The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	26 September 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]	No direct link.
Reports previously considered by	Consultant Appointments are submitted for information in the month following the Appointments Panel.

CONSULTANT APPOINTMENTS

1. APPOINTMENTS COMMMITTEE – CONSULTANT APPOINTMENTS

Appointments Committees were held between 1 August 2023 and 9 September 2023 and by unanimous resolution, the Committees were in favour of appointing the following:

Appointed	Job title	Proposed start date
Dr. Mathew Elameer	Consultant Neuroradiologist	29/08/2023
Dr. Vartan Balian	Consultant Interventional Neuroradiologist	25/09/2023
Dr. Matthew Naylor	Consultant Radiologist	25/09/2023
Dr. Jessica McArdle	Consultant Paediatric Anaesthetist	01/11/2023
Dr. Nicola Watson	Consultant Dermatologist	04/12/2023

2. RECOMMENDATION

For the Board to receive the above report.

Report of Andy Welch
Medical Director
26 September 2023

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	26 September 2023						
Title	A framework of quality assurance for responsible officers and revalidation Annex D – annual board report and statement of compliance						
Report of	Andy Welch, Medical Director/ Deputy Chief Executive Officer						
Prepared by	Michael Wright, Deputy Medical Director						
Status of Report	Public		Private		Internal		
	☒		☐		☐		
Purpose of Report	For Decision		For Assurance		For Information		
	☐		☒		☐		
Summary	Annual Board Report and Statement of Compliance.						
Recommendation	The Board of Directors is asked to note the contents of the report.						
Links to Strategic Objectives	Putting patients at the heart of everything we do and providing care of the highest standard focusing on safety and quality.						
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☒	☒	☐	☐	☐	☐	☐
Link to Board Assurance Framework [BAF]	No direct link						
Reports previously considered by	Submitted annually to the Trust Board.						

Classification: Official

Publication reference: PR1844

NHS England

A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1.1 Feb 2023

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Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A – G.

In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

The AOA exercise has been stood down since 2020 but has been adapted so that organisations have still been able to report on their appraisal rates.

Whilst a designated body with significant groups of doctors (e.g. consultants, SAS and locum doctors) will find it useful to maintain internal audit data of the appraisal rates in each group, the high-level overall rate requested in the table provided is enough information to demonstrate compliance.

The purpose of this Board Report template is to guide organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,
b) provide the necessary assurance to the higher-level responsible officer,
c) act as evidence for CQC inspections.

Designated Body Annual Board Report

Section 1 – General:

The Board of The Newcastle upon Tyne Hospitals NHS Foundation Trust can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year: Responsible Officer is in place and appropriately trained.

Comments: The Medical Director is the Responsible Officer and is supported in this role by the Deputy Medical Director who is the Associate Responsible Officer. He manages the operational delivery of the Medical Appraisal and Revalidation programme with the Medical Appraisal Lead, the Head of Medical Staffing and a small but very experienced team in Medical Staffing.

Action for next year: The Responsible Officer and Associate Responsible Officer will maintain appropriate training.

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes

Action from last year: Ensure ongoing support for the appraisal and Revalidation process.

Comments: Medical appraisal and Revalidation is supported by 2 part time staff in the Medical Staffing Department (0.6 FTE Band 5 and 0.4 FTE Band 6) and the Head of Medical and Dental Staffing. The Associate Responsible Officer is supported by a Medical Appraisal Lead for the Trust who receives a responsibility allowance for this role. Appraisal of locally employed doctors (previously known as Trust doctors) is managed by the medical education team.

A number of appraisers had retired during 2022/2023. Training of a new cohort of appraisers to support the existing experienced appraisers is planned for November 2023.

The number of doctors with a prescribed connection to Newcastle Hospitals continues to rise and a review of available resource is required.

Action for next year: Complete training of additional appraisers. Carry out a review of the resources available to support appraisal and Revalidation and perform a gap analysis against required resource.

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: To complete the implementation of SARD/GMC connect link. Review the systems available for support of locally employed junior medical staff.

Comments: The SARD system provides a record of all doctors with a prescribed connection to the organisation. This is cross referenced with the records on GMC connect.

An initial review of the processes in place for locally employed doctors suggests further work is required particularly for those working on the staff bank. This does not however affect the accuracy of records of those with a prescribed connection.

Action for next year: Complete a further review of systems for locally employed doctors and doctors working on the staff bank.

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: Complete resubmission and ratification of appraisal policy.

Comments: Appraisal policy has been reviewed and updated. Ratified by clinical policy group in January 2023.

Action for next year: Ensure all policies relating to Appraisal and Revalidation reflect the restructure of Newcastle Hospitals from Directorates to Clinical Boards.

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

Actions from last year: To reconsider an external audit with a peer Trust.

Comments: The combination of operational pressures, restructuring of the Trust and Industrial action has made it impossible to undertake and external review.

Action for next year: This will be reconsidered in the coming year.

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: To complete review of processes for supervision of junior doctors on short term contracts and implement findings.

Comments: A review of arrangements for junior doctors on short terms contracts has highlighted the need for further consideration of arrangements for those working solely on the staff bank. Arrangements have been put in place to improve information on appraisal and Revalidation at induction for this staff group.

Senior doctors working on short term placements are supported by the appropriate Clinical Board in discussion with the Revalidation team to ensure arrangements are in place for CPD, appraisal and Revalidation.

Action for next year: An action plan is being developed to clarify and improve arrangements for appraisal and Revalidation for doctors working solely on the staff bank.

Section 2a – Effective Appraisal

All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.[1]

[1] For organisations that have adopted the Appraisal 2020 model (recently updated aby the Academy of Medical Royal Colleges as the Medical Appraisal Guide 2022), there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal

Action from last year: To reconsider the utility of the Appraisal 2020 model for future appraisals.

Comments: We have continued to operate our existing appraisal system rather than formally moving to the Appraisal 2020 model. Our appraisers however take a pragmatic approach to the provision of supporting evidence for appraisal and we emphasise the importance of the appraisal discussion and reflection by the appraisee rather than relying on the provision of large amounts of documentary evidence. We are effectively operating under the recommendations of the Medical Appraisal Guide 2022.

