements.				✓
Objective 6: Invest in skills	6.1	Undertake an annual training needs analysis and make training available to all staff in line with the core competency framework.	✓	Partially compliant: Progressing		
	6.2	Ensure junior and SAS obstetricians and neonatal medical staff have appropriate clinical support and supervision in line with RCOG guidance and BAPM guidance, respectively.	✓	Compliant		
	6.3	Ensure temporary medical staff covering middle grade rotas in obstetric units for two weeks or less possess an RCOG certificate of eligibility for short-term locums.	✓	N/A		
	6.4	Refresh the curriculum for maternity support workers (MSWs) by June 2023.				✓
	6.5	Provide tools to support implementation of the MSW competency, education, and career development framework by September 2023.				✓
	6.6	Work with RCOG to develop leadership role descriptors for obstetricians by summer 2023 to support job planning, leadership, and development				✓
	6.7	Work with Royal Colleges and professional organisations to understand and address the challenges involved in recruiting and training the future neonatal medical workforce.				✓
	6.8	Through action set out above to grow the workforce, help to address pressures on backfill for training.				✓
	Theme 3: Developing and sustaining a culture of safety, learning, and support					

		Measures: Staff surveys / education & medical training surveys / appreciative inquiry / CQC inspection				
Objective 7: Develop a positive safety culture	7.1	Make sure maternity and neonatal leads have the time, access to training and development, and lines of accountability to deliver the ambition above. Including time to engage stakeholders, including MNVP leads.	✓	Partially compliant: Progressing		
	7.2	Support all their senior leaders, including board maternity and neonatal safety champions, to engage in national leadership programmes (see below) by April 2024, identifying and sharing examples of best practice.	✓	Partially compliant: Progressing		
	7.3	At board level, regularly review progress and support implementation of a focused plan to improve and sustain maternity and neonatal culture	✓	Partially compliant: Progressing		
	7.4	Ensure staff are supported by clear and structured routes for the escalation of clinical concerns, based on frameworks such as the Each Baby Counts: Learn and Support escalation toolkit.	✓	Partially compliant: Guideline in place -further embedding		
	7.5	Ensure all staff have access to Freedom to Speak Up training modules and a Guardian who can support them to speak up when they feel they are unable to in other ways.	✓	Partially compliant: Workforce FTSU training to be explored		
	7.6	Monitor the impact of work to improve culture and provide additional support when needed.			✓	
	7.7	Provide opportunities for leaders to come together across organisational boundaries to learn from and support each other.			✓	
	7.8	By April 2024, offer the Perinatal Culture and Leadership Programme to all maternity and neonatal leadership quadrumvirates. This includes a diagnosis of local culture through a culture survey and provides practical support to nurture culture and leadership.				✓
Objective 8: Learn and improve	8.1	Understand 'what good looks like' to meet the needs of their local populations and learn from when things go well and when they do not.	✓	Partially compliant: Progressing		
	8.2	Respond effectively and openly to patient safety incidents using PSIRF.	✓	Partially compliant: Progressing		
	8.3	Ensure there is adequate time and formal structures to review and share learning, and ensure actions are implemented within an agreed timescale.	✓	Partially compliant:		

				Progressing		
	8.4	Consider culture, ethnicity and language when responding to incidents (NHS England, 2021).	✓	Compliant		
	8.5	Act, alongside maternity and neonatal leaders, on outcomes data, staff and MNVP feedback, audits, incident investigations, and complaints, as well as learning from where things have gone well.	✓	Compliant		
	8.6	Share learning and good practice across all trusts in the ICS.			✓	
	8.7	Oversee implementation of the PSIRF safety improvement plan, monitoring the effectiveness of incident response systems in place.			✓	
	8.8	Support the transition to PSIRF through national learning events.				✓
	8.9	Through regional teams, share insights between organisations to improve patient safety incident response systems and improvement activity.				✓
Objective 9: Support and oversight	9.1	Maintain an ethos of open and honest reporting and sharing information on the safety, quality and experience of their services.	✓	Compliant		
	9.2	Regularly review the quality of maternity and neonatal services, supported by clinically relevant data including – at a minimum – the measures set out in the perinatal quality surveillance model and informed by the national maternity dashboard.	✓	Compliant		
	9.3	Appoint an executive and non-executive maternity and neonatal board safety champion to retain oversight and drive improvement. This includes inviting maternity and neonatal leads to participate directly in board discussions.	✓	Compliant		
	9.4	Involve the MNVP in developing the trust's complaints process, and in the quality safety and surveillance group that monitors and acts on trends.	✓	Partially compliant: Progressing		
	9.5	At Board level listen to and act on Freedom to Speak Up data, concerns raised and suggested innovations in line with the FTSU Guide and improvement tool.	✓	Still Benchmarking		
	9.6	Commission services that enable safe, equitable and personalised maternity care for the local population.			✓	
	9.7	Oversee quality in line with the PQSM and NQB guidance, with maternity and neonatal services included in ICB quality objectives.			✓	
	9.8	Lead local collaborative working, including the production of a local quality dashboard that brings together intelligence from trusts.			✓	
	9.9	National bodies, ICBs and trusts to address issues escalated to national level.				✓
	9.10	Provide nationally consistent support for trusts that need it through the Maternity Safety Support Programme (MSSP).				✓
	9.11	Work to align the MSSP with the NHS oversight framework and improve alignment with the recovery support programme and evaluate the programme by March 2024.				✓

	9.12	During 2023/24, test the extent to which the PQSM has been effectively implemented.				✓
	9.13	By March 2024, provide targeted delivery of the Maternity and Neonatal Board Safety Champions Continuation Programme to support trust board assurance, oversight of maternity and neonatal services, and a positive safety culture.				✓
Theme 4: Standards and structures that underpin safer, more personalised, and more equitable care **Measures: existing safety ambition themes – maternal mortality, stillbirths, neonatal mortality, brain injury during or soon after birth, preterm births / implementation of saving babies lives care bundle v3 / avoiding term admissions to NICU / CQC inspection / CNST Maternity incentive scheme**						
Objective 10: Standards to ensure best practice	10.1	Implement version 3 of the Saving Babies' Lives Care Bundle by March 2024 and adopt the national MEWS and NEWTT-2 tools by March 2025.	✓	Partially compliant: Progressing		
	10.2	Regularly review and act on local outcomes including stillbirth, neonatal mortality and brain injury, and maternal morbidity and mortality to improve services.	✓	Compliant		
	10.3	Complete the national maternity self-assessment tool if not already done, and use the findings to inform maternity and neonatal safety improvement plans.	✓	Partially compliant: Progressing		
	10.4	Prioritise areas for standardisation and co-produce ICS-wide clinical policies such as for implementation of the Saving Babies' Lives Care Bundle.			✓	
	10.5	Oversee and be assured of trusts' declarations to NHS Resolution for the Maternity Incentive Scheme.			✓	
	10.6	Monitor and support trusts to implement national standards.			✓	
	10.7	Commission care that has regard to NICE guidelines.			✓	
	10.8	Keep best practice up to date through version 3 of the Saving Babies Lives Care Bundle and the MEWS and NEWTT-2 tools, as well as developing tools to improve the detection and response to suspected intrapartum fetal deterioration.				✓
	10.9	By spring 2024, identify the common challenges trusts and ICSs face in meeting national standards, and take action where national solutions may help.				✓
	10.10	Support the integration of MEWS, NEWTT-2, and other clinical tools into existing digital maternity information systems by autumn 2024.				✓
	10.11	Provide support to capital projects to increase and better align neonatal cot capacity throughout 2023/24 and 2024/25.				✓
	10.12	Provide support to capital projects to increase and better align neonatal cot capacity throughout 2023/24 and 2024/25.				✓

Objective 11: Data to inform learning	11.1	Review available data to draw out themes and trends and identify and address areas of concern including consideration of the impact of inequalities.	✓	Partially compliant: Progressing		
	11.2	Ensure high-quality submissions to the Maternity Services Data Set and report information on incidents to NHS Resolution, the Healthcare Safety Investigation Branch and National Perinatal Epidemiology Unit.	✓	Partially compliant: Progressing		
	11.3	Use data to compare their outcomes to similar systems and understand any variation and where improvements need to be made.			✓	
	11.4	At a regional level, understand any variation in outcomes and support local providers to address identified issues.				✓
	11.5	Convene a group to progress the recommendation from the Kirkup report for an early warning system to detect safety issues within maternity and neonatal services, reporting by autumn 2023.				✓
	11.6	Create a single notification portal by summer 2024 to make it easier to notify national organisations of specific incidents.				✓
	11.7	Publish a digital version of the national recommendations register by summer 2024, to support trusts to learn from and comply with national recommendations.				✓
Objective 12: Make better use of digital technology in maternity and neonatal services	12.1	Have and be implementing a digital maternity strategy and digital roadmap in line with the NHS England What Good Looks Like Framework.	✓	Compliant		
	12.2	Procure an EPR system – where that is not already being managed by the ICB – that complies with national specifications and standards, including the Digital Maternity Record Standard and the Maternity Services Data Set and can be updated to meet maternity and neonatal module specifications as they develop.	✓	Compliant		
	12.3	Aim to ensure that any neonatal module specifications include standardised collection and extraction of neonatal national audit programme data and the neonatal critical care minimum data set.	✓	Compliant		
	12.4	Have a digital strategy and, where possible, procure on a system-wide basis to improve standardisation and interoperability.			✓	
	12.5	Support women to set out their personalised care and support plan through digital means, monitoring uptake and feedback from users.			✓	
	12.6	Support regional digital maternity leadership networks.			✓	
	12.7	Set out the specification for a compliant EPR, including setting out the requirements for maternity by March 2024.				✓
	12.8	Publish a refreshed Digital Maternity Record Standard and Maternity Services Data Set standard by March 2024.				✓

	12.9	Grow the digital leaders' national community, providing resources, training and development opportunities to support local digital leadership.				✓
	12.01	Incorporate pregnancy-related data and features into the NHS App to enhance the facility for women to view their patient records via the NHS app.				✓
	12.11	Develop facets of a Digital Personal Child Health Record with citizen-facing tools to support neonatal and early years health by March 2025.				✓

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	27 July 2023						
Title	Freedom to Speak Up Guardian (FTSUG) Report						
Report of	Maurya Cushlow, Executive Chief Nurse						
Prepared by	Andy Pike, Freedom to Speak Up Guardian						
Status of Report	Public		Private		Internal		
	☒		☐		☐		
Purpose of Report	For Decision		For Assurance		For Information		
	☐		☒		☒		
Summary	This report provides a summary of the activity undertaken by the Trust's Freedom to Speak Up Guardian since the last report, dated June 2022. It outlines the number and nature of concerns raised, staff groups contacting the FTSUG and an update on the development of the service. The reporting arrangements for FTSU are to be reviewed to ensure visibility in line with the FTSU strategy.						
Recommendation	The Board of Directors is asked to receive the report, reflect on the themes raised in staff concerns and continue to support the Freedom to Speak Up function within the Trust.						
Links to Strategic Objectives	People – Supported by Flourish, our cornerstone programme, we will ensure that each member of staff is able to liberate their potential.						
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☒	☐	☐	☒	☒	☒	☐
Link to Board Assurance Framework [BAF]	No direct link. The FTSUG role and monitoring of concerns raised through this service are essential to the delivery of safe, high quality services and a culture of fairness, equality and openness.						
Reports previously considered by	Presented to the People Committee in April 2023.						

FREEDOM TO SPEAK UP GUARDIAN REPORT

EXECUTIVE SUMMARY

The FTSU service continues to receive an increasing number of contacts from staff as a result of the promotional work, consistency of message regarding speaking up generally and, essentially, the increased number of staff-to-staff recommendations. The service has seen growth in excess of 200% in the last 3 years. Staff satisfaction with the service they receive remains consistently high with excellent responses in feedback questionnaires.

Although the main themes for investigations continue to centre on inter-personally relationships, there are also sub-themes being raised informally which should be acknowledged.

FREEDOM TO SPEAK UP GUARDIAN REPORT

1. INTRODUCTION

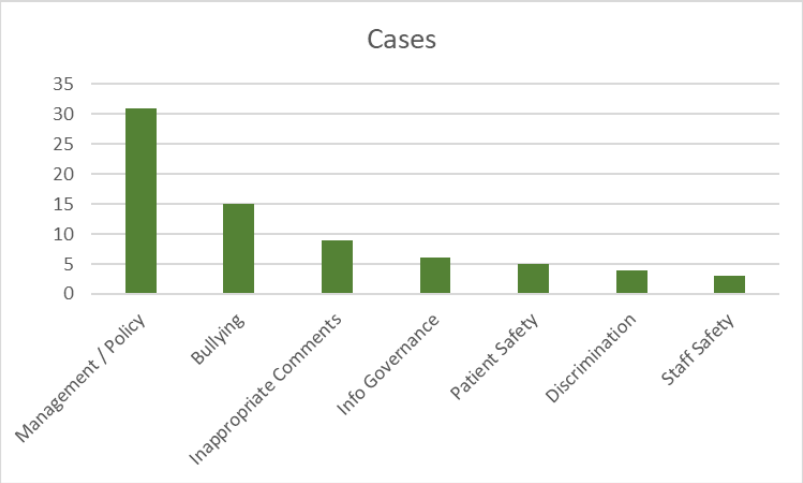
This report provides detail of the activity undertaken by the Trust's Freedom to Speak Up Guardian (FTSUG) since June 2022, outlining the number and nature of concerns raised. Further, it provides the Trust with broad themes arising from the concerns raised for consideration and an update on the on-going development of the service.

1.1 Activity

Between June 2022 and March 2023, the FTSUG has managed 73 cases which required intervention beyond advice and support being given to the complainant. The increasing level of activity, and the greater number of concerns being raised with a degree of seriousness which required significant intervention, reflects the growing credibility of the service. I believe staff are feeling progressively more confident in speaking up and, although there is significant work still to be done in many areas, psychologically safe to do so. Staff continue to express concerns about possible repercussions for speaking up, particularly when the issue relates to their line manager; however, more (but not all) are confident in doing so after speaking with the FTSUG or colleagues who have used the service.

All staff who accessed the service were given the opportunity to feedback via a questionnaire. Of those who responded, 100% said that they would recommend the service to a colleague and 100% rated it as 5 out of 5. Free text feedback highlighted the value of the service to staff in need, the responsiveness of the FTSUG, how helpful the insightful advice had been in trying to address challenging situations, and the speed in which the Guardian was able to help staff navigate to a positive resolution to their problems.

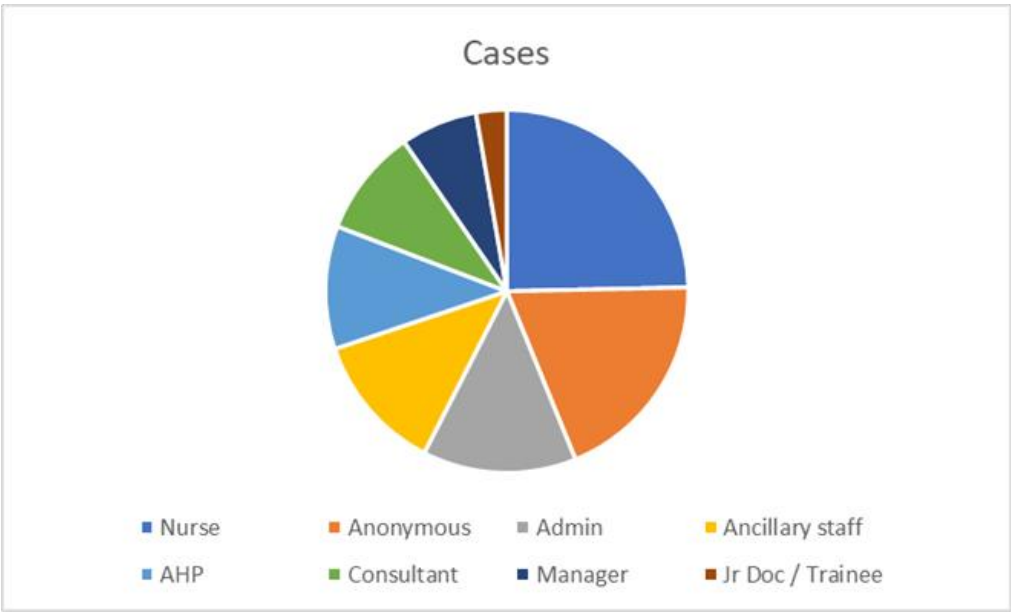
The vast majority of concerns raised continue to relate to interpersonal relationships, particularly between line managers (or Human Resources (HR)) and staff. These do not necessarily equate to bullying allegations but perceptions of mismanagement, ineffective or unfair HR processes or inequity.



In addition to the concerns raised which result in investigations, there are also themes in the issues raised with the FTSUG informally. These include:

- Inconsistent application of policy such as sickness management
- Flexible working arrangements
- Staff morale
- Communication between managers and staff

Various groups of staff continue to use the service to raise concerns. The largest groups remain nursing and administrative, although there has been a considerable and sustained increase in consultant staff, senior management, trainees and specialist roles which reflects the increasing awareness of, and confidence in, the FTSU service. When asked, most of these groups of staff contacted the Guardian following a recommendation from a colleague.



1.2 Service Development

A FTSU Strategy has been produced and ratified in late 2022 (appended). There have been some delays in the communication of this across the Trust, but this is anticipated imminently. It is hoped that this will build on the growing awareness of the service across the workforce.

The FTSUG is planning to work with the newly formed Clinical Boards to address any speak up related concerns following the publication of departmental level Staff Survey results and the embedding of the new structure.

The FTSU service has developed significantly in recent years, from a reactive service to a proactive part of the Trust's speak up offer. Service developments include:

- Establishing a network of Freedom to Speak Up Champions, reporting to and supported by the FTSUG.
- Enhanced staff training and awareness with inclusion in induction, education days, staff network links, online training development and attendance at staff forums.

- Regional and National FTSU network links.
- Supporting / informing Trust initiatives such as 'What Matters to You'.

2 RECOMMENDATIONS

The Board is asked to receive the report and support the on-going development of the Freedom to Speak Up Guardian role and service.

Report of Maurya Cushlow
Executive Chief Nurse

Prepared by Andy Pike, FTSUG

Freedom to Speak Up Strategy

Newcastle upon Tyne Hospitals NHS Foundation Trust

Purpose:

Sir Robert Francis's 'Freedom to Speak Up Review' published in February 2015 highlighted the need 'to ensure that NHS staff in England feel safe to raise concerns, confident that they will be listened to and the concerns will be acted upon'. The Review recommended a number of principles and actions, including the creation of a Freedom to Speak Up Guardian (FTSUG) to support staff to raise concerns. This report also provided recommendations for NHS Trusts, supported by the National Guardian's Office, and is now included in the NHS Contract which is monitored by the Care Quality Commission (CQC). The CQC assess a Trust's speaking up culture during inspections under key line of enquiry (KLOE) 3 as part of the well-led domain.

This Strategy sets out the Trust's vision and strategy for Freedom to Speak Up, the proposed outcomes and measures. It should be read in conjunction with the Trust's 'Speak Up - We're Listening Policy' and the 'Dignity and Respect at Work Policy', which provide guidance to all staff on the behaviours expected to ensure everyone is treated respectfully at work, and the services available to any staff needing support, underpinning the development of a culture that embraces transparency and supports raising concerns to improve patient safety.

Our Vision:

We are committed to promoting an open and transparent culture across the organisation to ensure that all members of staff feel safe and confident to speak out about any issues that concern them.

Our Board and senior leadership team will support this agenda by:

- modelling the behaviours to promote a positive culture in the organisation
- supporting the Freedom to Speak Up Guardian when issues of concern are escalated to them
- providing the resources required to deliver an effective Freedom to Speak Up function
- having oversight to ensure the policy and procedures are being effectively implemented.

Our FTSU Guardian has a key role in:

- helping to raise the profile of raising concerns in our organisation and helping embed a culture of transparency
- cultivating confidence in the service by offering timely responses to concerns and ensuring staff are supported appropriately throughout the investigation of their concerns
- developing and supporting a team of Champions who can promote the service, speaking up in general and signpost staff to the Guardian
- engage with the National Guardian's Office and the local network of Freedom to Speak Up Guardians in our region to learn and share best practice
- providing independent, confidential advice and support to staff in relation to concerns they have

- providing timely intelligence to the organisation regarding hotspot areas, themes in concerns and/or other pertinent information

Activities in these areas will be led by the Guardian, with support from the Executive Sponsor (the Executive Chief Nurse), and the lead Non-executive Director, with additional support and commitment from the Board of Directors as well as the network of Freedom to Speak Up Champions.

Together, we will all work to provide an open and transparent culture across our Trust to ensure that all members of staff feel safe and confident to speak out and raise their concerns.

Our Strategy

We will focus on the following actions to deliver our vision.

- Ensure that all staff aware of the services available to them through which they can raise concerns from the start of their employment by incorporating FTSU information in the induction process
- Provide central support to deliver regular and diverse communication and education to ensure that everyone is aware of how they can speak up. A rolling communications programme ensures all workers are made aware of the Speaking Up programme through marketing materials in all areas of the hospital (posters and leaflets), regular intranet updates and face to face communications
- Provide the Trust Board (via the People Committee) with bi-annual reports, detailing the nature and volume of concerns being raised and highlighting and areas of concern or improvement
- Ensure reports are submitted to the National Guardians Office within set deadlines to help inform national strategies and monitoring
- Provide the appropriate training to ensure managers are clear about their roles and responsibilities when handling concerns and are supported to do so effectively
- Ensure monitoring and evaluation of the number and nature of concerns is timely and used to inform Trust action
- Ensure that key learning related to concerns are shared in an open and transparent manner, while respecting confidentiality
- Ensure feedback is gathered from staff using the Freedom to Speak Up service to enable proactive continuous improvement through lessons learnt
- Provide regular monitoring and review of policies relating to speaking up
- Ensure staff confidentiality is fully respected to maintain the credibility of the service and raise staff confidence in speak up

Outcomes and measures

The measures to monitor progress against the actions are as follows:

- Consistently high compliance for corporate induction training and local induction
- Staff engagement with the Freedom to Speak Up educational modules on ESR

- Regular communications to staff and other workers in the Trust about speaking up services
- The number of concerns being raised to the Guardian
- Responses to annual Staff Survey questions regarding speaking up, patient safety culture and staff psychological safety
- Benchmarking data to show how the Trust compares with comparative hospitals nationally
- Feedback from those who have raised concerns (i.e. whether they would recommend the service to a colleague)
- A bi-annual update on the Freedom to Speak Up service presented to the Board via the People Committee by the Freedom to Speak Up Guardian
- Monitoring and triangulation of key data such as grievances, exit interviews, retention figures, serious incidents and concerns raised via alternative speak up routes.

Author: Andy Pike, Freedom to Speak Up Guardian

Executive Sponsor: Maurya Cushlow, Executive Chief Nurse

Ratifying Committee: People Committee

Date of Ratification: 18th October 2022

Review Date: October 2025

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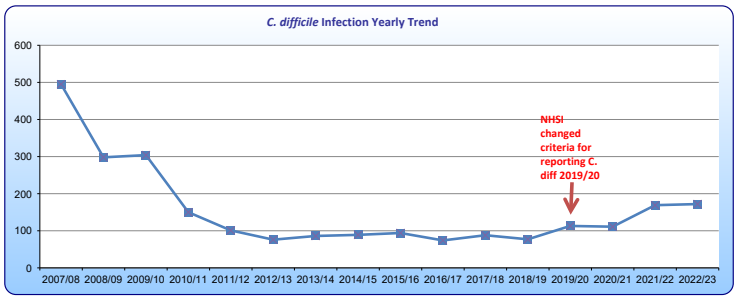
PUBLIC BRP - Agenda item A10(d)

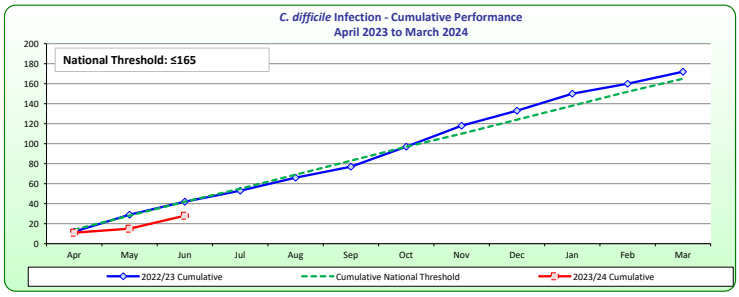
Healthcare-Associated Infections Report
June 2023

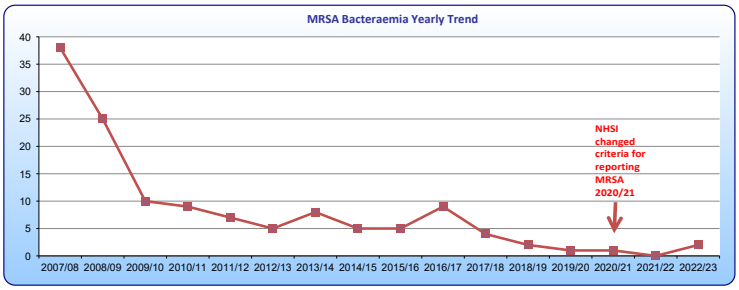
The Newcastle upon Tyne Hospitals
NHS Foundation Trust

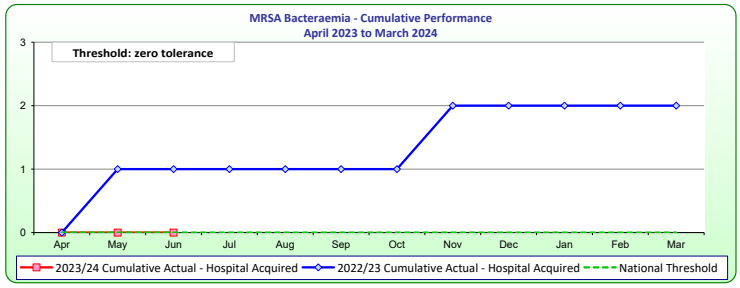
MRSA Bacteraemia - Cumulative Performance
April 2023 to March 2024

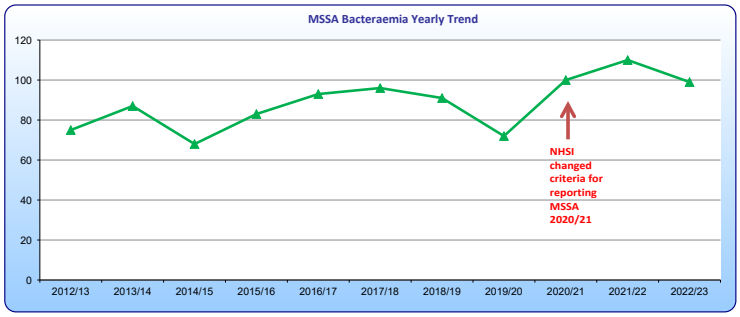
C. difficile - Cumulative Performance
April 2023 to March 2024

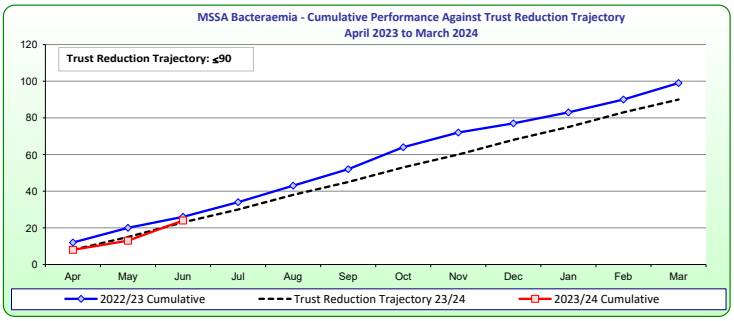

C. difficile Infection Yearly Trend
600
500
400
300
200
100
0
NHSI changed criteria for reporting C. diff 2019/20
2007/08 2008/09 2009/10 2010/11 2011/12 2012/13 2013/14 2014/15 2015/16 2016/17 2017/18 2018/19 2019/20 2020/21 2021/22 2022/23

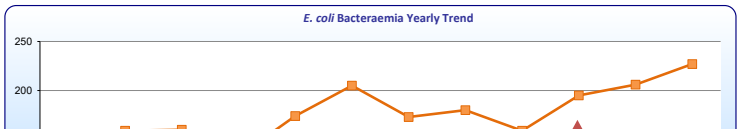

C. difficile Infection - Cumulative Performance
April 2023 to March 2024
National Threshold: ≤165
200
180
160
140
120
100
80
60
40
20
0
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2022/23 Cumulative
Cumulative National Threshold
2023/24 Cumulative


MRSA Bacteraemia Yearly Trend
40
35
30
25
20
15
10
5
0
NHSI changed criteria for reporting MRSA 2020/21
2007/08 2008/09 2009/10 2010/11 2011/12 2012/13 2013/14 2014/15 2015/16 2016/17 2017/18 2018/19 2019/20 2020/21 2021/22 2022/23


MRSA Bacteraemia - Cumulative Performance
April 2023 to March 2024
Threshold: zero tolerance
3
2
1
0
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2023/24 Cumulative Actual - Hospital Acquired
2022/23 Cumulative Actual - Hospital Acquired
National Threshold


MSSA Bacteraemia Yearly Trend
120
100
80
60
40
20
0
NHSI changed criteria for reporting MSSA 2020/21
2012/13 2013/14 2014/15 2015/16 2016/17 2017/18 2018/19 2019/20 2020/21 2021/22 2022/23


MSSA Bacteraemia - Cumulative Performance Against Trust Reduction Trajectory
April 2023 to March 2024
Trust Reduction Trajectory: ≤90
120
100
80
60
40
20
0
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2022/23 Cumulative
Trust Reduction Trajectory 23/24
2023/24 Cumulative


E. coli Bacteraemia Yearly Trend
250
200


E. coli Bacteraemia - Cumulative Performance Against Trust Reduction Trajectory & National Threshold
April 2023 - March 2024
National Threshold: ≤189
240
210
180

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	2										2
MRSA Bacteraemia - Trust-assigned (objective 0)	0	0	0										0
MSSA Bacteraemia - Healthcare Associated (local objective ≤90)	8	5	11										24
E. coli Bacteraemia - Healthcare Associated (National Threshold ≤189)	25	13	19										57
Klebsiella Bacteraemia - Healthcare Associated (National Threshold ≤130)	9	8	13										30
Pseudomonas aeruginosa Bacteraemia - Healthcare Associated National Threshold ≤38)	4	7	2										13
C. diff - Hospital Acquired (national threshold ≤165)	11	4	13										28
C. diff related death certificates	2	0	1										3
Part 1	2	0	1										3
Part 2	0	0	0										0
Periods of Increased Incidence (PIIs)	**April**	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Cumulative**
C. diff - Hospital Acquired	0	2	2										4
Patients affected	1	2	6										9
COVID-19 - Hospital Acquired	1	1	1										3
Patients affected	2	3	2										7
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)	23	8	6										37
Hospital onset Definite HC assoicated (≥15 days post admission)	39	20	7										66
Outbreaks	**April**	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Cumulative**
Norovirus Outbreaks	2	1	0										3
Patients affected (total)	18	8	0										26
Staff affected (total)	4	7	0										11
Bed days losts (total)	126	3	0										129
Other Outbreaks	0	0	1										1
Patients affected (total)	0	0	18										18
Staff affected (total)	0	0	6										6
Bed days losts (total)	0	0	51										51
COVID Outbreaks	8	2	1										11
Patients affected (total)	38	18	4										60
Staff affected (total)	0	4	0										4
***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	13:47	13:55	11:53										
Laboratory Turnaround Time	3:23	3:08	2:55										
Total to Result Availability	17:10	17:03	14:48										

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	95 %	94 %	93 %										94 %
Standard IPC Precautions (incl HH, ANTT, PPE) Audit Trust Total	96 %	96 %	93 %										95 %
Invasive Device Care Audit Trust Total	95 %	96 %	92 %										94 %
Matron Checks (IP; OP/Community/Dental; Theatres) Trust Total	94 %	96 %	91 %										94 %
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	95 %	93 %	92 %										93 %
Standard IPC Precautions (incl HH, ANTT, PPE) Audit Acute only Total	96 %	95 %	93 %										95 %
Invasive Device Care Audit Acute only Total	96 %	96 %	92 %										95 %
Matron Checks (IP; OP/Community/Dental; Theatres) Acute only Total	93 %	96 %	91 %										93 %
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	97 %	98 %	96 %										97 %
Standard IPC Precautions (incl HH, ANTT, PPE) Community only Total	91 %	100 %	95 %										95 %
Invasive Device Care Audit Community only Total	78 %	100 %	100 %										93 %
Matron Checks (OP/Community/Dental) Community only Total	98 %	99 %	99 %										99 %

Education & Training

23.05.2023

Infection Control Mandatory Training (%)	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Average
Infection Control (Level 1)	95 %	93 %	94 %										94 %
Aseptic Non Touch Technique Training (%)	**April**	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Average**
ANTT (M&D staff only)	65 %	65 %	65 %										65 %

ANTT compliance levels

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

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

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	27 July 2023						
Title	Update from Committee Chairs						
Report of	Non-Executive Director Committee Chairs						
Prepared by	Mrs Lauren Thompson, Corporate Governance Manager / Deputy Trust Secretary Mrs Gillian Elsender, PA to Chairman and Trust Secretary / Corporate Governance Officer						
Status of Report	Public	Private	Internal				
	☒	☐	☐				
Purpose of Report	For Decision	For Assurance	For Information				
	☒	☐	☒				
Summary	The report includes updates on the work of the following Trust Committees that have taken place since the last meeting of the Trust Board in May 2023: • Charity Committee – 8 June 2023; • People Committee – 22 June 2023; • Quality Committee – 18 July 2023; • Finance Committee – 26 July 2023; and • Audit Committee – 28 June 2023 *[EXTRAORDINARY]* and 25 July 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
	☒	☒	☒	☒	☒	☒	☐
Link to Board Assurance Framework [BAF]	No direct link.						
Reports previously considered by	Regular report.						

UPDATE FROM COMMITTEE CHAIRS

EXECUTIVE SUMMARY

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

UPDATE FROM COMMITTEE CHAIRS

1. CHARITY COMMITTEE

A meeting of the Charity Committee took place on 8 June 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 £ 238,295.00 as follows:

- Children Services: The Teapot Trust – Art therapy provision for paediatric rheumatology patients at the Great North Children's Hospital - £79,758.00
- Peri-Operative & Critical Care: Creating and installing information boards within the four NUTH adult critical care units - £26,664.00
- Peri-operative & Critical care: Difficult airway management training equipment for anaesthetist staff - £30,373.00
- People First: The People First (PF) Café: a place of 'happiness and hope' - £51,500.00
- Radio Tyneside: Digital Technology Studio Upgrade - £50,000.00

The next meeting of the Committee will take place on 10 August 2023.

2. PEOPLE COMMITTEE

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

- An industrial action status update was provided.
- The annual Trade Union Facility Time report which was approved.
- The Chief People Officer presented the planning and actions taken against the People Priorities.
- A detailed update in relation to Statutory and Mandatory Training was provided.
- The Guardian of Safe Working provided a comprehensive quarterly update and the annual report.
- The People and Culture dashboard was received and discussed.
- The NHS Equality Diversity and Inclusion Improvement plan was received.

The next formal meeting of the Committee will take place on 22 August 2023.

3. QUALITY COMMITTEE

A meeting of the Quality Committee took place on 18 July 2023. During the meeting, the main areas of discussion included:

- The Head of Corporate Risk and Assurance presented the Quality Committee Risk Report.