Action for next year: To continue to review the efficacy of appraisal within the organisation by feedback from appraisers and appraisees.

7. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year:

Comments: See answer to question 1.

Action for next year:

8. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: To complete review of appraisal policy and achieve ratification of policy.

Comments: This has been achieved.

Action for next year: To continue to review the appraisal policy in light of Trust restructure from Directorates to Clinical Boards.

9. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet moved to the revised model may want to describe their plans in this respect.

Action from last year: To continue to monitor appraisal numbers to ensure adequate appraisers are in place.

Comments: A number of appraisers have retired during 2022/23 with several upcoming retirements of some of our most experienced appraisers. As a result the number of available appraisers has fallen below 75. We aim to have 85 appraisers to ensure a breadth of experience, clinical specialty, gender and ethnicity.

Action for next year: Training of an additional 16 appraisers is planned for November 2023.

10. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Action from last year: Appraisers to participate in ongoing performance review and training.

Comments: Feedback is obtained from appraisees on each appraisal and is provided to appraisers. Monitoring of appraiser performance is carried out by the Trust medical appraisal lead and the Revalidation team.

Action for next year: To reconsider the development of additional appraiser performance measures in collaboration with SARD JV.

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/

11. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: To consider external peer review.

Comments: This has not been possible as described above. The appraisal system is however monitored by internal audit processes on a regular basis and the outcomes of the audit reviewed through internal governance processes. Annual reports to the Board are provided using this Template.

Action for next year: To consider external peer review.

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation:	
Total number of doctors with a prescribed connection as at 31 March 2023	1,290
Total number of appraisals undertaken between 1 April 2022 and 31 March 2023	996
Total number of appraisals not undertaken between 1 April 2022 and 31 March 2023	294
Total number of agreed exceptions	200

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: All recommendations to be made on time using appropriate protocol.

Comments: One recommendation was delayed by an administrative error on the part of the Associate Responsible Officer. This was corrected the following day. All other recommendations were made on time and according to GMC protocols.

Action for next year: All recommendations should continue to be made on time and according to protocol.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: To continue to contact all doctors when recommendation is made.

Comments: Doctors are informed of recommendations and where a deferral or non-engagement recommendation is likely to be made discussions are held with the doctor prior to the recommendation. No recommendations of non-engagement have been made this year.

Action for next year: To continue to inform doctors of recommendations with emphasis on those where deferral or non-engagement recommendations are likely.

Section 4 – Medical governance

3. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: To maintain and further develop clinical governance structures.

Comments: The Trust has undergone a restructure of existing clinical Directorates into Clinical Boards. This process is still underway. Careful monitoring of Clinical Governance structures and the need to ensure appropriate Quality and Safety processes are in place have been key elements of this process.

Action for next year: To continue to monitor Clinical Governance structures with particular focus on changes required in response to the Trust restructure.

4. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: To review preparation of information for appraisal by CGARD and performance monitoring of medical and dental staff.

Comments: A new system for monitoring clinical information generated in the organisation has been introduced. There are ongoing discussions on how best to provide information to doctors for appraisal.

The conduct and performance of doctors is monitored and managed according to existing Trust policies on conduct and capability.

Action for next year: To complete review of information provided to doctors for appraisal.

5. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: To consider establishment of further responding to concerns and fitness to practice structures.

Comments: There are existing policies to respond to concerns about conduct, capability and health for all staff groups including medical staff. An external review will be conducted of the organisation's response to concerns that were raised in one clinical area. The outcome of this review will be used to inform the further development of processes for responding to concerns.

Action for next year: Implement any relevant recommendations of external review of responding to concerns.

6. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and

outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[3]

Action from last year: To consider establishment of further responding to concerns and fitness to practice structures.

Comments: See response to question 3

Action for next year: See response to question 3.

7. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[4]

Action from last year: To continue with existing processes for transfer of information between ROs.

Comments: All concerns about the conduct or performance of a doctor in our organisation who also works elsewhere, whether connected to us or another organisation are communicated to the relevant RO by the RO or Associate RO.

Action for next year: To continue with existing processes for transfer of information between ROs.

8. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: To continue with current processes for review of policies.

[3] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Comments: All Trust policies are evaluated prior to implementation to ensure that they are fair and free from bias and discrimination.

Action for next year: To continue with current processes for review of policies.

Section 5 – Employment Checks

9. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: To continue existing systems for pre-employment checks.

Comments: All doctors employed undergo appropriate pre-employment checks prior to commencement.

Action for next year: To continue existing systems for pre-employment checks.

Section 6 – Summary of comments, and overall conclusion

Since the last Compliance report progress has continued with re-establishing regular appraisal post COVID. This has however been hindered by clinical pressures on staff due to COVID backlog recovery and to a lesser extent by recent Industrial Action. Despite this appraisal rates are now at a similar level to that seen pre COVID.

Most of the actions identified last year have been completed however there is still a need for further work to consider the appraisal and Revalidation process for locally employed doctors and for all doctors employed on the staff bank, particularly those in the locally employed group.

The number of doctors connected to Newcastle Hospitals has continued to rise however the resource available to manage the appraisal and Revalidation process has not increased.

Clinical governance structures are in place to monitor and respond to concerns about the conduct and capability of doctors working in Newcastle Hospitals.

Processes are in place to ensure the appraisal and Revalidation process is managed effectively and recommendations for Revalidation are made in a timely manner based on high quality appraisals delivered by well trained and appraisers.

Overall conclusion:

Medical Appraisal and Revalidation continue to be delivered effectively in Newcastle Hospitals. In the coming year there will be particular emphasis on appraisal processes for locally employed doctors and those working solely on the staff bank. A review will be carried out of the resource required and available to deliver appraisal and Revalidation effectively in the coming years.

Section 7 – Statement of Compliance:

The Board of The Newcastle upon Tyne Hospitals NHS Foundation Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: The Newcastle upon Tyne Hospitals NHS Foundation Trust.

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _ _

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This publication can be made available in a number of other formats on request.