- The following management group reports were received and discussed:
    - Clinical Outcomes and Effectiveness Group annual report; and
    - Clinical Outcomes and Effectiveness Group Chairs regular report.
- The Deputy Chief Operating officer presented the Intensive Support Team Report.
- The Director of Quality and Effectiveness and Director of Midwifery presented the CNST quarterly report.
- A comprehensive Newcastle Improvement update was received.
- An update was provided in relation to the Trust's response to the recent Care Quality Commission (CQC) inspections.
- The Deputy Director of Estates provided an update on the Patient-Led Assessments of the Care Environment (PLACE) assessments.
- The Committee received an update on leadership walkabouts and spotlights on services.

The next meeting of the Committee will take place on 19 September 2023.

4. FINANCE COMMITTEE

A meeting of the Finance Committee took place on 26 July 2023. During the meeting, the main areas of discussion included:

- The Chief Finance Officer provided an update on the month 3 finance position.
- The Productivity and Efficiency programme was discussed.
- The Executive Director of Business, Development and Enterprise presented the performance report and activity plan progress.
- The Director of Estates provided an update on Capital including projects.
- Tenders and Business Cases were presented for approval.
- The Committee received the Integrated Covid Hub North East (ICHNE), Nightingale Hospital North East (NHNE) and Day Treatment Centre (DTC) close out report.

The next meeting of the Committee will take place on 25 September 2023.

5. AUDIT COMMITTEE

An extraordinary meeting of the Audit Committee took place on 28 June 2023 to approve the annual report and accounts for 2022/23.

A meeting of the Audit Committee took place on 25 July 2023. During the meeting, the main areas of discussion included:

- The Head of Corporate Risk and Assurance presented the Audit Committee Risk Report.
- The Standards of Business Conduct Annual Report, including the Chairman's Fit and Proper Persons Statement.
- The draft Charity Annual Financial Statements.

- A detailed review of the Scheme o Delegation, Standing Financial Instructions and Standing Orders.
- A review of the Clinical Audit Process.
- External audit, internal audit and counter fraud reports.
- The Modern Slavery and Human Trafficking Act Annual Statement.
- The Committee received a number of reports including:
    - Debtors and creditors balances;
    - Schedule of losses and Compensation; and
- A review of the performance of external audit, internal audit and counter fraud reports.

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

6. 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
14 July 2023

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	27 July 2023						
Title	Integrated Board Report						
Report of	Angela O'Brien- Director of Quality and Effectiveness.						
Prepared by	Gavin Snelson- Head Quality and Effectiveness, Joanne Field – Senior Information Manager.						
Status of Report	Public		Private		Internal		
	☒		☐		☐		
Purpose of Report	For Decision		For Assurance		For Information		
	☐		☒		☐		
Summary	This paper is to provide assurance to the Board on the Trust's 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
	☒	☐	☒	☒	☐	☐	☐
Link to Board Assurance Framework [BAF]	Strategic risk SO1.1 [Capacity and Demand] Strategic risk SO1.4 [Core standards – patient safety and quality of care] 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. Throughout the month of May 2023, the total number of Trust onset C.Difficile infections has reduced (n= 4). At the same time, the number of Trust onset Pseudomonas Aeruginosa Bacteraemias has increased (n= 7).
2. There has been a continued reduction of inpatient acquired pressure ulcers since January 2023.
3. In 2022/23 the total number of patient falls increased by 25.6%, from 2,547 in 2021-22 to 3,200 in 2022-23.
4. There were 14 serious incidents in June 2023. The Duty of Candour (DoC) process has been initiated for all cases.
5. One Never Event was reported in June 2023.
6. The Trust has opened a total of 117 (110 with identified patient activity) formal complaints up to the end of June 2023.
7. There were 48 sharps incidents reported in June 2023.
8. Baseline assessments were completed for nine national audits in June 2023.
9. Mandatory training compliance stands at 92**%** at end of June 2023, against an end of year target of 95%.
10. Appraisal compliance stands at 80.44% at end of June 2023, against an end of year target of 95%.
11. In the period ending 30 June 2023 the Trust incurred expenditure of £374 million and received and income of £364 million leaving a deficit of £9.9 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

July 2023

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

Operational pressures have receded. COVID numbers are the lowest they have been at 3-4 patients and there is less pressure to board patients into Surgery. Some patients however continue to be delayed in accessing assessment and packages of care which would optimise their discharge and improve bed occupancy.

A&E performance continues to show improvement with increasing days of performance at the higher level of 80+%. There remains good management of ambulance handovers. Ongoing periods of Industrial Action continue to adversely impact on the elective programme.

Report Highlights

1. Throughout the month of May 2023, the total number of Trust onset **C.Difficile infections has reduced (n= 4)**. At the same time, the number of Trust onset **Pseudomonas Aeruginosa Bacteraemias has increased (n= 7)**.

2. There has been a **continued reduction of inpatient acquired pressure ulcers since January 2023.**

3. **In 2022/23 the total number of patient falls increased by 25.6%,** from 2,547 in 2021-22 to 3,200 in 2022-23.

4. There were **14 serious incidents in June 2023.** The Duty of Candour (DoC) process has been initiated for all cases.

5. One Never Event was reported in June 2023.

6. The Trust has **opened a total of 117 (110 with identified patient activity) formal complaints** up to the end of June 2023.

7. There **were 48 sharps incidents** reported in June 2023.

8. **Baseline assessments were completed for nine national audits** in June 2023.

9. **Mandatory training compliance stands at 92%** at end of June 2023, against an end of year target of 95%.

10. **Appraisal compliance stands at 80.44%** at end of June 2023, against an end of year target of 95%.

11. In the period ending 30 June 2023 the Trust incurred expenditure of £374 million and received and income of £364 million leaving a **deficit of £9.9 million.**

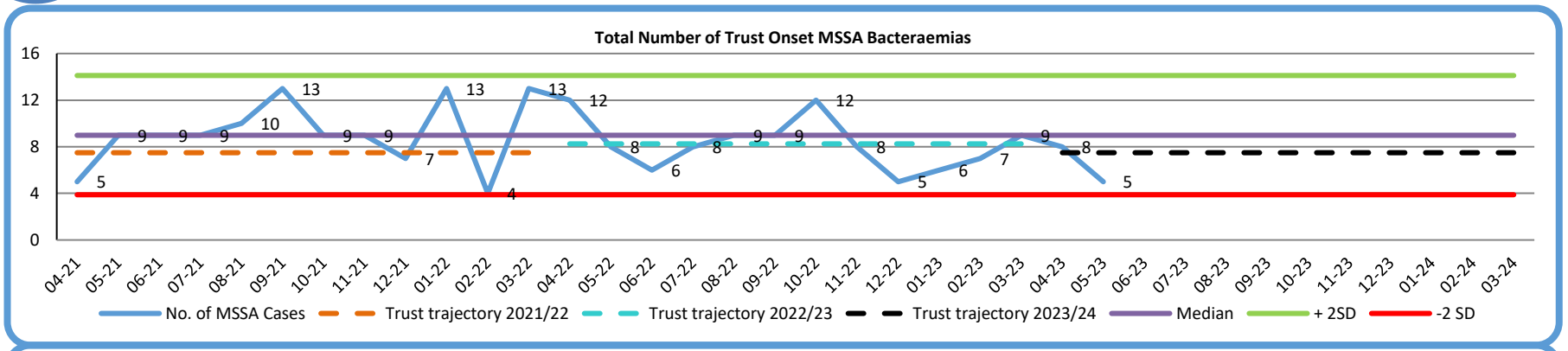
Contents: July 2023

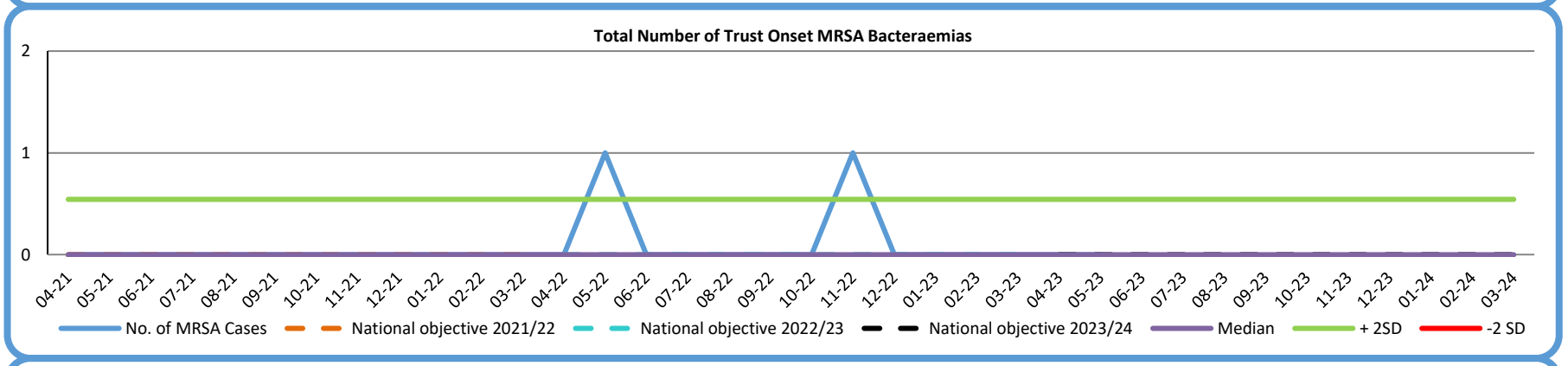
Quality

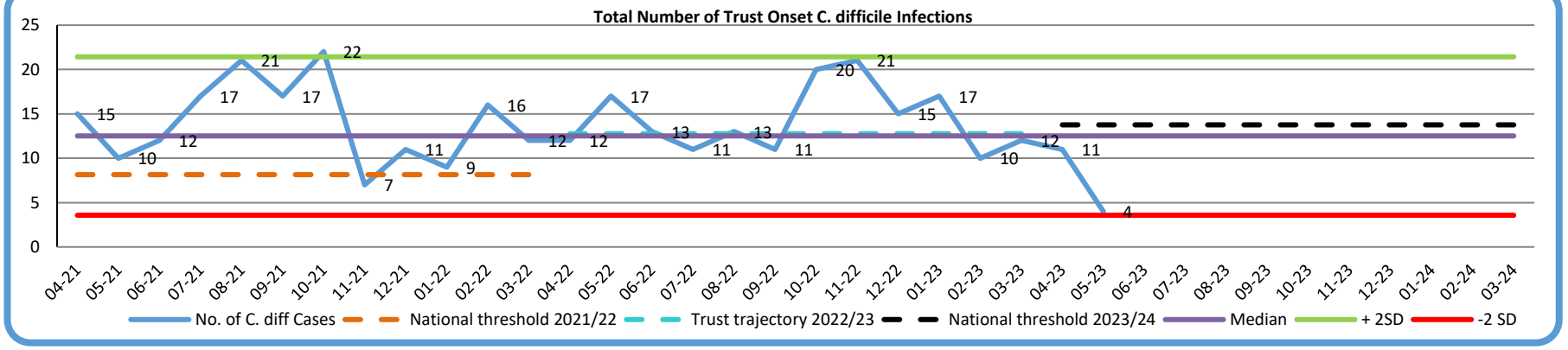
People

Finance

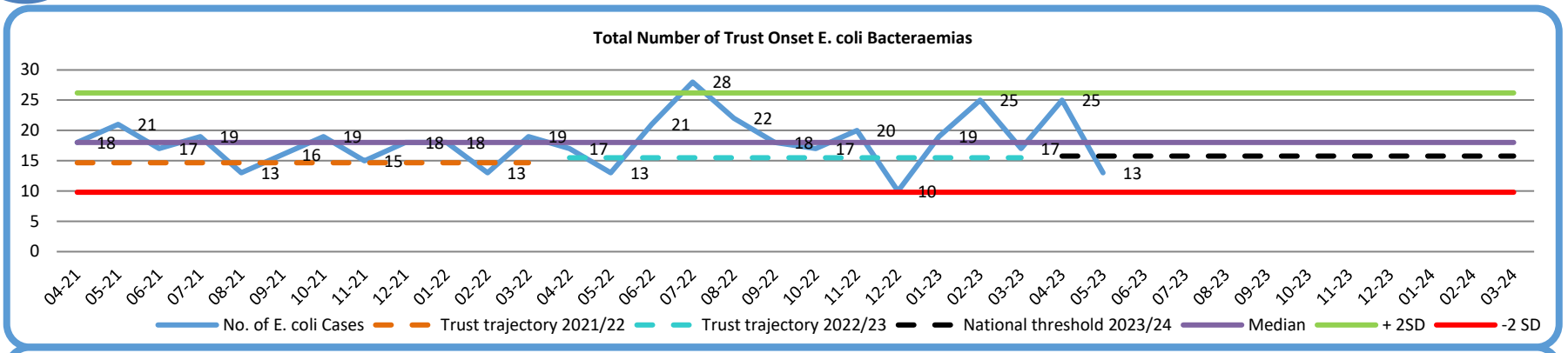
Quality: Healthcare Associated Infections 1/2

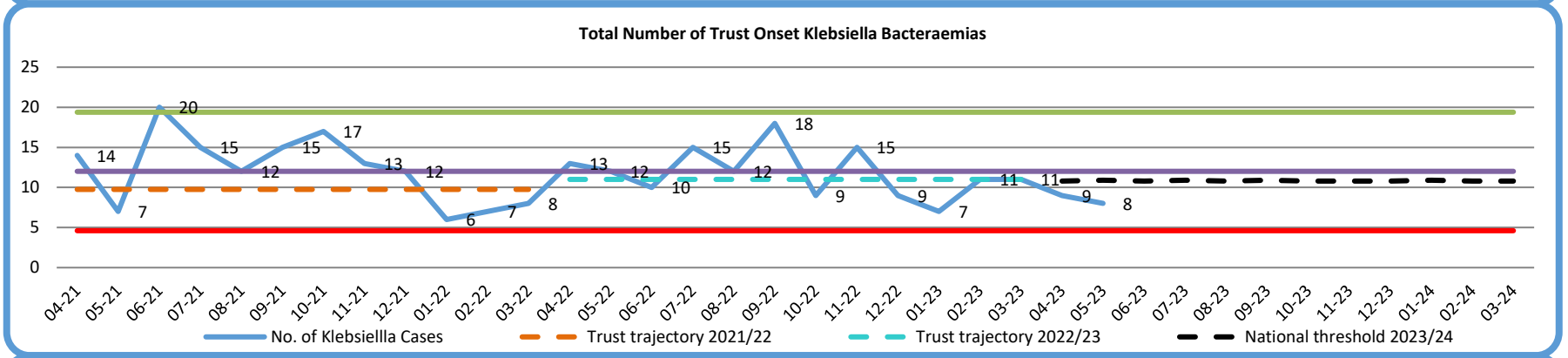


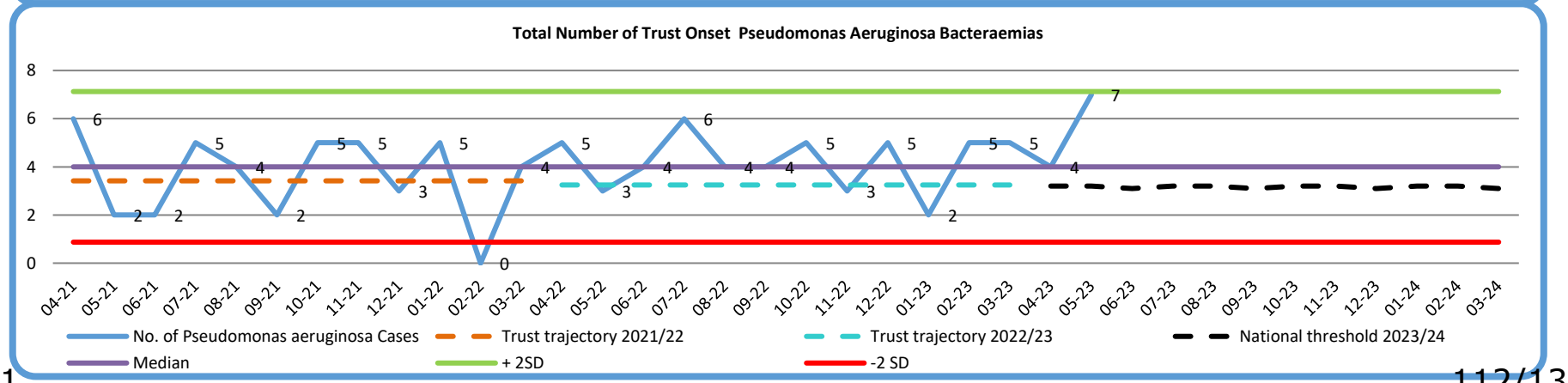




Quality: Healthcare Associated Infections 2/2







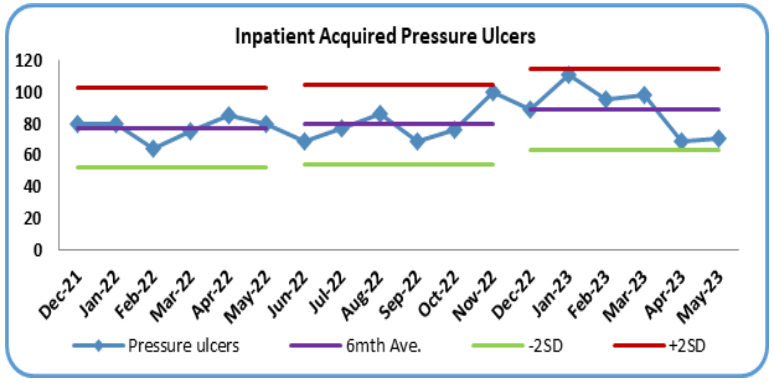
Quality: Harm Free Care – Pressure Damage

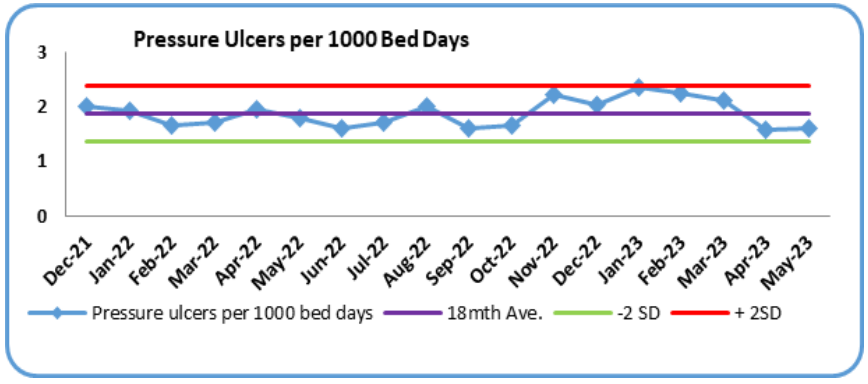
Analysis of data has demonstrated the following key points:

- There has been a continued reduction of inpatient acquired pressure ulcers since January 2023. This is both in terms of total numbers and per 1000 bed days. The figures for the last quarter also demonstrate a reduction compared to the same period in 2022.
- 97% of acquired pressure ulcers reported were Category II damage, graded low/minor harm. The remaining 3% were graded as Category III damage, and therefore are identified as serious incidents, requiring a root cause analysis (RCA) which has been completed.
- No Category IV or above damage has been reported and compared to 2021/2022 figures, there has been a 5% reduction in acquired pressure damage of Category III and above.
- There has been an increase in patients presenting to the Trust with significant existing damage. This group are at a higher risk of developing further pressure damage or deterioration of existing damage. It was highlighted through the RCA process that noted 19.3% (23 of 117) of RCAs undertaken were for patients who presented with existing damage which had deteriorated.