Publication reference: PR1844

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	26 September 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 Clinical Assurance Toolkit • Nursing and Midwifery Safer Staffing • Patient Experience Quarter one (Q1) Summary • Safeguarding and Mental Capacity Act Q1 summary • Learning Disabilities Q1 summary • Flu/Covid vaccination overview						
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:

Section one of the report contains this month's 'Spotlight' section which provides an overview of the Trust's Clinical Assurance Toolkit (CAT).

Maintaining high clinical standards is fundamental to professional practice. When high standards are delivered and maintained, care quality and outcomes are improved, and the patient experience is optimised. Leadership of clinical and professional standards at a ward and departmental level is pivotal with monitoring and audit supporting local ownership and improvement.

The CAT was originally introduced within Newcastle Hospitals in 2010/11 as a Trust-wide tool to provide continuing clinical oversight and assurance of performance for each ward and department. It remains one of the most fundamental Trust audit tools for assurance that the highest clinical and professional standards are met.

The CAT audit is undertaken monthly by Ward Sisters and Charge Nurses with a separate audit undertaken by Matrons to assess how their teams are performing in relation to core standards. Questions and observations relate to subjects ranging from:

- The cleanliness of the ward/environment.
- Compliance with the monitoring of equipment such as medication fridges and resuscitation equipment.
- Observations of clinical practice including a review of standard Infection Prevention and Control (IPC) precautions, hand hygiene and Aseptic Non-Touch Technique (ANTT) compliance.
- Review of patient notes and documentation and risk assessments compliance.
- Invasive device care compliance comprising of assessing device care bundles, completion of required documentation and evidence of ongoing care, as per policy.
- Testing of staff knowledge through focused questions.

Results are produced on completion and are visible to staff immediately. To support appropriate scrutiny and audit data accuracy, the Matrons undertake a peer review twice a year with feedback provided peer to peer. This has been a pivotal part of the process, ensuring a 'fresh eyes' assessment of standards in clinical areas.

The report includes an overview of the August CAT results which demonstrate that whilst performance remains high in most areas, further work is required to ensure all audits are completed as required and robust action plans are created to increase compliance.

Oversight and assurance are provided through the following mechanisms.

- The clinical teams have responsibility for completion of the audits to promote ownership, drive improvement and positive reinforcement.
- To ensure completion, areas that have not yet completed near month end are highlighted and the Associate Directors of Nursing follow this up with Matrons and teams to action.
- Action plans for improvement are the responsibility of the Matron and Ward management team and are held at local level.
- Results and action plans to address areas of concern are discussed in Matrons monthly 1 to 1's with the Associate Directors of Nursing.
- Results are presented and discussed bi-monthly in the ECN Meeting. Areas of concern are highlighted and followed up by the appropriate Associate Director of Nursing for that area.

It has recently been recognised that further work is required to strengthen the work regarding assurance around the actions taken in response to low scores and areas for improvement at a local level. Work is underway with the company who designed the tool to strengthen internal reporting and governance and explore the most effective way in which to report, monitor and document compliance to support sustained improvement.

Section 2: Nursing and Midwifery Safer Staffing

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

The nurse staffing escalation 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:

- Three wards have required high-level support over the last three months, two of which have now stepped down to medium level. All wards have action plans in place, overseen by the Nurse Staffing and Clinical Outcomes Group and by the ECN Team.
- 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 Matrons and are reported daily into the ECN Team. In the last three months, 545 red flags have been generated across the Trust which is similar to the previous quarter (n=535). The highest numbers are from across Medical Wards (n=155), Cardiothoracic Wards (n=103) and Childrens Wards (n=80).
- All staffing related DATIX reports have been reviewed and were graded no harm, low/minor or moderate. The last three months datix sustained the previous quarters average of 10 per month and are listed below:

June: 5
July: 10
August: 16

- New guidelines for roster optimisation "Check, Challenge and Coach" have been developed and are currently under review. This process will provide assurance of nursing roster optimisation and will support nursing leaders, by providing clear expectations, along with supportive education and training where required.

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.

The following key points are contained within the report:

- The current total Registered Nursing and Midwifery workforce combined turnover is 8.65%. This is based on Month 4 data and demonstrates a reduction from 9.61% reported in July. This compares favourably with the national median of 12.45%.
- The Band 5 Registered Nurse (RN) vacancy rate is 4.99% based on the financial ledger at Month 4 and current substantive staff in post. This is a favourable position when compared to the Month 4 vacancy rate of 10.9% in 2022. It does not include those nurses currently in the recruitment process, where there is a pipeline of 306 (head count) and does not include internationally recruited staff across adult and Paediatrics.
- There are areas where the vacancy rate remains above the Trust average, and this particularly relates to Paediatrics where a number of commissioned beds remain closed.
- The Nursing, Midwifery and Allied Health Professions (AHP) Recruitment and Retention Group provides oversight and analysis of the staffing data to determine additional requirements in the short, medium, and longer term. The focus for the next 12 months will be on the retention of staff to replicate the good practice and lessons learned from the HCSW retention work.
- The Trust made a successful bid for 2023/24 NHS England (NHSE) funding to continue with the ambitious international nursing recruitment plan for the deployment of 180 nurses by the 10 January 2024. The Trust also pledged to add a further 44 nurses to this plan to be deployed by the end of March 2024, giving a total of 224 nurses to add to the nursing and midwifery workforce. Recruitment and deployment remain on track.
- An essential component of the NHSE funding and the release of second tranche of funding requires the Trust to apply and submit evidence of the pastoral care provided to the international nursing recruits; this has been submitted and is awaiting approval.
- The national HCSW programme requires Trusts to achieve a zero-vacancy position. The HCSW vacancy rate is 5.3% based on the financial ledger at Month 4 and relates to current substantive staff in post. It does not include those HCSW's currently in the recruitment process, where there is a pipeline of 100 (headcount).

Section Two also includes an overview of the midwifery staffing position.