Current actions in place:

- On a monthly basis, each inpatient ward area receives their harm free care dashboard to guide local improvement and inform good practice.
- The tissue viability team identify areas of high incidence, undertaking focussed work where required. This includes staff education as well as examining themes of RCA's, such as ensuring patients risk factors are identified and appropriate preventative measures are put in place, as well as assessing mattress quality.
- In 2022-23 all inpatient areas (with the exception of the Great North Childrens Hospital (GNCH)) were given a 20% reduction trajectory. End of year data identified 8% achieved a 20% reduction with a number exceeding this 20% reduction. 4% had no pressure ulcers.
- A pilot has commenced to introduce a new risk assessment tool called PURPOSE T to replace the existing tool (Braden) and support staff to identify and plan care for those patients at risk of pressure damage.





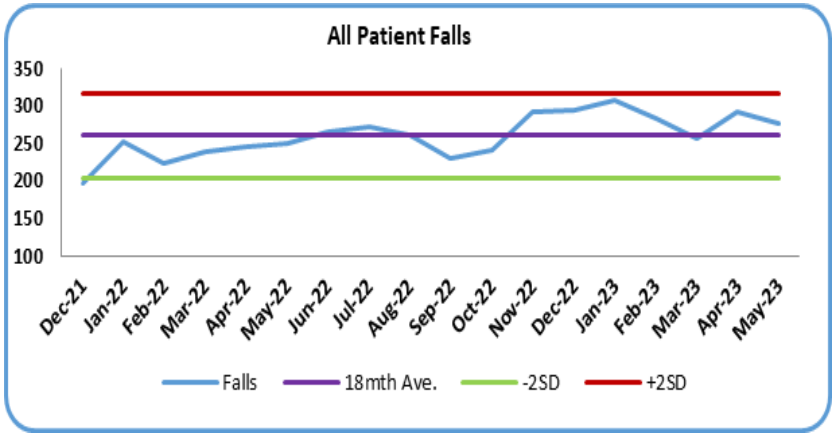
Quality: Harm Free Care - Falls

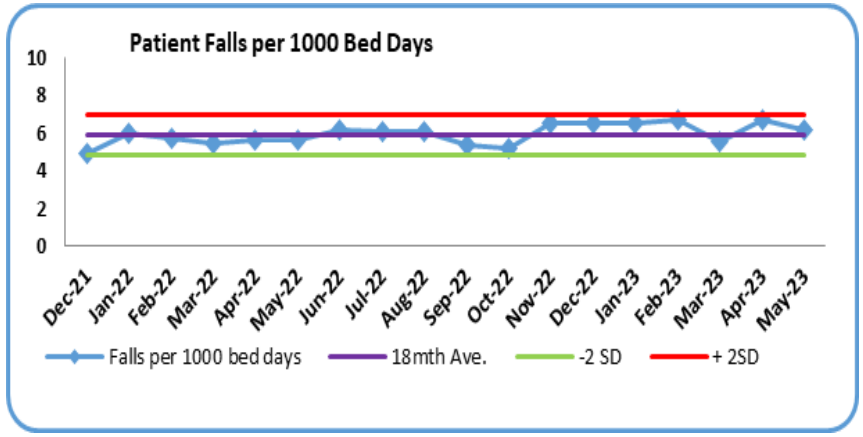
Analysis of data has demonstrated the following key points:

- In 2022-23 the total number of falls has increased by 25.6%, from 2,547 in 2021-22 to 3,200 in 2022-23.
- 98% of reported falls, are classified as low/no harm and staff are actively encouraged to report any fall/slip/trip no matter how insignificant.
- The increase in total falls is mirrored by the increase in bed occupancy and the evidence of significantly increased acuity and dependency of our patients. This is closely monitored by the Nurse Staffing and Clinical Outcomes Group to support active intervention where required.

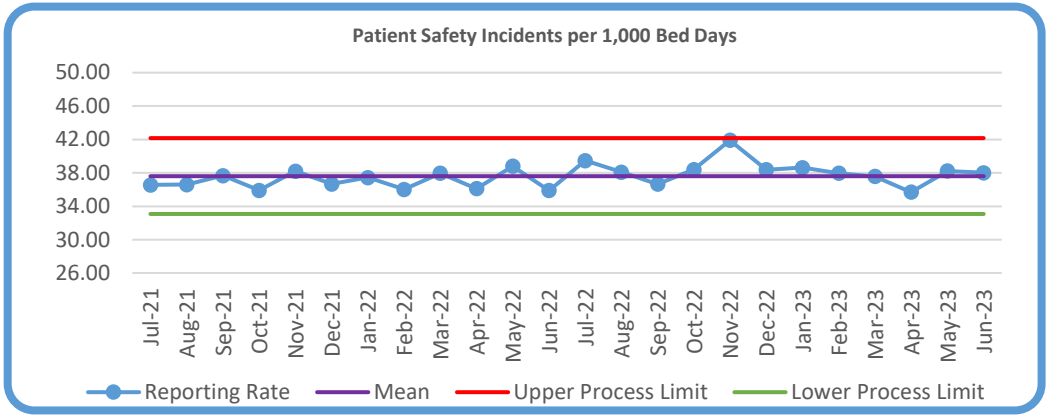
Current actions in place:

- The Falls Co-ordinator reviews ward level data on a monthly basis. Wards with the highest incidence of falls, reviewing contributing factors and identifying learning and solutions, with the aim to reduce numbers of falls in the Trust.
- Focused work has taken place promoting the importance of preventative measures such as lying and standing blood pressure measurements in patients over 65.
- In line with Trust assurance measures, focused auditing has taken place to monitor compliance with the Trust's Enhanced Level of Care (ELOC) assessments. The purpose of which, was firstly to validate that individual risk factors were correctly identified, and secondly that appropriate provision of care was implemented according to risk. This work has highlighted the requirement for focused education to take place, as well as a recap for clinical staff. Work continues on a rolling programme across the organisation.
- Work is underway in conjunction with the Dementia Specialist Nursing Team to reduce falls in patients with dementia as this group of patients are at higher risk.
- In 2022-23 all inpatient area were given a 20% reduction trajectory. 13% achieved a 20% reduction with a number exceeding this and a number demonstrating no falls.

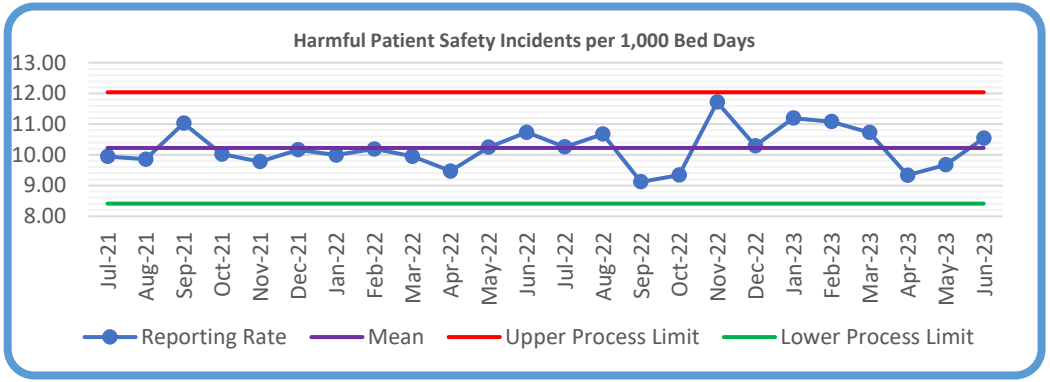




Quality: Incident Reporting

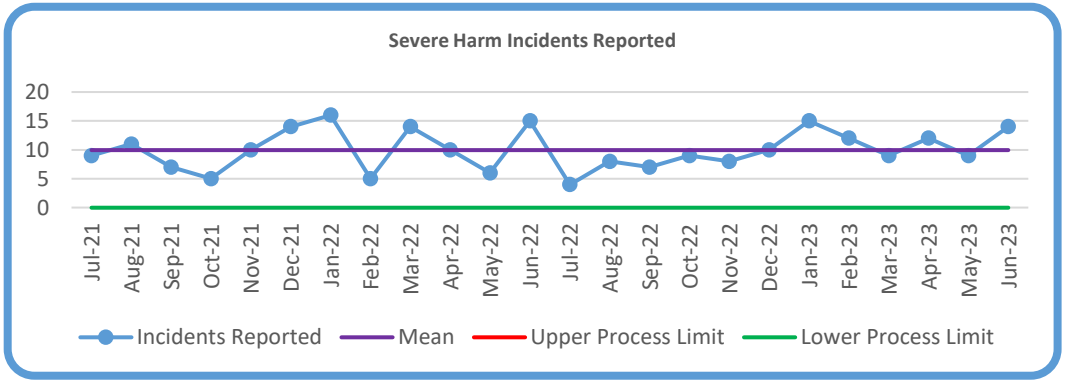


All patient incidents: The number of patient safety incidents reported per 1,000 bed days has remained stable in June 2023 and continues to be within close proximity to the mean.



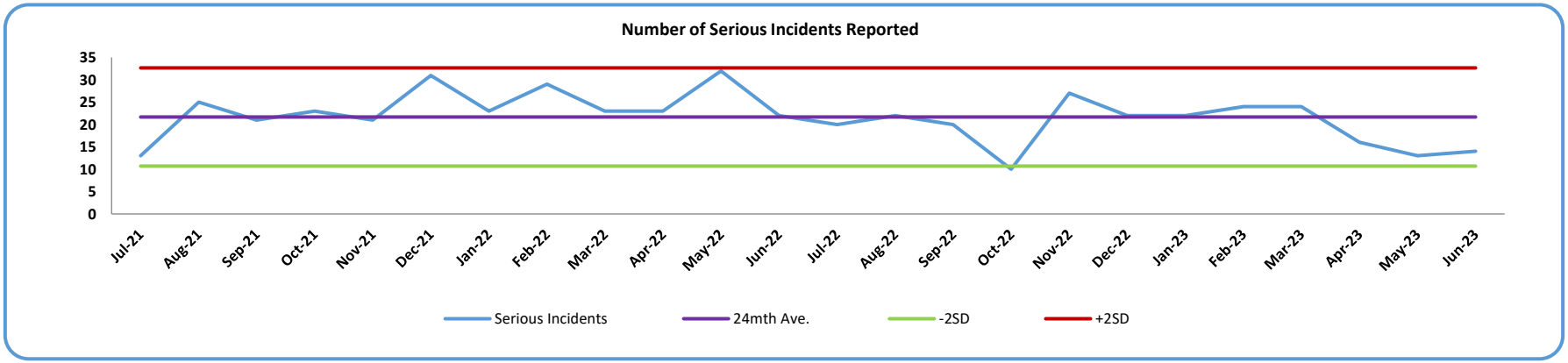
Harmful incidents: The number of *harmful patient safety incidents per 1,000 bed days has risen above the mean in June 2023, but is 10% lower than it was in November 2022 and remains well within the expected common cause variation. Severity grading of reported incidents may be modified following investigation 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.*

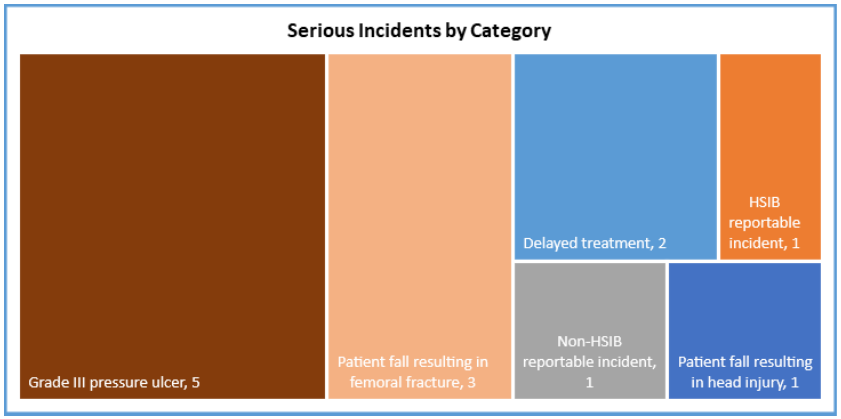


Severe harm incidents: There were 14 patient safety incidents reported that resulted in severe harm in June 2023, which is 5 more than May. However, it still remains within close proximity to the mean and well within the common cause variation. Severity grading of reported incidents may be modified following investigation and is therefore subject to change in future reports.

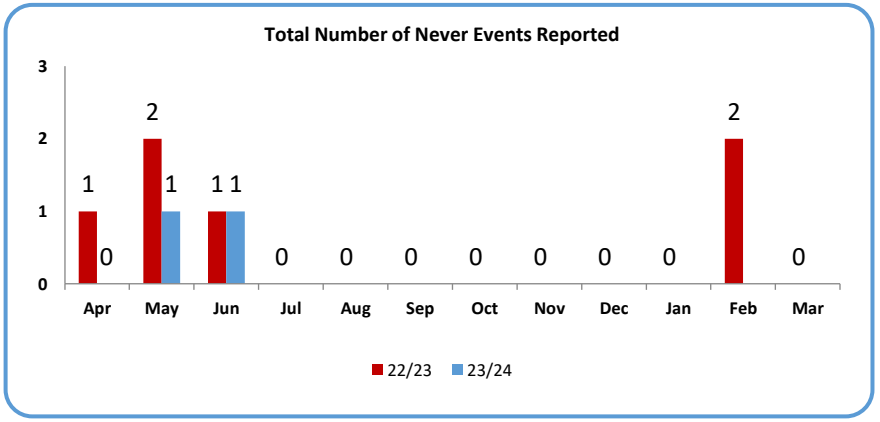
Quality: Serious Incidents and Never Events



There were 14 Serious Incidents (SIs) reported in June 2023, which is one more than May and remains below the mean and well within the accepted common cause for variation. The statutory requirement 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 for all cases reported in June 2023.



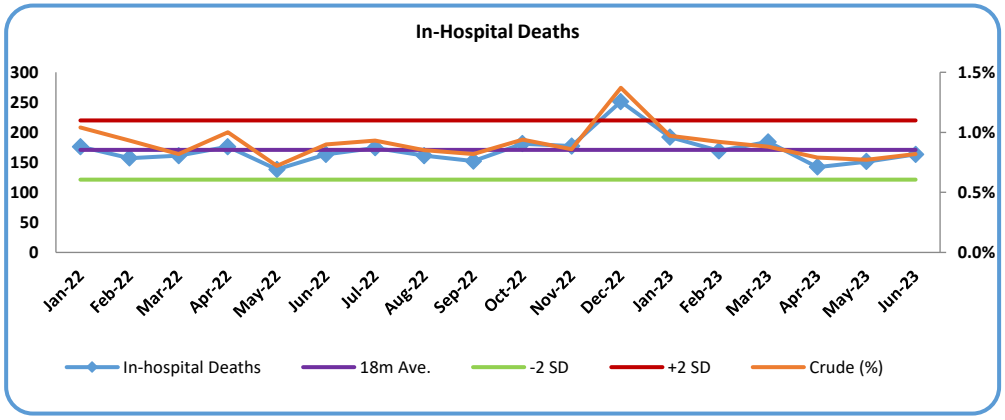
The categories of reported SIs for June 2023 are displayed in the table to the above. The highest number of SIs relate to grade III pressure damage, followed by patient falls resulting in harm.



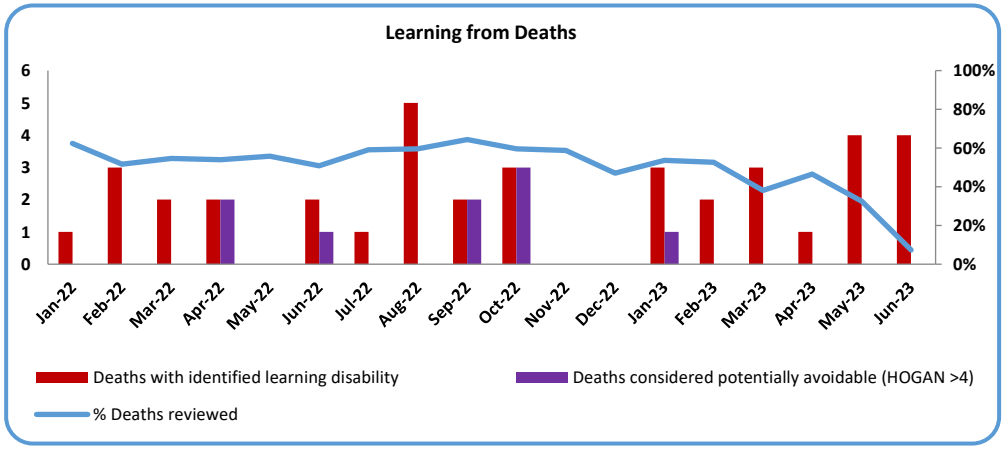
There were 6 Never Events reported in the Trust in 2022-23. One Never Event has been reported in June 2023 bringing the total number of Never Events to two for the time period of 2023-24.