The following key points are contained within the report:

- The Maternity Service has continued to experience midwifery workforce pressures through Q1 and Q2. A combination of increased long and short-term sickness absence, maternity leave, and high turnover has contributed to these challenges.
- The current Registered Midwife vacancy rate is 7%. There are 31 whole-time-equivalent (wte) Midwives due to commence in post by November which will lead to an over recruited position and mitigate gaps for maternity leave and sickness absence once staff have completed their supernumerary period.
- Increased turnover rates continue at 12.4%, with attrition for a variety of reasons. Tables 2 and 3 show the percentage of Midwives leaving the Trust by band, and their reasons for doing so. The most common reasons for leaving are retirement, consistent with an ageing workforce, work-life balance, and relocation. The service's newly published retention action plan identifies key actions and targeted interventions for staff at all stages of their career, from students, through early and mid-career, to late-career midwives approaching retirement.
- From 1 February 2023 to 31 July 2023, there have been 4 occasions against a possible 1,086 episodes, recorded where the midwife has been unable to provide continuous one-to-one care and support to a woman in established labour; and four occurrences where the delivery suite coordinator has not remained supernumerary and has resulted in the coordinator being the named midwife for a woman. On these occasions, a review of the acuity and activity was undertaken, and together with professional judgement, the most appropriate utilisation of the available workforce resource has been made, thereby preserving, and maintaining safety.
- In June and July 2023, the number of red flags recorded on Delivery Suite was 25 and 24 respectively. This represents an increase on the monthly average which is usually below 10. The most common red flag reported is the delay between admission for, and commencement of, induction of labour. As induction of labour is a planned, elective procedure, the decision to commence the process is based on the judgement of the clinical team on duty following a review of the variable nature of clinical activity and acuity at the time.
- Due to the increased staffing pressures experienced in July, August and into September, following senior clinical review and discussion, a decision was made to temporarily close the Newcastle Birth Centre (NBC). Women eligible and expressing a wish to use the Birth Centre are diverted to Delivery Suite where a low-risk midwifery service is being provided. A Quality Impact Assessment has been undertaken which indicates that this process supports the safety of women and babies.

Section 3: Patient Experience Q1 Summary

Section three provides a Q1 summary of the work of the Patient Experience team.

The Trust has opened 119 formal complaints in Q1, which is a decrease of 13% from the previous quarter and a 13% decrease from the previous year, when an average of 46 complaints were received each month.

This quarter, 167 complaints were closed, which is an increase of 11% from the previous quarter. Of these, 26 complaints were upheld, 34 partially upheld and 107 not upheld.

The report provides an overview of several patient experience initiatives, improvements and work streams. This includes a detailed overview of the following:

- Sophie's Legacy - Earlier this year, the Trust was granted £10,000 by the Children's Hospital Alliance to implement a pilot aimed at improving the food provision for parents/carers of child in hospital. A multi-disciplinary task and finish group was established to assess current provision and implement any changes required. The group reviewed current provision on all Great North Childrens Hospital (GNCH) wards, undertook a survey of parents to find out what would help them during their stay and initiated a pilot of free lunch and evening meals for a three-week period. The pilot has evaluated very positively, and the working group are now exploring options for continuing this support for parents.
- Learning Disability Fun Day – Took place on 23 June 2023 at the Royal Victoria Infirmary (RVI) to celebrate the learning disability week. The Patient Experience Team had a stall asking staff, patients and visitors of their experience when coming into hospital with a learning disability. The team asked people what has worked well, and three things would they like to see improved. This feedback will be provided to the Learning Disability Steering Group to help drive forward improvements in the Learning Disability Passport and use of Easy Read information.
- Communication Support for Patients with a Learning Disability - The Patient Experience Team and Learning Disability Liaison Team are working closely with Skills for People to develop Easy Read information for patients. Skills for People is a local charity based in Byker supporting people with a learning disability and/or autism, and they have expertise in developing Easy Read information which is co-led by people with learning disability.

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

Section 4: Safeguarding and Mental Health Capacity Act (MCA) Q1

Section four of the report provides a Q1 summary update of Safeguarding and Mental Capacity Act activity throughout the Trust and includes references to activity, education and training. and audit and assurance.

Safeguarding activity for Q1 evidences the following key high-level points:

- In Adult Safeguarding, 1,052 referrals/cause for concerns were received in Q1 which is 100 more than the same period last year and an 11% increase in activity. Self-neglect continues to be the most significant case for referral accounting for 513 of the concerns received in Q1. Recent investment into the team is in progress, and the impact will be closely monitored.
- The Safeguarding Children's team continue to see an increase overall in activity since the pandemic. In Q1, there has been over a 12% increase in activity in comparison to Q1 last year. Child self-harm/overdose/substance misuse, Neglect and Domestic Abuse all feature high in the categories of referral. Maternity activity remains relatively stable.

- In Q1 there were 45 reported MCA enquiries, with 15 regarded as complex. 'Complex' can be where external legal advice has been required and/or have cases that have been put before the Court of Protection.
- Q1 Urgent Deprivation of Liberty Safeguard (DoLS) applications received and sent to Local Authorities continues to increase monthly, which has been an ongoing trend since October 2022. DoLS numbers for May and June were significantly greater than those of any month since the DoLS dashboards were created.

The report includes an update in relation to compliance with Safeguarding and Mental Capacity Act training requirements which continues to be closely monitored.

- In Adults and Children, Level 1 and Level 2 training demonstrates good compliance with 97% and 94% respectively for both programmes.
- Whilst Level 3 compliance has improved over the last 2 quarters, it remains lower than expected at 81% in adults and 83% in Childrens. Work remains in progress to maximise compliance across all Clinical Boards and workforce groups.
- In Q1, the Trust has embarked on a significant mandatory and best practice MCA training programme. This has been achieved through a level 1 MCA mandatory training for all clinical and patient facing staff. Compliance as of the 3 September sits at 89%. Regular updates have been provided to leaders across the Trust via the operational meetings to increase compliance.

Section 5: Learning Disabilities Q1

This section of the report provides a Q1 summary update regarding the work of the Learning Disability Liaison Team.

In Q1, there were 783 referrals, a slight increase in comparison to 763 in the previous quarter but a substantial 26% increase when compared to 623 in Q1 of 2022/2023. Whilst the Liaison Team has recently increased in size, this increased activity impacts on the team, and is being closely monitored. There have been 329 inpatients and 339 Accident and Emergency (A&E) attendances in Q1 demonstrating an increase of 41 from the previous quarter.