Quality: Mortality Indicators 1/2

In-hospital Deaths: In total there were 163 deaths reported in June 2023, which is identical to the amount reported 12 months previously (n=163). The crude death rate is 0.82%. Nationally the deaths were high in December 2022, with influenza reported to be the main cause of death.

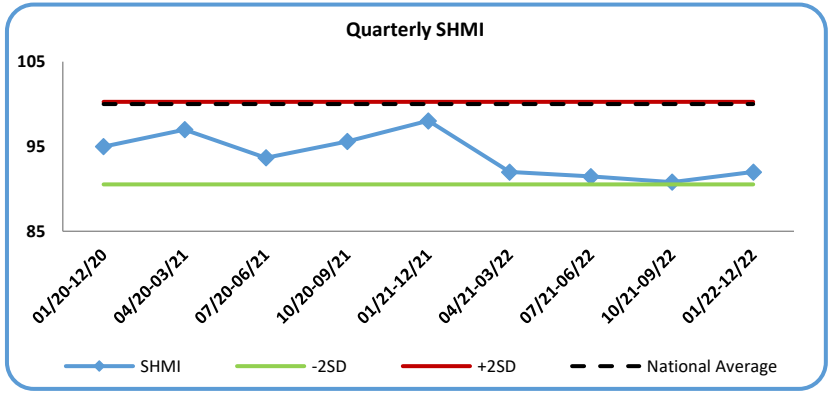


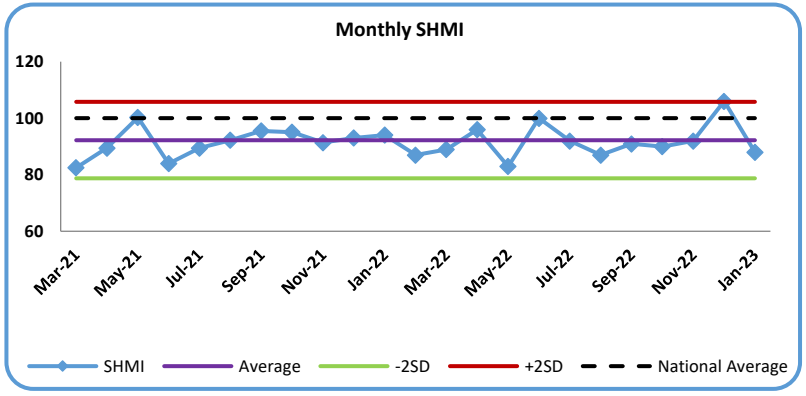
Learning from Deaths: Out of the 163 deaths reported in June 2023, twelve patients have, to date, received a level 2 mortality review. However, these figures will continue to rise due to ongoing M&M meetings held over the forthcoming months. All figures will continue to be monitored and modified accordingly. Four patients had a diagnosed learning disability.



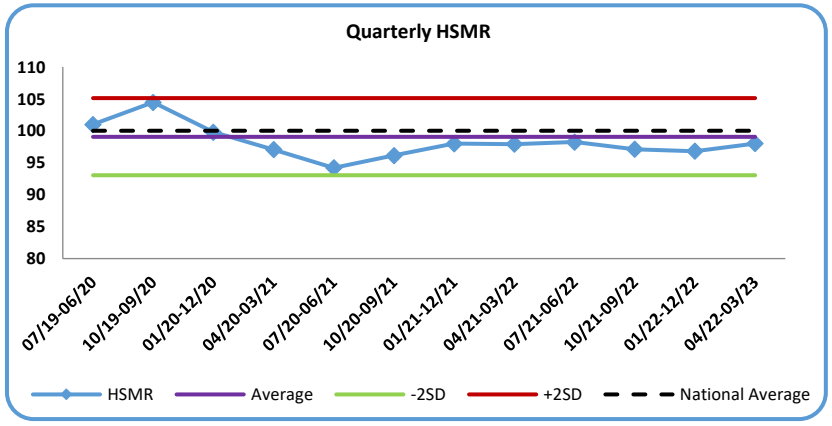
Quality: Mortality Indicators 2/2

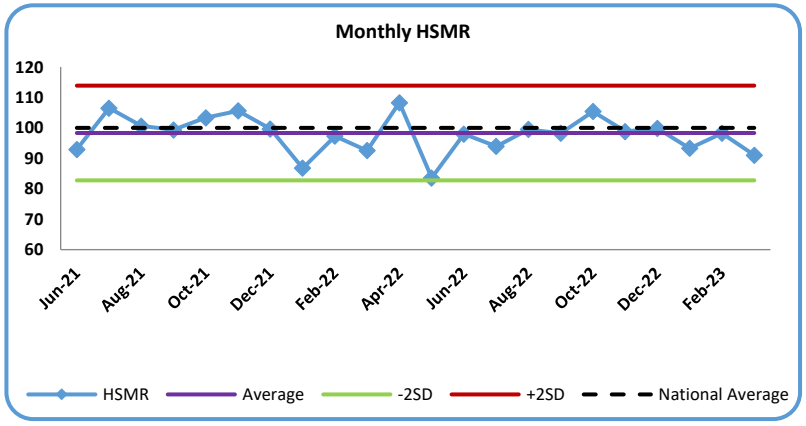
SHMI: The latest published SHMI quarterly data from NHS Digital shows the Trust has scored 92 from months January 2022 to December 2022. This is below the national average and is within the "as expected" category. Monthly SHMI data is published up to December 2022 and shows the Trust to be above the national average. This is due to the high number of deaths reported in December 2022, with influenza being the main cause of death. COVID-19 data continues to be excluded from SHMI data published from NHS England.



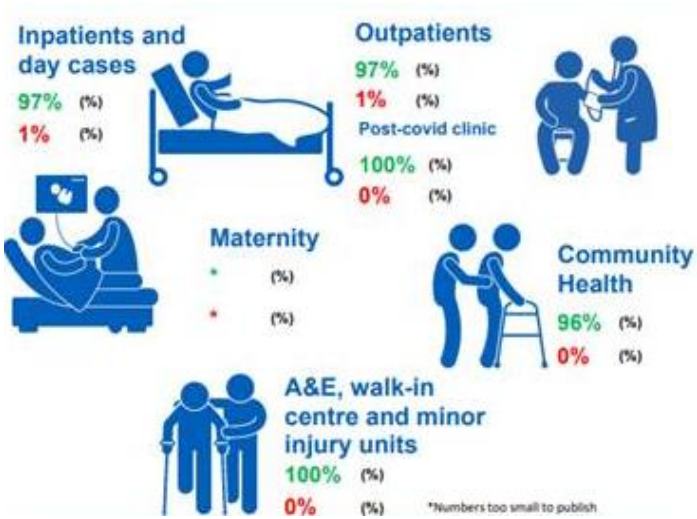


HSMR: The HSMR data shows a 12 month rolling HSMR score by quarter as well as monthly data up to March 2023 and is showing just below the national average. However, this number may rise or fall as the percentage of discharge coding increases. All figures will continue to be monitored and modified accordingly. Unlike SHMI data, HSMR data does not include deaths within 30 days of discharge.





Quality: FFT and Complaints



Friends and Family Test

Unpublished data to date shows that there were 2,079 responses to the Friends and Family test from the Trust in May 2023 (published April 2023) compared to 1,662 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 normally shown in brackets for comparison after the Trust data but this data is not currently available due to a technical issue with National reporting.

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

*numbers too small to publish

Trust Complaints 2023-24

The Trust has opened a total of 117 (110 with identified patient activity) formal complaints up to the end of June 2023.

The Trust has opened an average of 39 new formal complaints per month, which is 4 less than the average complaints for the last full financial year 2022-23.

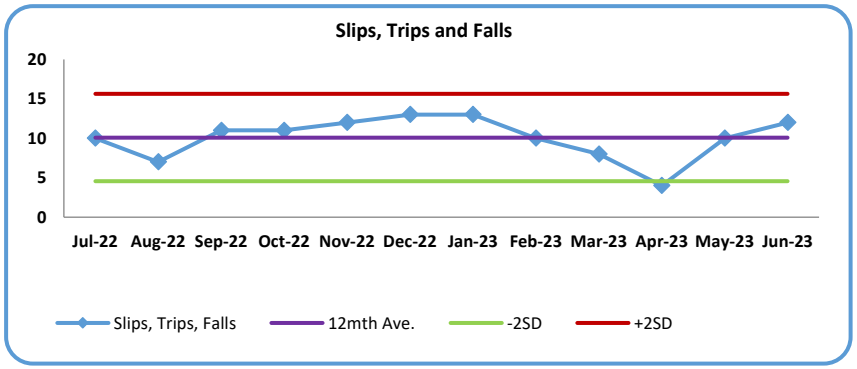
Taking into consideration the number of patients seen and areas with patient contact, the highest percentages of patients complaining to date are within Surgery with 0.05% (5 per 10,000 contacts). The lowest complaint percentages are with ePOD, Community and Cancer Services with 0.01% (1 per 10,000 contacts).

	2023-24				
Directorates	Complaints	Activity	Patient % Complaints	Ratio (YTD)	22-23 Ratio (Full Year)
Cardiothoracic	10	26,437.00	0.038%	1:2644	1:3974
Children's Services	4	18,408.00	0.022%	1:4602	1:2137
Community Services	1	15,678.00	0.006%	1:15678	1:7837
Dental	4	24,657.00	0.016%	1:6164	1:15521
Medicine	9	33,521.00	0.027%	1:3725	1:2780
Medicine (ED)	17	43,244.00	0.039%	1:2544	1:5184
ENT, Plastics, Ophthalmology & Dermatolog	12	95,359.00	0.013%	1:7947	1:8802
Musculoskeletal	6	24,212.00	0.025%	1:4035	1:3883
Cancer and Haematology	5	49,653.00	0.010%	1:9931	1:8154
Neurosciences	8	25,419.00	0.031%	1:3177	1:3280
Patient Services	10	11,128.00	0.090%	1:1113	1:544
Perioperative Care	2	8,984.00	0.022%	1:4492	1:3167
Surgery	8	15,910.00	0.050%	1:1989	1:1845
Renal	4	17,109.00	0.023%	1:4277	1:2926
Women's Services	10	34,546.00	0.029%	1:3455	1:3304
Trust (with activity)	**110**	**444,265.00**	**0.025%**	**1:4039**	**1:3759**

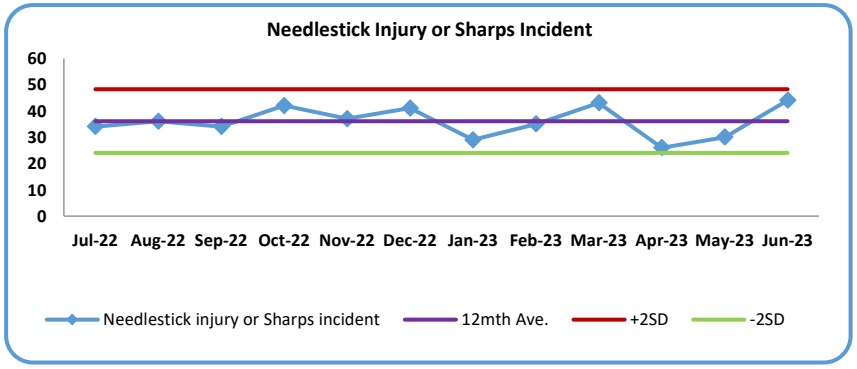
"Communication" and "Clinical Treatment – Surgery" are the highest primary subject area of complaints at 15% of all the subjects Trust wide.

Quality: Health and Safety (1/2)

There are currently 1,156 health and safety incidents recorded on the Datix system from the 1st July 2022 to 30th June 2023. This represents an overall rate of 74 per 1,000 staff. The Clinical Boards with the highest number of health and safety incidents over this period are Clinical Board 1 (159), Clinical Board 8 (156) and Clinical Board 3 (154). 37% of these incidents are linked to needlestick injuries (see below for further details). The overall trend for health and safety incidents remains relatively static with no significant increases or areas of statistical significance.

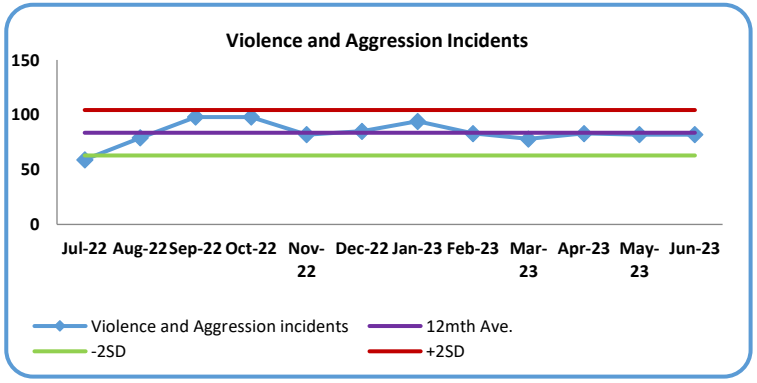


121 incidents were reported between 1st July 2022 to 30th June 2023. 59% of these incidents were related to trips and slips. The year-on-year comparison for slips, trips and falls shows a decreasing trend. Regular zonal inspections take place every month by Estates and any areas of concern are reported immediately with the Estates Helpdesk and acted upon. A Slips, Trips and Falls dashboard has been built, which provides the ability to further analyse incidents and identify key themes and trends. For example, incidents have recently been reported within Facilities, which has led to further work around appropriate footwear. There was an increase in slips, trips and falls in May 2023 and June 2023. Almost half of these incidents were related to staff slipping on wet floors across a range of services. Further analysis will be undertaken when the July 2023 data is available.



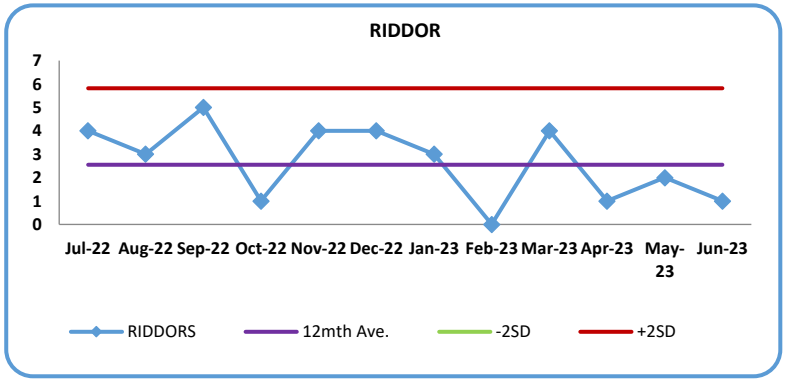
There have been 431 incidents during 1st July 2022 to 30th June 2023 (average 36 incident per month, 80% of these involve used needles) a slight increase in comparison to previous months. Further data breakdown has shown a slight increase in incidents during administration of insulin, further enquiries are being made around correct disposal of needles in this process. Detailed analysis is now possible via the Safer Sharps Incident Dashboard, which has recently been upgraded. Training around dashboard use will be rolled out in June/July 23. Non-safe sharps risk assessments have been re-evaluated and the tracker updated, covering all non-safe sharps. The format of risk assessment is currently being considered and modelled against the North Cumbria version, which has approval from Health and Safety Executive. The new Safer Sharps Training package is under development and due to be shared with the TEL team for further work to upgrade this into an e-learning package.

Quality: Health and Safety (2/2)



1,004 incidents of physical and verbal aggression against staff by patients, visitors or relatives recorded on the Datix system from 1st July 2022 to 30th June 2023. This represents an overall rate of 64 per 1,000 staff during this period. The yearly trend for physical assaults on staff shows a 28% increase in 2022-23 in comparison to 2021-22. The Trust Violence Reduction Group meets every quarter. Several initiatives to reduce these incidents are already underway, for example:

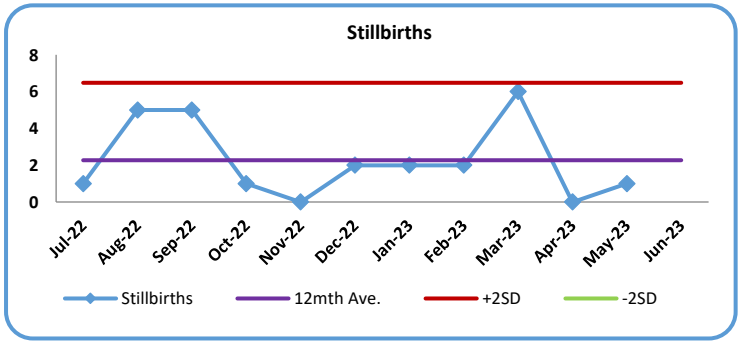
- The Trust Violence Reduction Strategy was approved at May 2023 Health and Safety Committee.
- Further improvements to our overall compliance with the National Violence Reduction Standards.
- Further development of the violence data dashboards to provide improved analysis.
- The introduction of ED Navigators in Summer 2023.
- Ward based violence and aggression risk assessments currently being re-evaluated in line with HSE expectations.
- Ward violence and aggression questionnaires have been developed and will be rolled out in June – July 2023.



Incidents reportable to the Health and Safety Executive in line with RIDDOR expectations remain relatively low. Incidents are scrutinised on a daily basis and any incidents meeting the threshold for RIDDOR are further investigated prior to information being shared with the Health and Safety Executive. A majority of the incidents reported via RIDDOR are either Slips, Trips and Falls or Moving and Handling type incidents; however, no significant themes have been identified recently. RIDDOR breakdown by incident category during the period is as follows:

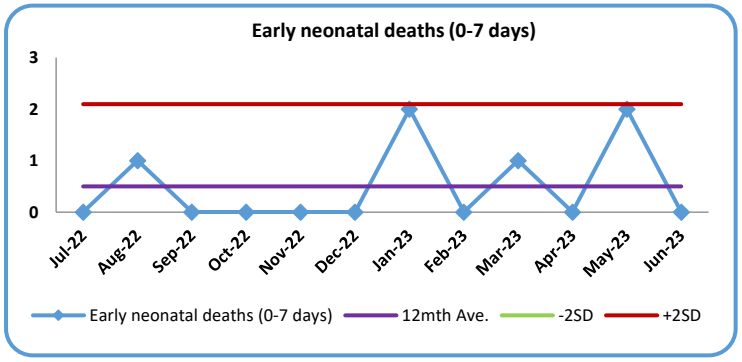
- Manual Handling – 9 incidents
- Non-Patient Slips Trips and Falls – 8 incidents
- Accident Involving Staff – 7 incidents
- Violence and Aggression – 6 incidents
- Accident (Involving patient) – 1 Incident
- Security – 1 Incident

Quality: Maternity (1/3)



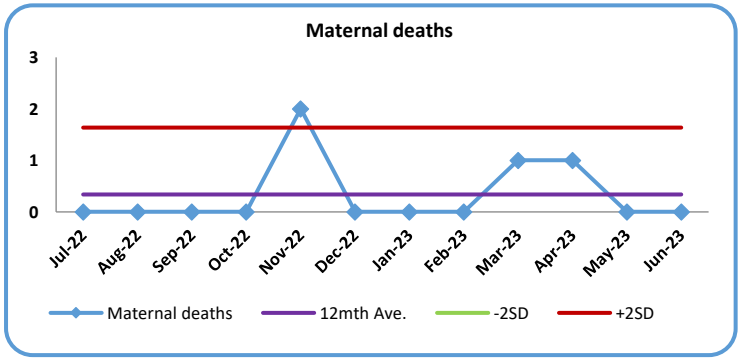
Stillbirths

As NuTH is a tertiary referral Fetal Medicine Unit, complex cases are often referred to the Trust from other units within the region, with women opting to deliver here rather than return to their local unit. This data includes termination for fetal anomalies > 24 weeks gestation. 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. There were no stillbirths in June.



Early Neonatal Deaths

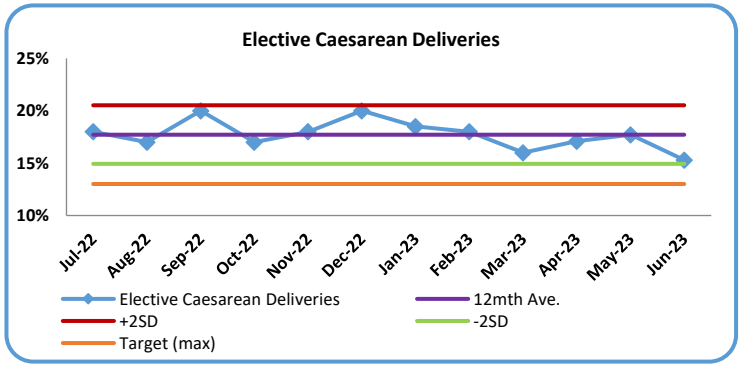
These figures are for term infants (born between 37 and 41 weeks) who delivered at the Trust but sadly died within the first week of life. These deaths are reported to the Child Death Review panel (as are all neonatal deaths regardless of gestation) who will have oversight of the investigation and review process. Neonatal deaths of term infants are also reported to HSIB (Healthcare Safety Investigation Branch) and the Coroner. A post mortem examination may be requested to try and identify the cause of death. In June there were no term early neonatal deaths.



Maternal Deaths

Maternal deaths are reported to MBRRACE-UK and a national report is provided annually. Early maternal deaths are categorised as the death of a woman while pregnant or within 42 days of pregnancy (including termination of pregnancy). Late maternal deaths are reported from 42 days and within a year of pregnancy. Direct deaths are those resulting from obstetric complications of the pregnant state. Indirect deaths are those from pre-existing disease or disease that developed but has no direct link to obstetric cause, but was aggravated by pregnancy.
Early maternal deaths are also reported to HSIB, investigation is dependant on certain criteria. There were no cases reported in June.

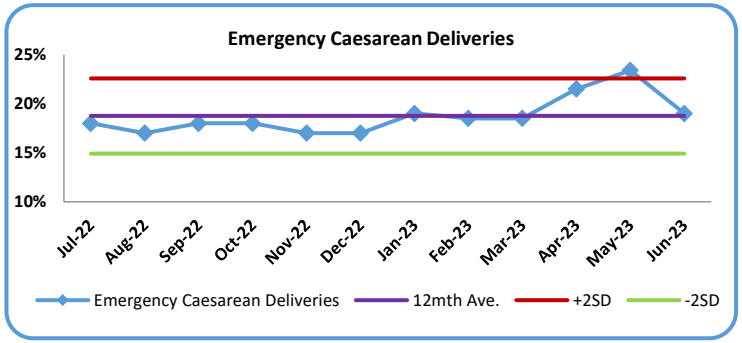
Quality: Maternity (2/3)



Elective Caesarean section

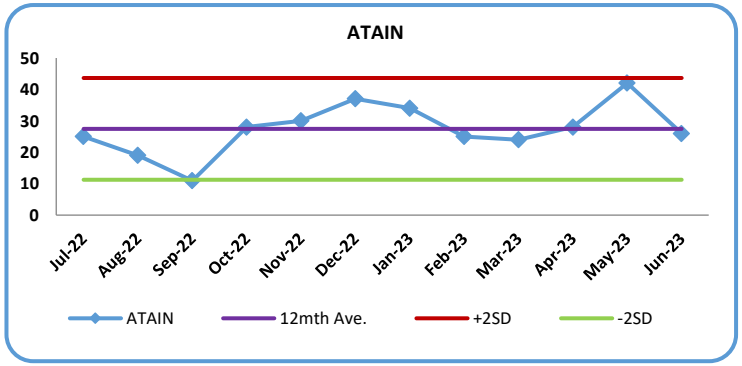
Maternity at the Trust is an outlier for elective Caesarean section compared to other UK Trusts. However, the rates are comparable to that of other tertiary centres in the UK.

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

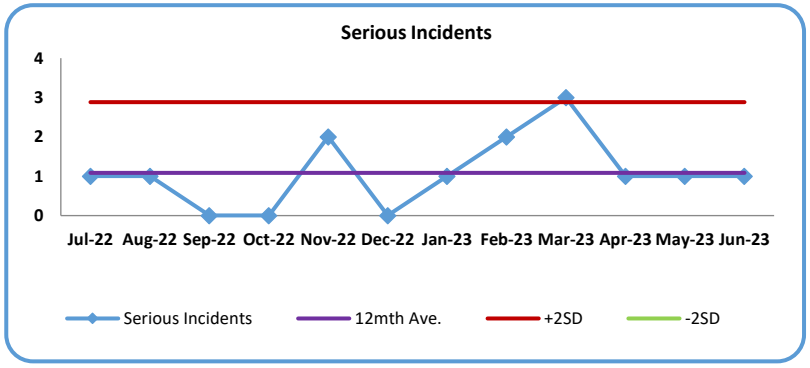
The emergency Caesarean section rate is comparable to other Trusts. Maternity is a consultant led service with dedicated consultant presence on Labour Ward 8am-10pm daily, consultant led multi-disciplinary ward rounds occur twice daily. The majority of obstetric consultants remain onsite overnight, from 10pm-8am and are involved with all decisions for emergency Caesarean section.



ATAIN

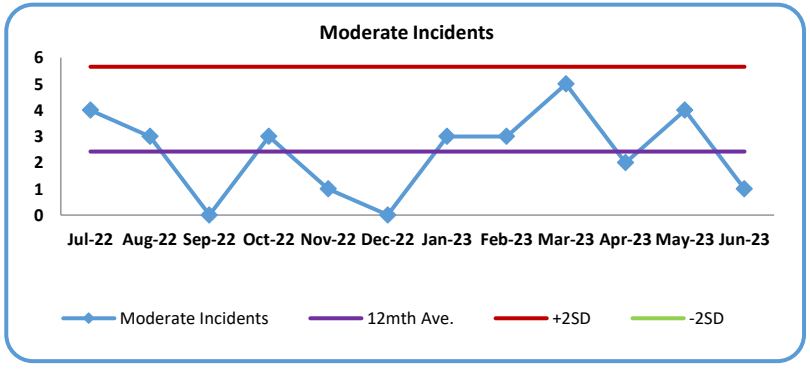
All unplanned admissions of term babies (37 – 41 weeks) into the neonatal unit are reviewed at a weekly multi-disciplinary meeting and a quarterly report is produced and shared. Some of these cases will be reviewed in more detail if they have been identified as a Serious Incident. In quarter 3 (Oct-Dec 2022-23) there was an increase in the number of term admissions and these have all been reviewed. Admissions in March and April had reduced with an increase in May. There has been a decrease in the number of admissions in June, not all cases have yet been audited, currently 3 cases have been identified as avoidable.

Quality: Maternity (3/3)



Serious Incidents

There have been 13 incidents escalated as Serious Incident's within the last 12 months. These include cases of potential or confirmed Hypoxic Ischaemic Encephalopathy (HIE), neonatal death, maternal bowel injury, intrapartum stillbirth, antepartum intrauterine death and maternal death. The HIE, Intrapartum Stillbirths, Neonatal deaths and Maternal deaths were all reported to HSIB (Healthcare Safety Investigation Branch) for external review. There has been one Serious Incident in June.



Moderate incidents

There was one moderate (and above) incident reported in Maternity this month. 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 1/2

Audit / NCEPOD	Date of Report	Areas of Good Practice	Areas for improvement	Action Plan Developed
Trauma Audit and Research Network (TARN)	1 December 2022	• Extended senior medical and nursing cover implemented in the Paediatric Emergency Department until 22:00.	• Rehabilitation staff are not available at weekends on the ward. ➢ Weekend provision of physiotherapists is key for early intervention to reduce length of stay. ➢ Provision of Occupational therapy. ➢ Provision of Psychology support for paediatric trauma.	Discussed at June 2023 Clinical Audit and Guidelines Group
Paediatric Intensive Care Audit Network (PICANet)	9 March 2023	• Mortality is within the expected range. • Actual mortality below expected mortality on funnel plot. • Emergency readmissions rate (0.8) lower than national average (1.0).	• Timeliness of data submission (52% submitted within timeframe vs 87.7% national average).	Discussed at June 2023 Clinical Audit and Guidelines Group
National Audit of Pulmonary Hypertension (PH)	19 January 2023	• 78% of patients seen or discharged within 30 days (76% national average). • 99% of patients had quality of life scores recorded (88% national average). • 100% of patients receiving a PH drug had an annual consultation (96% national average).	• No recommendations were made, and Trusts were not assessed against national targets due to COVID-19 recovery.	Discussed at June 2023 Clinical Audit and Guidelines Group
Case Mix Programme (CMP)	17 February 2023	• No recommendations or Trust level data published, only national data		Discussed at June 2023 Clinical Audit and Guidelines Group
Learning Disability Mortality Review Programme (LeDeR)	27 April 2023	• No recommendations or Trust level data published, only national data		Discussed at June 2023 Clinical Audit and Guidelines Group

Quality: Audit 2/2

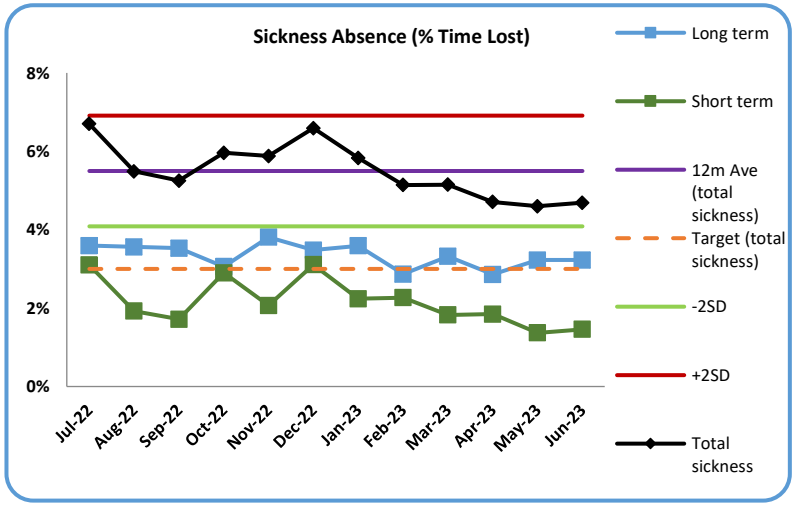
Audit / NCEPOD	Date of Report	Areas of Good Practice	Areas for improvement	Action Plan Developed
UK Cystic Fibrosis Registry	1 September 2023	• No recommendations or Trust level data published, only national data		Discussed at June 2023 Clinical Audit and Guidelines Group
Breast and Cosmetic Implant Registry	2 March 2023	• No recommendations or Trust level data published, only national data		Discussed at June 2023 Clinical Audit and Guidelines Group
Serious Hazards of Transfusion (SHOT)	1 July 2023	• Major haemorrhage protocol (MHP) and blood provision in major haemorrhage is exemplar. • Local anticoagulant reversal policy used locally by other regional trusts. • Trust invested heavily in Transfusion IT systems. • Run a Cell-free fetal deoxyribonucleic acid (cffDNA) system within midwifery and obstetrics department. • Developed a transfusion reaction order set. • Paediatric MHP developed. • Haemoglobinopathy MDT for both paediatrics and adults.	• Regional Laboratory Information Management System (LIMS) project. • Staffing vacancies within the Haematology/ Blood Transfusion section of Blood Sciences at the Freeman.	Discussed at July 2023 Clinical Audit and Guidelines Group
National Lung Cancer Audit (NLCA)	12 April 2023	Data completeness better than national average for the following indicators: • Disease stage (90% vs 86%) • Performance status (86% vs 83%) • Basis of diagnosis (95% vs 90%) • Ethnicity (99% vs 97%) • Clinical Nurse Specialist (64% vs 59%) • 87.6% of patients with stage I/II PS 0–2 NSCLC underwent curative treatment vs 79.3% national average • 72% of patients with stage IIIB-IV and PS 0-1 received systemic anti-cancer therapy vs 61.1% national average • 99.2% of patients seen by CNS vs 92.3% national average	• Resource lung cancer MDTs according to the commissioning guidance set out by the Lung Cancer Clinical Expert Group, and update the guidance to reflect current best practice.	Discussed at July 2023 Clinical Audit and Guidelines Group

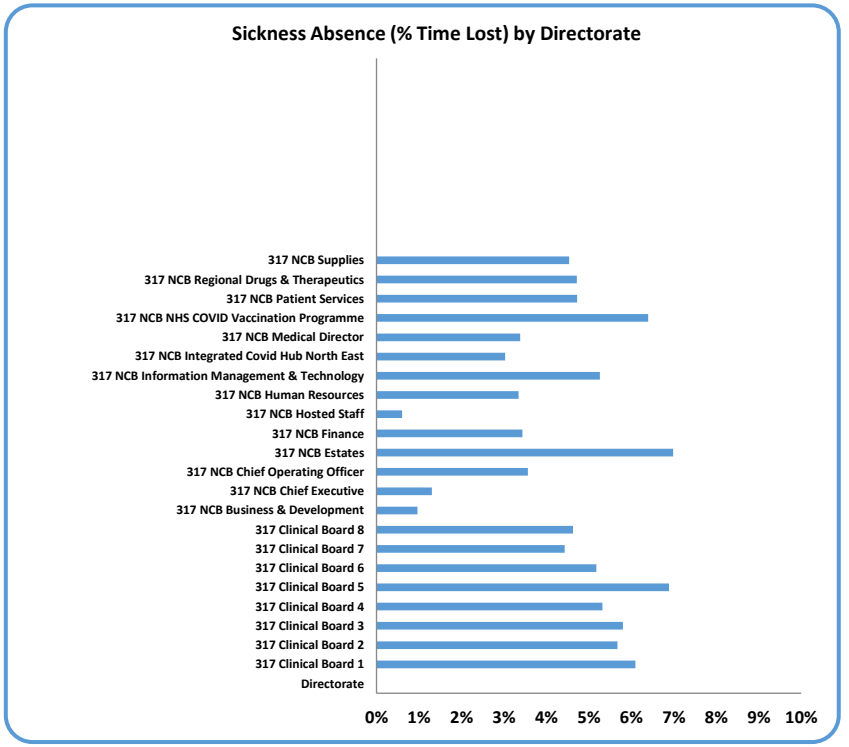
People: Sickness Absence 1/2

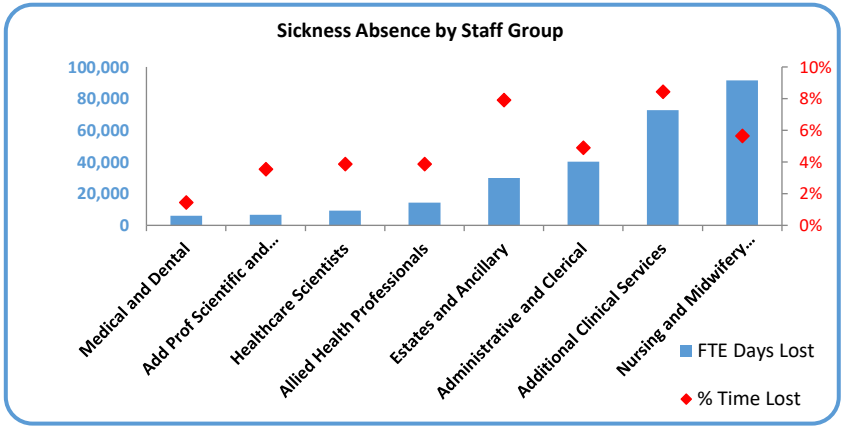
- Year to year comparison for sickness absence (including COVID-19 related sickness (rolling 12 months):

	Jun-22	Jun-23	
Long-term	3.90	3.50%	↓
Short-term	2.68	2.00%	↓
Total	6.58	5.50%	↓

- 271,438 FTE working days were lost due to sickness (including COVID-19 related sickness) in the year to June 2023, compared to 329,985 for the previous year.
- Overall sickness absence (including COVID-19 related sickness) is 5.50%, which is down from end of June 2022 position of 6.13% (% FTE Time Lost).
- The top three reasons for non-COVID related sickness absence are Anxiety/stress/depression/other psychiatric illnesses (28%), Other Musculoskeletal (10%), and Cold, Cough, Flu (10%).
- The top reason for "Other" absences is Maternity Leave (50% of total absence.