The report includes an overview of the work undertaken in response the Care Quality Commission (CQC) report which highlighted concerns around record keeping of reasonable adjustments for people with a Learning Disability. The Liaison Team and the Digital Health Team worked at pace and implemented alterations to the triage and admission documentation with regard to the diagnosis of a learning disability and subsequently documenting reasonable adjustments. Audit demonstrates that compliance is improving but remains lower than required. Further adjustments to the digital system have been made with focused education being undertaken by a temporary Clinical Educator.

The Code of Practice (Health and Social Care Act 2008) consultation paper pertaining to mandated training on learning disability and autism has been released and an overview of the proposed requirement is provided within the report. The training proposal is very prescriptive to be led by a 'Trio' of three trained individuals – a facilitator, a person with lived experience of learning disability and a person with lived experience of autism. The consultation paper closed on 19 September.

The Trust has been asked by the A2A (a North and East and North Cumbria Regional Learning Disabilities Network) to participate in a regional pilot to support the evaluation of the training to understand the potential barriers in achieving the proposed compliance. A Task and Finish Group has been developed to consider the implications of the pilot and further updates will be provided to the Trust Board in future reports.

Section 6: Flu/Covid Vaccination

Section six of the report contains an overview of the planned Covid and Flu winter vaccination programme.

The Joint Committee on Vaccination and Immunisation (JCVI) advises that the Covid vaccination programme should be brought forward to September 2023, in light of new variants to maximise protection for those who are most vulnerable to serious infection ahead of the winter months. Recent government announcements have confirmed the eligible cohorts for this programme which includes front line health and social care workers. Winter influenza vaccines are also to be delivered in the autumn in line with the normal yearly vaccination programme.

At the time of writing, it is expected that the vaccination programme will commence on the 25 September for both vaccines.

The delivery of both vaccines will be closely monitored with high level data broken down to Clinical Board level and regular reporting to the Executive Team and Trust Board.

The Department of Health and Social Care (DHSC), together with Public Health England (PHE) have previously outlined their expectation to Trusts regarding Flu vaccine uptake. This included completion of a 'self-assessment checklist' published in Board papers at the start of the flu season. This has not been received this year, but the Trust has used previous versions to ensure all necessary preparations are in place.

RECOMMENDATION

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

Report of Maurya Cushlow
Executive Chief Nurse
26 September 2023

EXECUTIVE CHIEF NURSE REPORT

1. SPOTLIGHT – CLINICAL ASSURANCE TOOLKIT

Maintaining high clinical standards is fundamental to professional practice. When high standards are delivered and maintained, care quality and outcomes are improved, and the patient experience is optimised. Leadership of clinical and professional standards at a ward and departmental level is pivotal and the monitoring and audit of standards supports local ownership and improvement.

1.1 The tool and audit process

The CAT was originally introduced within Newcastle Hospitals in 2010/11 as a Trust-wide tool to provide continuing clinical oversight and assurance of performance for each ward and department. It remains one of the most fundamental Trust audit tools for assurance that the highest clinical and professional standards are met.

The CAT audit is undertaken monthly by Ward Sisters and Charge Nurses with a separate audit undertaken by Matrons to assess how their teams are performing in relation to core standards. The audit includes all areas (In-Patient/Out-Patient/Theatres/Community) with questions amended as required. Questions and observations relate to subjects ranging from:

- The cleanliness of the ward/environment.
- Compliance with the monitoring of equipment such as medication fridges and resuscitation equipment
- Observations of clinical practice including a review of standard IPC precautions, hand hygiene and ANTT compliance.
- Review of patient notes and documentation and risk assessments compliance.
- Invasive device care compliance comprising of assessing device care bundles, completion of required documentation and evidence of ongoing care, as per policy.
- Testing of staff knowledge through focused questions.

Results are produced on completion and are visible to staff immediately. To support appropriate scrutiny and audit data accuracy, the Matrons undertake a peer review twice a year with feedback provided peer to peer. This has been a pivotal part of the process, ensuring a 'fresh eyes' assessment of the clinical areas.

1.2 Current Performance

Since its inception, the CAT has had agreed thresholds regarding compliance. These are:

- <91% - non-compliant
- 91-97% - partially compliant
- 98-100% - compliant

Outlined below is the current performance by Trust and Clinical Board of the audits undertaken in August 2023. Results are split across the horizontal live by audit section and by audit completion compliance as well as audit score along the vertical line.

		CAT Total	Standard IPC Precautions Total	Care Total	Matron Checks Total			CAT Total	Standard IPC Precautions Total	Care Total	Matron Checks Total
Trust	Total Commenced	164	155	97	157	FH Surgical & Specialist Services Clinical Board	Total Commenced	20	20	17	20
	Total % Commenced	98%	91%	97%	97%		Total % Commenced	100%	100%	94%	100%
	Total Commenced Correct Answers	97%	99%	98%	96%		Total Commenced Correct Answers	99%	98%	98%	95%
Cancer & Haematology Clinical Board	Total Commenced	7	7	6	7	Medicine & Emergency Care Clinical Board	Total Commenced	29	30	20	30
	Total % Commenced	83%	78%	100%	83%		Total % Commenced	67%	100%	100%	100%
	Total Commenced Correct Answers	99%	100%	99%	98%		Total Commenced Correct Answers	64%	99%	97%	96%
Cardiothoracic Services Clinical Board	Total Commenced	12	12	10	13	Nursing & Patient Services	Total Commenced	1	1		1
	Total % Commenced	97%	92%	91%	100%		Total % Commenced	100%	100%		100%
	Total Commenced Correct Answers	97%	99%	99%	95%		Total Commenced Correct Answers	100%	96%		96%
Clinical & Research Services Clinical Board	Total Commenced	14	14	1	17	Peri-operative & Critical Care Clinical Board	Total Commenced	7	7	5	7
	Total % Commenced	93%	88%	50%	100%		Total % Commenced	100%	100%	100%	100%
	Total Commenced Correct Answers	99%	99%	100%	98%		Total Commenced Correct Answers	95%	99%	93%	68%
Family Health Clinical Board	Total Commenced	45	38	26	40	RVI Surgical Specialist Clinical Board	Total Commenced	28	26	12	28
	Total % Commenced	98%	90%	93%	100%		Total % Commenced	93%	84%	86%	100%
	Total Commenced Correct Answers	97%	99%	99%	91%		Total Commenced Correct Answers	97%	99%	97%	97%

August results demonstrate that whilst performance remains high in the majority of areas, a number of areas are required to ensure all audits are completed and robust action plans are created to increase compliance.

Oversight and assurance is provided through the following mechanisms:

- The clinical teams have responsibility for completion of the audits to promote ownership, drive improvement and positive reinforcement.
- To ensure completion in all areas, areas that have not yet completed near month end are highlighted and the Associate Directors of Nursing follow this up with Matrons and teams to ensure completion.
- Action plans for improvement are the responsibility of the Matron and Ward management team and are held at local level.
- Results and action plans to address areas of concern are discussed in Matrons monthly 1 to 1's with the Associate Directors of Nursing.

- Results are presented and discussed bi-monthly in the ECN Meeting. Areas of concern are highlighted and followed up by the appropriate Associate Director of Nursing for that area.

1.3 Future Improvements

Further work is required to strengthen the work regarding assurance and actions in response to low scores and areas for improvement at a local level. Work is underway with the company who designed the tool to strengthen internal reporting and governance and explore the most effective way in which to report, monitor and document compliance. Work is in progress to agree the reporting of CAT data through the Clinical Board governance structure to improve governance and oversight.

2. NURSING AND MIDWIFERY SAFER STAFFING UPDATE

2.1 Nurse 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.

Although nursing vacancy levels have improved overall and bed capacity has been increased, 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 and inability to deliver full commissioned bed capacity.
- 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 continued increasing requirement for enhanced care observation and high acuity and dependency continues and whilst robust oversight remains in place, it is recognised that this cannot be met on all occasions.

2.2 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 meets 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	No of wards reviewed by speciality	Monitor	Low level support	Medium level support	High level support	No further support
May-23	21	Childrens x5 Neurosciences x3 Musculoskeletal x3 Cardiothoracic x2 Medicine x6 Urology x2	6	5	4	2	4
Jun-23	24	Childrens x4 Neurosciences x3 Musculoskeletal x3 Burns/Plastics x1 Cardiothoracic x2 Medicine x6 Renal x1 Urology x2 Surgery x1 Cancer x2		8	6	1	9
Jul-23	20	Childrens x2 Musculoskeletal x2 Neurosciences x1 Cardiothoracic x3 Medicine x7, Renal x1 Urology x2 Surgery x1 Cancer x1		12	5	1	2

The following key points from this group are noted below:

- Three wards have required high-level support over the last three months, two have now stepped down to medium level. All wards have action plans in place, overseen by the Nurse Staffing and Clinical Outcomes Group and by the ECN Team.
- 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 Matrons and are reported daily into the ECN Team. In the last three months, 545 red flags have been generated across the Trust. The highest numbers are from across Medical Wards (n=155), Cardiothoracic Wards (n=103) and Childrens Wards (n=80).
- All staffing related DATIX reports have been reviewed and were graded no harm, low/minor or moderate. The last three months datix sustained the previous quarters average of 10 per month and are listed below:
  June: 5

July: 10
August: 16

- New guidelines for roster optimisation "Check, Challenge and Coach" have been developed and are currently under review. This process will provide assurance of nursing roster optimisation and will support nursing leaders, by providing clear expectations, along with education and training where required.

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.

2.3 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	Care Hours Per Patient Day	RN day fill rate %	HCA Day fill rate %	RN Night fill rate %	HCA Night fill rate %	Trust fill rate %
May-23	8.7	92%	98%	91%	121%	100%
June-23	8.6	91%	96%	90%	119%	99%
July-23	8.5	87%	94%	86%	118%	96.%

Key points to note:

- There has been a reduction in fill rates over the last three months with a reciprocal reduction in CHPPD. This is due to increased bed capacity and a reduction in staff undertaking overtime over the summer period. This is an annual pattern with fill rates higher than the previous year.
- 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 13% on days and 14% on nights continues to be challenging on wards and departments when trying to provide the highest possible standard of care.

2.4 Recruitment and International Recruitment

2.4.1 Registered Nurse Recruitment

The current total Registered Nursing and Midwifery workforce combined turnover is 8.65%. This is based on Month 4 data and demonstrates a reduction from 9.61% previously reported in July and compares favourably with the national median of 12.45%.

Improving the retention figure remains a key priority in the year ahead and beyond. The Trust has appointed two Legacy Mentors who will provide support to new registrants through coaching, mentoring and pastoral support. The aim of this role is to retain both our experienced staff late in career and support our new staff in practice. The Legacy mentors will be professional points of contact for staff wellbeing and career progression.

The Band 5 RN vacancy rate is 4.99% based on the financial ledger at Month 4 and relates to current substantive staff in post. This is a favourable position compared to the Month 4 vacancy rate of 10.9% in 2022. It does not include those nurses currently in the recruitment process, where there is a pipeline of 306 (head count) and does not include international recruitment) staff across adult and paediatrics. There are areas where the vacancy rate remains above the Trust average and focused work continues. This particularly relates to Paediatrics.

The Nursing, Midwifery and AHP Recruitment and Retention Group continue to provide oversight and analysis of the staffing data to determine additional requirements in the short, medium, and longer term. This group's focus for the next 12 months will be on the retention of staff to replicate the good practice and lessons learned from the HCSW retention work across all disciplines.

2.4.2 International Recruitment

The Trust made a successful bid 2023/24 NHSE funding to continue with the ambitious international nursing recruitment plan for the deployment of 180 nurses by the 10 January 2024. The Trust also pledged to add a further 44 nurses to be deployed by the end of March 2024, giving a total of 224 nurses to add to the nursing and midwifery workforce.

An essential component of the NHSE funding and the release of second tranche of funding requires the Trust to apply and submit evidence of the pastoral care provided to the international nursing recruits, this has been submitted and is awaiting approval.

The international recruitment team have been shortlisted for two categories in the Trusts Celebrating Excellence Awards – Team of the Year (support and corporate services) & Partnership Working.