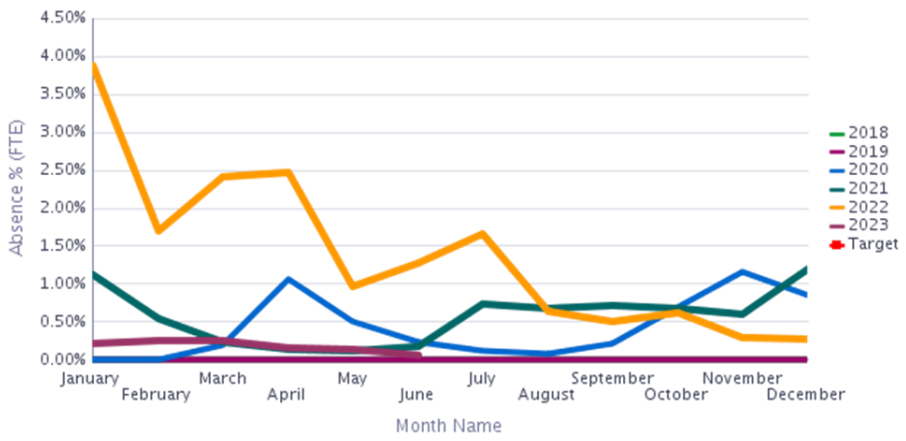




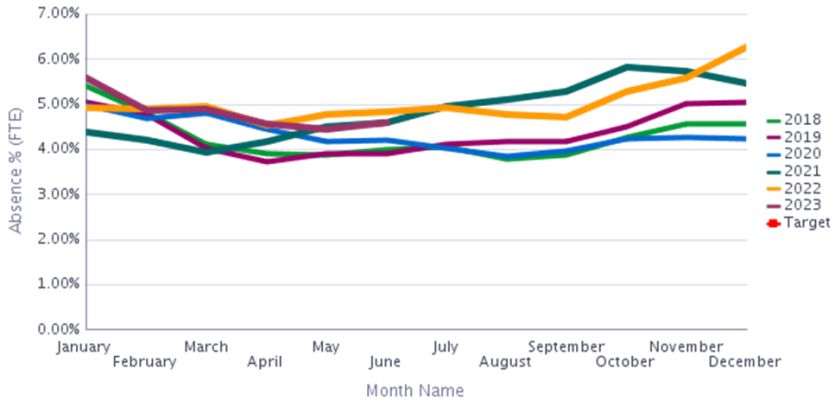


People: Sickness Absence 2/2

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

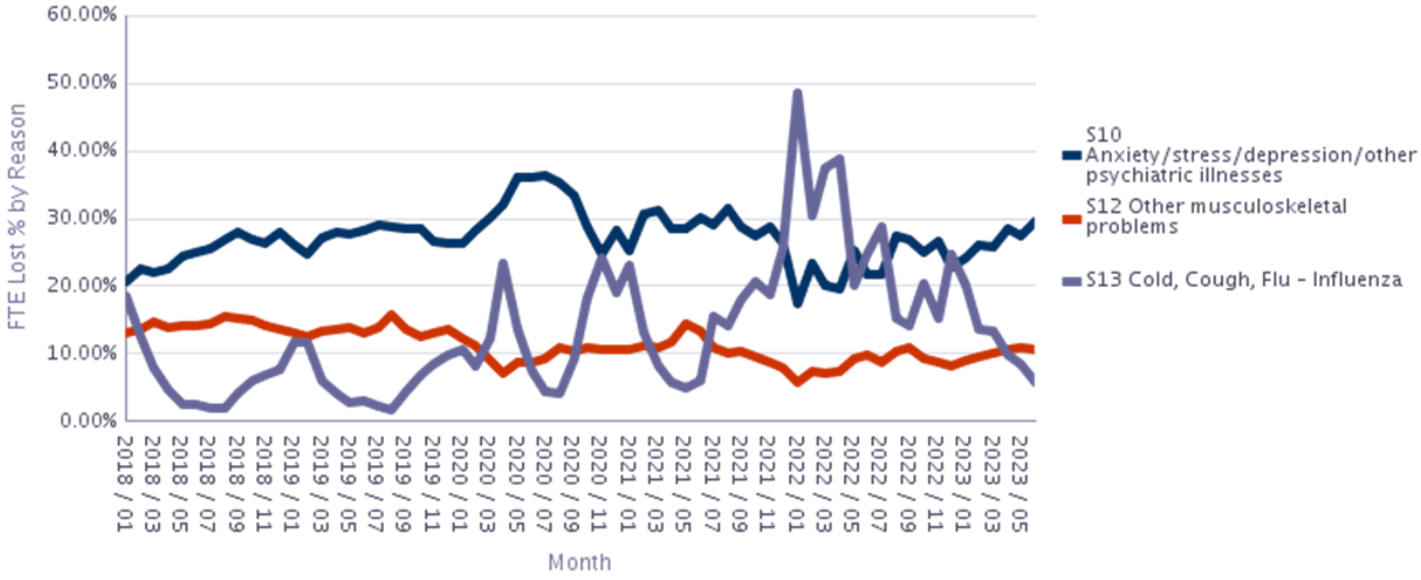


Non-COVID-19 Related Sickness Jan 2018 – June 2023 (%FTE)

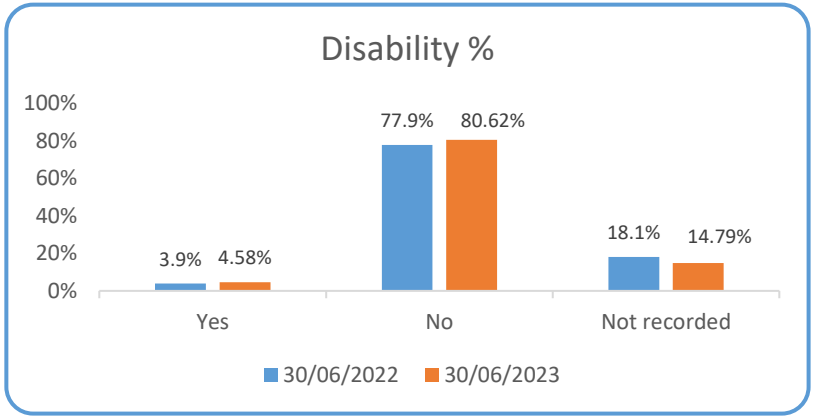


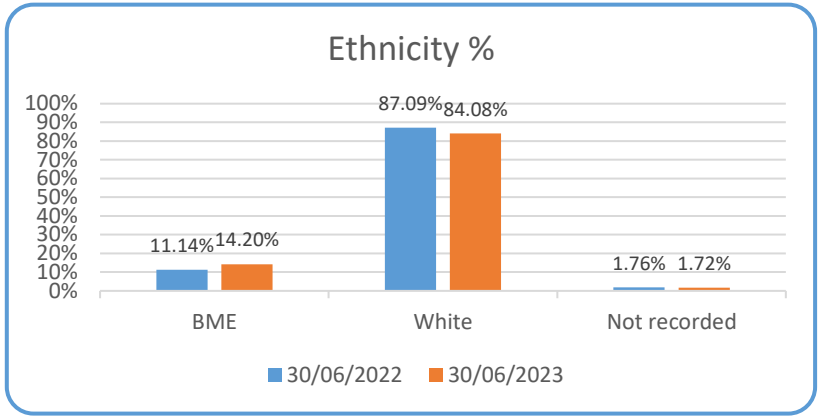
Top 3 Sickness Reasons Jan 2018 - June 2023 (%FTE)

S13 includes Covid sickness

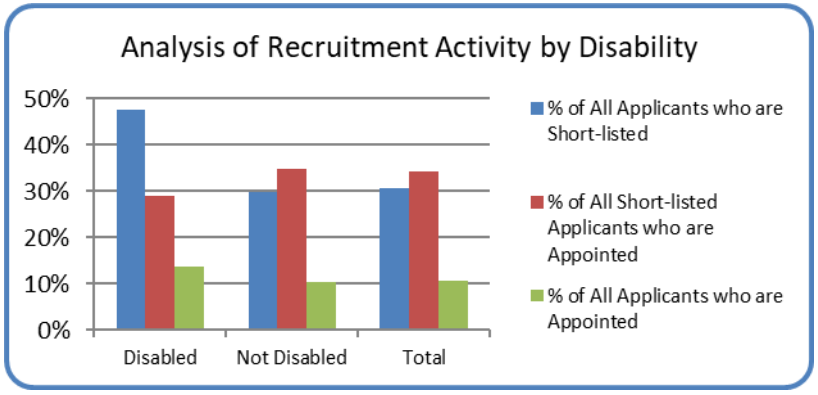


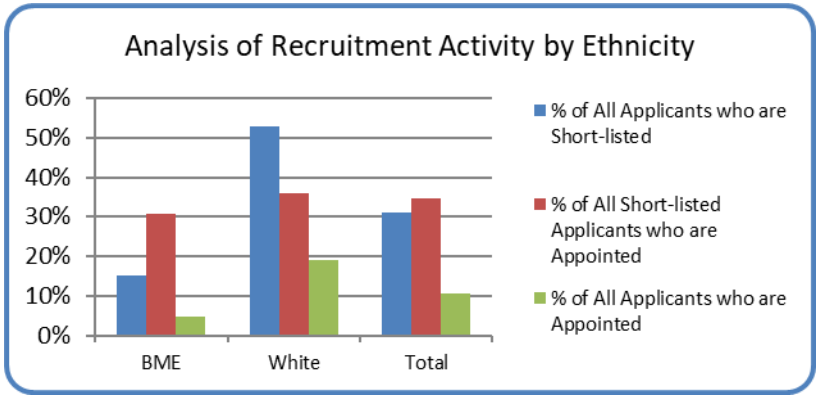
People: Equality and Diversity





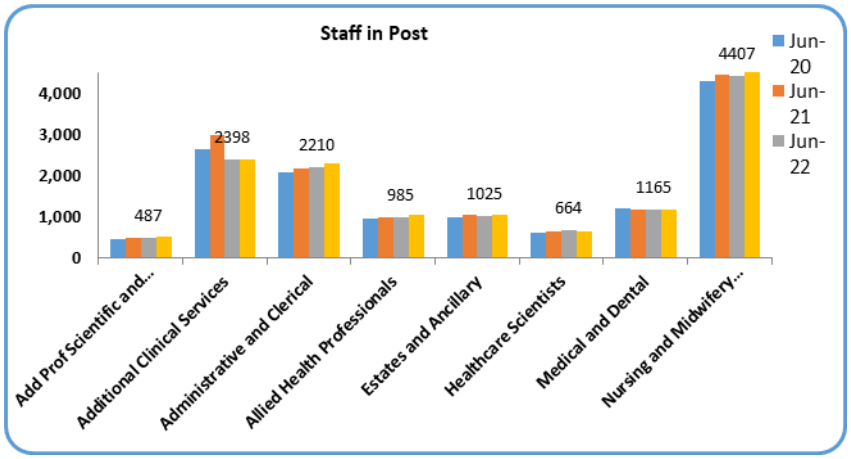
- The graphs above identify, by disability and ethnicity, the recruitment outcome of applicants during the twelve months ending June 2023.

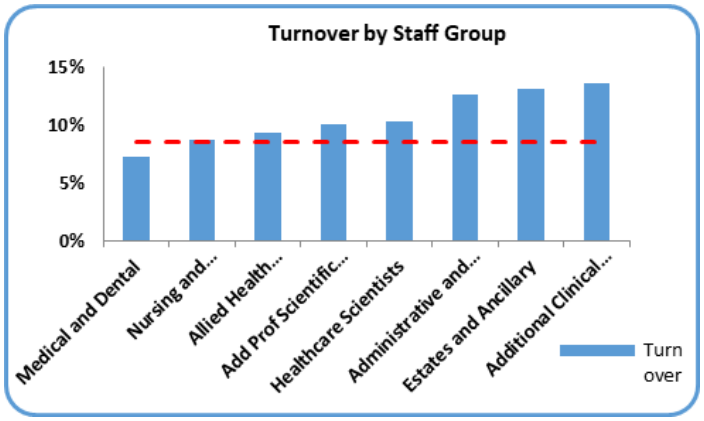


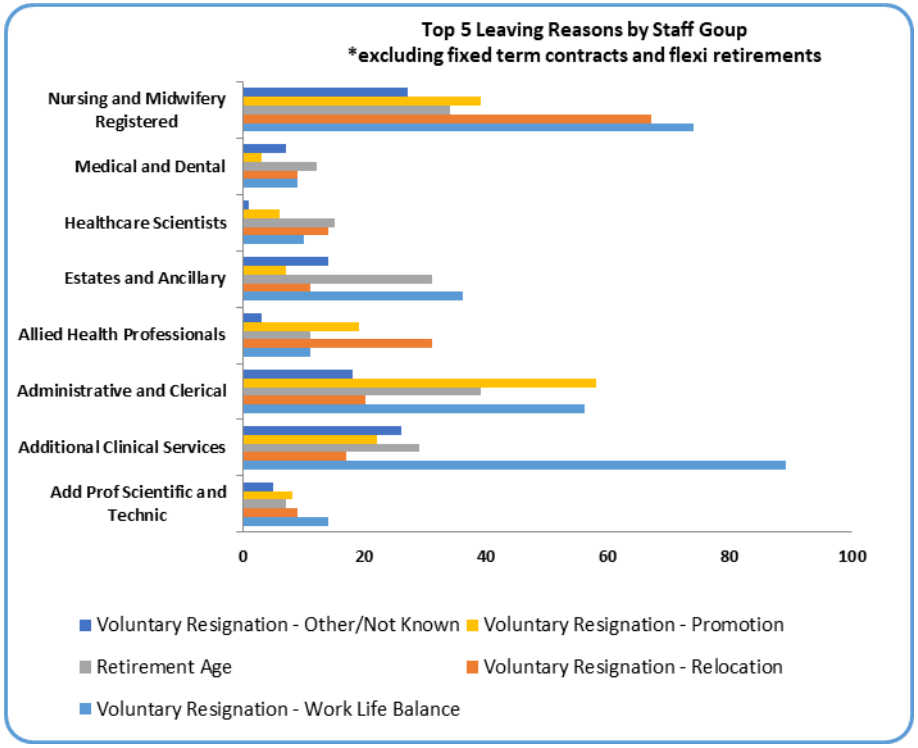


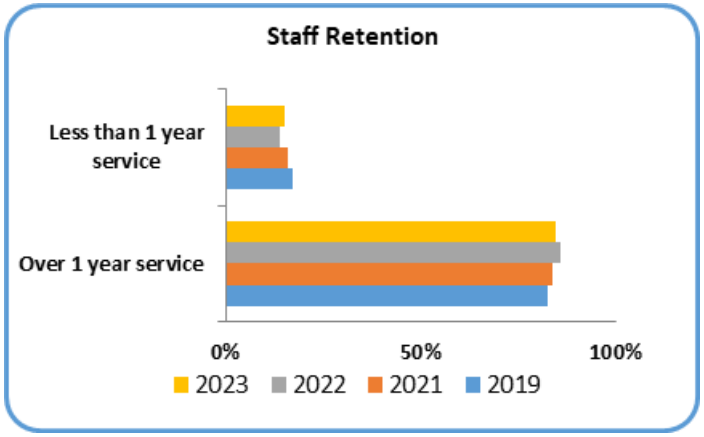
- The graphs above identify, by headcount, the percentage of staff in post in July 2022 and July 2023 by disability and ethnicity. The percentage of staff employed disclosing a disability has increased from 3.94% to 4.58% and the percentage of BAME staff has increased from 11.14% to 14.20%.

People: Workforce 1/3









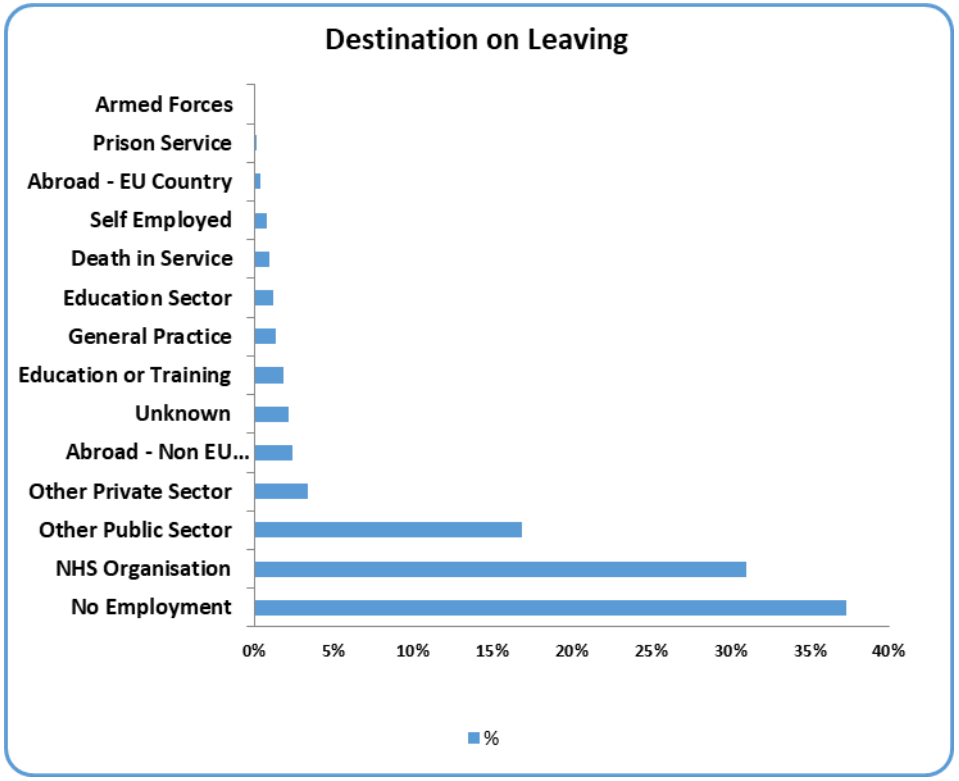
- Staff in post has increased by 3.22% since June 2020. The staff groups with the largest increase are Add Prof Scientific and Technic and Administrative and Clerical.
- Staff turnover has decreased from 16% in June 2022 to 11% in June 2023, against a target of 8.5%.
- The total number of leavers in the period July 2022 to June 2023 was 1,624.
- Retention for staff over 1 year service is 84.8%, a decrease from 86.6% in June 2022.