The international recruitment team have been successful in creating an external support offer, providing paediatric NMC OSCE preparation and training for Trusts unable to provide this independently. This work has been shortlisted for the Nursing Times Workforce Awards due to take place on 21 November 2023.

2.4.3 Healthcare Support Workers (HCSW)

The national HCSW programme the requires Trust's to achieve a zero-vacancy position. The HCSW vacancy rate is 5.3% based on the financial ledger at Month 4 and relates to current substantive staff in post. It does not include those HCSW's currently in the recruitment process, where there is a pipeline of 100 (headcount).

Maintaining a zero position is challenging due to staff turnover and service innovation but this is closely monitored monthly by the HCSW steering group with proactive recruitment remaining a priority whilst reviewing performance and focussing on retention. The pastoral support offered to all HCSW's across the organisation includes the provision of a monthly career conversation, professional development and retention discussions. All HCSWs have undertaken and completed a high-quality induction package and training within the Healthcare Academy.

The NHSE Funded 'Widening Access Transformation project' which was a large-scale community recruitment event is now complete with the appointment of Band 3 and Band 2 apprentices. Candidates received a pre-application engagement offer with webinars for completion of applications and interview preparation delivered jointly by the Human Resources and Nursing teams. This work has been sshortlisted for a Nursing Times Workforce Award. This innovative work links to the 'Altogether Better' programme which looks at ideas, practices, tools and support to deliver a more diverse workforce. It encourages us to explore bias in the recruitment process and in how people gain promotion. The aim of the programme is to deliver a more diverse Healthcare Support Worker workforce that meets the needs of our organisation.

2.5 Midwifery Staffing

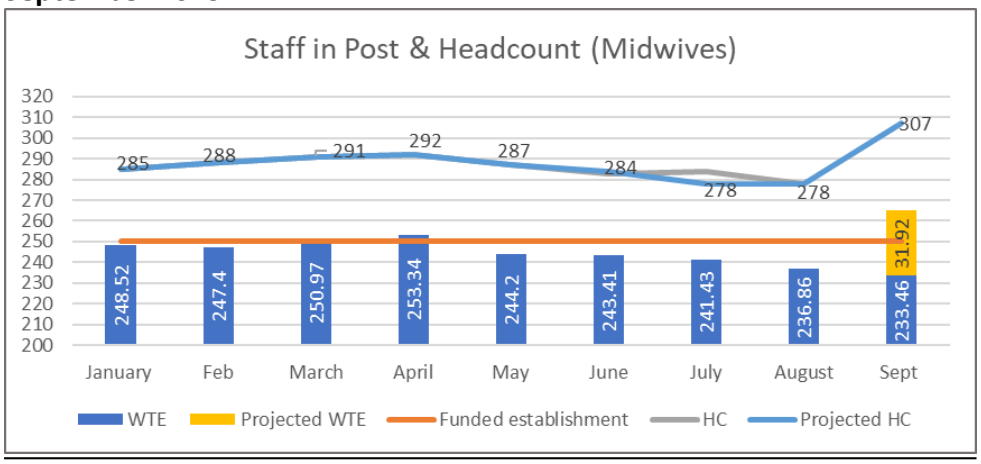
2.5.1 Current Staffing Position

The Maternity Service has continued to experience midwifery workforce pressures through Q1 and Q2.

A combination of increased long and short-term sickness absence, maternity leave, and high turnover has contributed to these challenges. This, combined with high levels of activity and acuity, has created increased pressures for the service. In addition, there has been a gap whilst awaiting new registrants who were appointed earlier in the year and who are due to commence in post before November.

Table 1 illustrates the current midwifery staffing position, including frontline clinical staff and those in specialist and management roles. This highlights the current whole time equivalent (wte) midwives against the funded establishment of 250.50wte and the projected impact of 30 newly qualified Midwives and 2 experienced Band 6 Midwives due to commence in post from September.

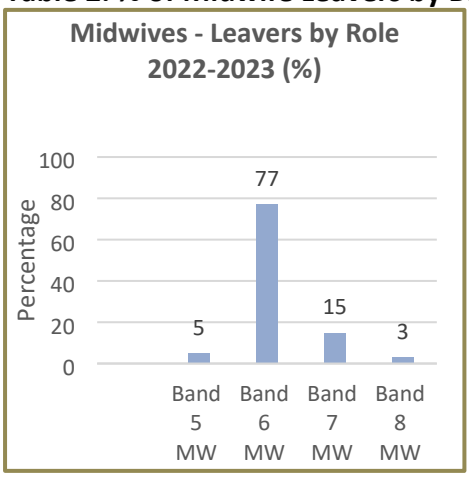
Table 1: Midwives in Post (WTE and Headcount) against funded establishment – January to September 2023

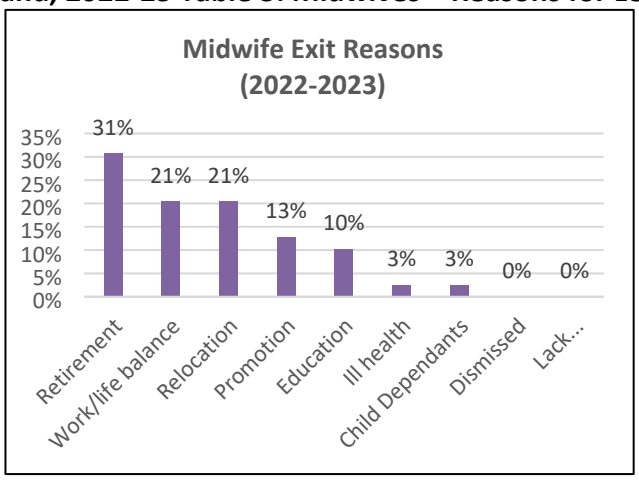


The Trust has a permanently approved 20wte over-establishment to allow for increased levels of maternity leave and to account for one workforce supply annually, to ensure a consistent, sustainable position within the large midwifery workforce at Newcastle.