People: Workforce 2/3

Turnover by Clinical Board

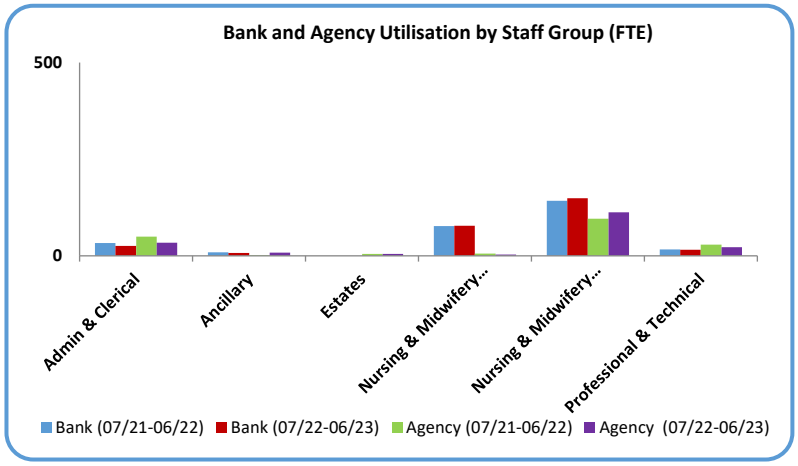
Directorate	Turnover
NCB Regional Drugs & Therapeutics	5.80%
NCB Patient Services	8.44%
NCB Chief Operating Officer	9.73%
Clinical Board 3	10.06%
Clinical Board 7	10.71%
Clinical Board 5	11.11%
Clinical Board 6	11.92%
Clinical Board 2	11.97%
Clinical Board 4	12.11%
NCB Business & Development	12.53%
Clinical Board 8	12.58%
Clinical Board 1	12.79%
NCB Estates	14.02%
NCB Supplies	14.20%
NCB Information Management & Technology	14.46%
NCB Chief Executive	15.93%
NCB Medical Director	18.04%
NCB Finance	18.92%
NCB Human Resources	19.11%
NCB Hosted Staff	22.89%
NCB Integrated Covid Hub North East	38.60%
Trust Total	**11.54%**

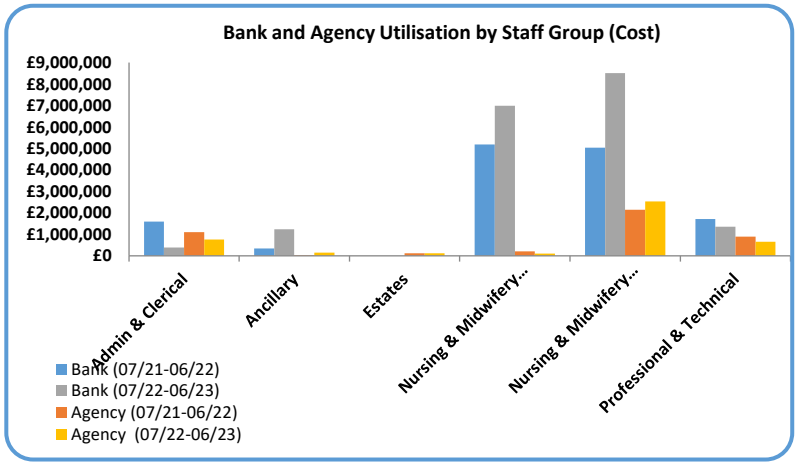
- Only 31% of leavers across the Trust disclosed they were going to another NHS organisation.

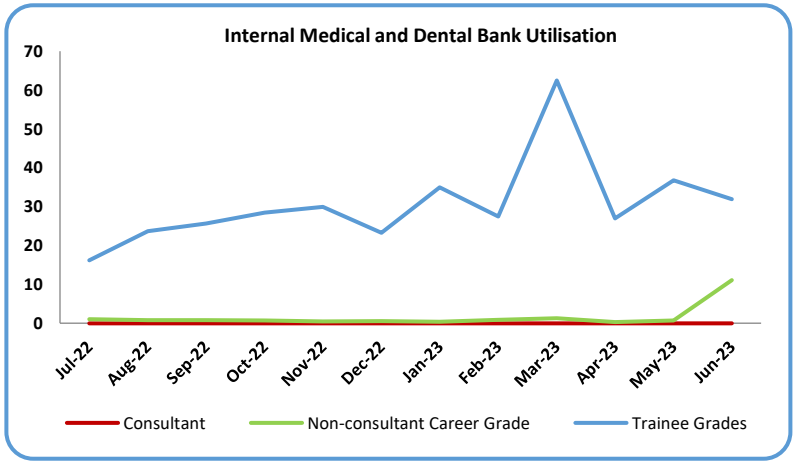


Please refer to the key on the last slide for the full list of Clinical Board names

People: Workforce 3/3

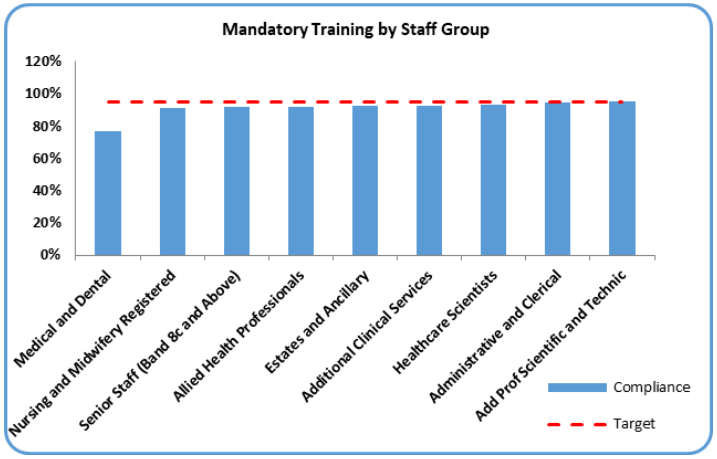


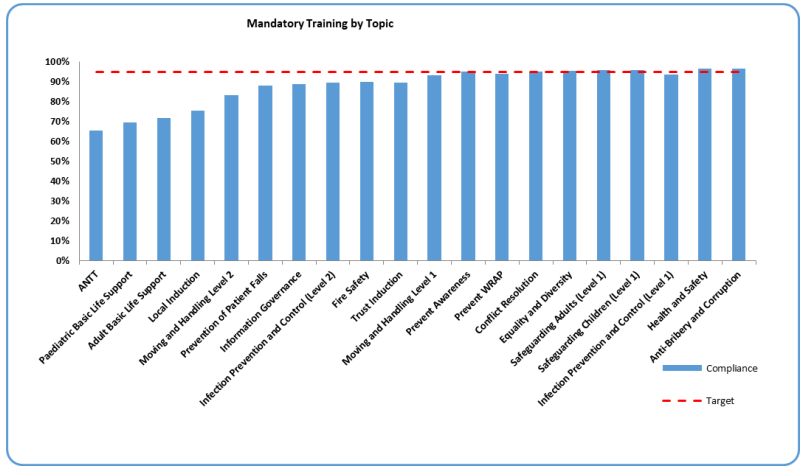


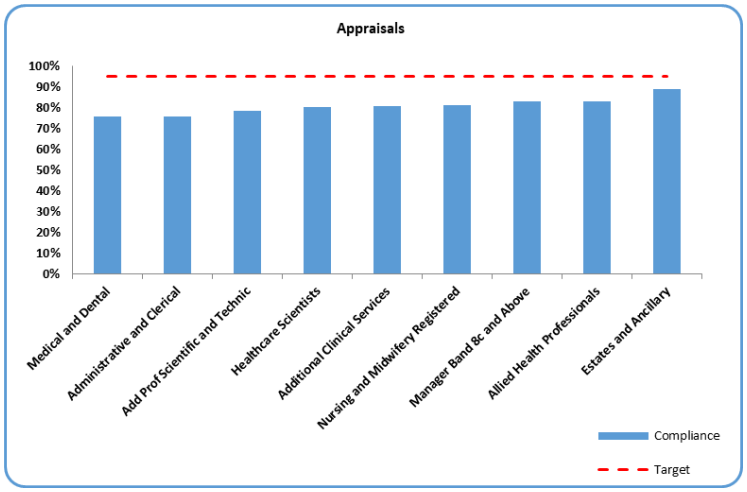


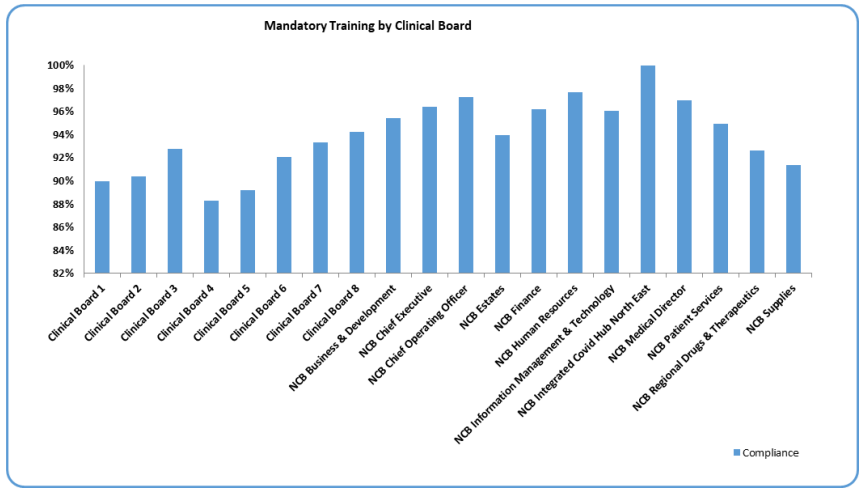
Comparing the periods July 2021 – June 2022 to July 2022 – June 2023, overall bank utilisation decreased from 277 wte to 274 wte and agency utilisation has decreased from 184 wte to 183 wte.

People: Delivering Excellence in Education & Training







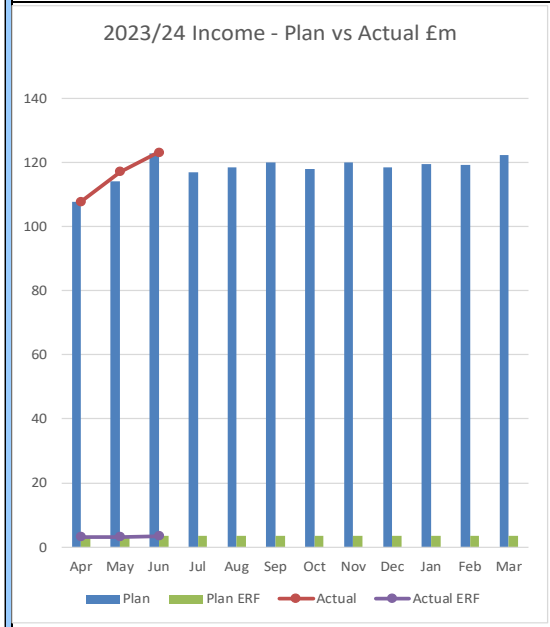


- Mandatory training compliance stands at 92% at end of June 2023, against an end of year target of 95%. The June 2022 position was 87.96%.
- Medical and Dental are the staff group with the lowest training compliance at 76.9% in June 2023 compared to 71.6% in June 2022.
- Appraisal compliance stands at 80.44%, at end of June 2023, against an end of year target of 95%. The June 2022 position was 73.57%. Interventions are in hand to improve this position.

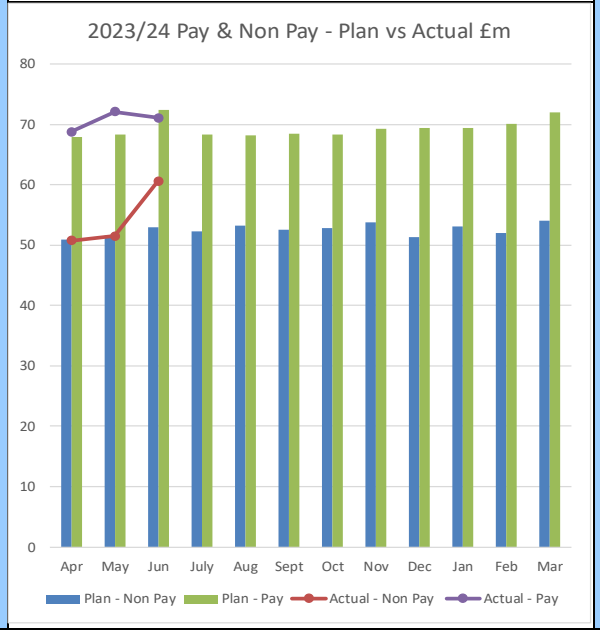
Finance: Overall Financial Position

Financial Overview as at 30th June 2023

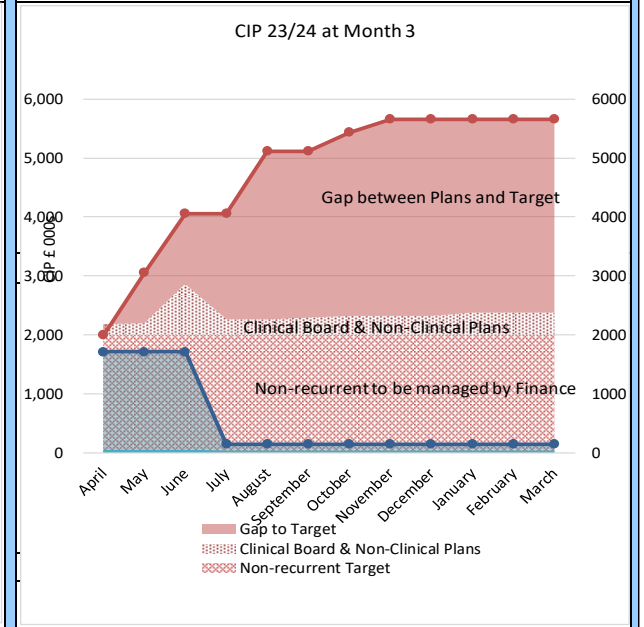
Income



Expenditure



Cost Improvement Analysis



Commentary

This page summarises the financial position of the Trust for the period ending 30 June 2023. The Trust has agreed a Financial Plan for 2023/24 with a break-even position. As at Month 3 the Trust is reporting an adverse variance of £1.56 millions against the agreed Financial Plan. This mainly relates to the financial impact of industrial action that is apparent within the spend trajectory. The Trust incurred expenditure of £374 million and received income of £364 million, leaving a deficit of £9.9 million.

The delivery of the plan relies on a number of factors which are subject to significant risk

- Delivery of required levels of activity compared with 2019/20 activity levels. This target is subject to change due to the impact of industrial action on activity plans.
- Reliance on non-recurrent income and expenditure benefits
- Achievement of CIP targets
- Assumptions relating to inflation, subject to change and unfunded

Risk

Capital Expenditure

The Plan for June is £7.6 million and the year to date expenditure is £2.5 million creating a variance of £5 million to date. This is expected to catch up.

Key: Clinical Board Names

Clinical Board	Clinical Board Name
1	Family Health Clinical Board
2	Surgical and Specialist Services (mainly Royal Victoria Infirmary)
3	Peri Operative and Critical Care
4	Cardiothoracic Services
5	Medicine and Emergency Care
6	Surgical and Associated Services (mainly Freeman Hospital)
7	Cancer and Haematology Board
8	Clinical and Research Services

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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	25 May 2023	PUBLIC	23/10 STRATEGIC ITEMS vi) Pioneers: Research Update Nurse	VMR highlighted that the infrastructure chart includes a number of abbreviations and recommended that a summary be shared with Board members to expand out/explain further which Mr Isaacs agreed to action [**ACTION01**].	VMR			Summary of the NIHR infrastructure circulated to Non-Executive Directors on 9 June 2023. Key abbreviations include: - Academic Health Science Centre (AHSC) - Biomedical Research Centre (BRC) - Patient Safety Research Collaboration (PSRC) - Local Clinical Research Network (LCRN) - Clinical Research Facility (CRF) - Clinical Trials Unit (CTU) - MedTech and In vitro diagnostics Co-operative (MIC) - Public Health (P/H) - Experimental Cancer Medicine Centre (ECMC) - National Institute for Health and Care Research Innovation Observatory (NIHR IO)
102	25 May 2023	PUBLIC	23/11 BUSINESS ITEMS b. Executive Chief Nurse	With regards to the recent CQC report on Mental Health, Mental Capacity Act and DOLS, the ECN confirmed that she will provide an update in relation to staff engagement at a future meeting **[ACTION02].**	MC			Discussed at the Well Led meeting on 14 July 2023 and briefing document shared in the Trust Board Teams Group.

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.