Turnover rates continue at 12.4%, with attrition for a variety of reasons. Tables 2 and 3 show the percentage of Midwives leaving by Band, and their reasons for doing so. The most common reasons for leaving are retirement, consistent with an ageing workforce, work-life balance, and relocation. The service's newly published retention action plan identifies key actions and targeted interventions for staff at all stages of their career, from students, through early and mid-career, to late-career Midwives approaching retirement.

Table 2: % of Midwife Leavers by Band, 2022-23 Table 3: Midwives – Reasons for Leaving





2.5.2 Red Flags: 1:1 Care in Labour and Supernumerary Status of the Labour Ward Coordinator

In the six months 1 February 2023 to 31 July 2023, there have been 4 occasions against a possible 1,086 episodes recorded where the midwife has been unable to provide continuous one-to-one care to a woman in established labour; and 4 occurrences where the Delivery Suite Co-ordinator has not remained supernumerary and was the named Midwife for a woman. On these occasions, a review of the acuity and activity was undertaken, and together with professional judgement, the most appropriate utilisation of the available workforce resource has been made, thereby preserving, and maintaining safety.

In June and July 2023, the number of red flags recorded on delivery suite was 25 and 24 respectively. This represents an increase on the monthly average which is usually below 10. The most common red flag reported is the delay between admission for, and commencement of, induction of labour. On average, the Trust performs 2,600 inductions of labour in a six-month period. There were seventy red flags recorded in this time period for delay between admission and the beginning of the process, equating to 2.7%. As induction of labour is a planned, elective procedure, the decision to commence the process is based on the judgement of the clinical team on duty following a review of the variable nature of clinical activity and acuity at the time. The clinical needs of individuals are prioritised and assessed as part of this process in mitigation of risk.

2.5.3 Risk and Mitigation

Due to the increased staffing pressures experienced in July, August and into September, following senior clinical review and discussion, a decision was made to temporarily close the NBC. Women eligible and expressing a wish to use the Birth Centre are diverted to Delivery Suite where a low-risk midwifery service is being provided. A Quality Impact Assessment has been undertaken which indicates that this process supports the safety of women and

babies. However, this decision impacts on patient experience as partners are unable to stay overnight on the postnatal ward, in contrast to their expected experience on the Birth Centre.

4. PATIENT EXPERIENCE Q1 SUMMARY

4.1 Complaints Activity

The Trust has opened 119 formal complaints in Q1, which is a decrease of 13% from the previous quarter and a 13% decrease from the previous year, when an average of 46 complaints were received each month.

In Q1, Medicine & Emergency Care and Surgical and Specialist Services (RVI) received the most complaints, with 28 complaints (23%) each.

This quarter, 167 complaints were closed, which is an increase of 11% from the previous quarter. Of these, 26 complaints were upheld, 34 were partially upheld and 107 were not upheld.

4.2 Patient Advice and Liaison Service (PALS)

933 issues have been raised with PALS over this period. This compares to 1,060 in the previous quarter, and 999 in the same quarter 2022-23. 51 enquiries were from carers. There has been a 14% reduction in the number of enquiries regarding appointments, 166 this quarter compared to 192 in Q4. Care & Treatment is comparable to last quarter noting 209 in Q1 and 221 in Q4.

4.3 NHS Friends and Family Test (FFT)

The FFT data submitted in Q1 shows that there were 5,988 responses in April – June 2023. 97% of patients reassuringly reported a positive rating in both inpatient and out-patient services.

The NHSE Insight team have reported that due to technical issues, the publication of the March FFT data onwards has been delayed, and there is no estimate as to when it will be published therefore, we are unable to display Trust performance against the national figures.

4.4 NHS Choices

The Trust received 33 items of feedback with most comments being in relation to Medicine (n8) and Community (n7) Services. The Trust received the maximum score rating of five stars from 67% (n22) of comments received.

Community (5 Star) – *"I can't fault the treatment and advice I received yesterday. The Dr was thorough and very easy to talk to. I left fully reassured and confident the treatment prescribed would make a difference to my aliment."*

4.5 Sophie's Legacy

Earlier this year, the Trust was granted £10,000 by the Children's Hospital Alliance to implement a pilot aimed at improving the food provision for parents/carers of child in hospital. A multi-disciplinary task and finish group was established to assess current provision and implement any changes required. The group carried out a review of current provision on all GNCH wards, undertook a survey of parents to find out what would help them during their stay and initiated a pilot of free lunch and evening meals for a three-week period.

The pilot has evaluated very positively with:

- 96% of parents rated the food they were given as 'Very good' or 'Good'
- 98% of parents said it was useful to receive the voucher
- 96% of parents said that it made a difference to their stay in hospital
- 89% of parents said they tended to eat their meals in the child's room
- 49% of parents used the vouchers to get both hot and cold meals (74)
- 26% (39) had cold meal only and 21% (32) hot meal only
- 92% of parents said they were given the right amount of food

The Working Group are now exploring options for continuing the additional support for parents and have reinforced the offer of breakfast and hot and cold drinks which is already provided.

4.6 Advising on the patient experience (APEX)

This quarter, APEX have contributed to the work being undertaken by 'We Are Stand' to co-produce the Trust's patient experience strategy.

The Group also heard back from the Nurse Specialist Acute Pain Team who presented the initial findings from research to understand what influences opioid prescribing for acute pain. APEX was able to contribute from their own experiences around the information given to patients and the experience of using opioids for pain management.

APEX have also received information about the new Trust Food and Drink Strategy which will run until 2027. APEX was particularly interested in sustainability aspects of food service and supported the planned introduction of electronic meal ordering.

4.7 Maternity Voice Partnership (MNVP)

Maternity Voices Partnerships has been renamed to Maternity Neonatal Voices Partnership (MNVP) which is in line with the national direction to promote inclusivity of all families, all voices, particularly those with babies receiving neonatal intensive care.

The 2023-2024 MNVP work plan has been a central focus of this quarter and a valuable co-production opportunity to identify shared aims and actions that will reach and empower the voice of all Trust maternity service users. The work plan priorities are presented in three domains: more voices, more choices and more connections. More voices summarises the MNVP vision to provide a safe space, reachable by all service users that enables sharing of experiences and feedback; More choices relates to championing personalised care planning,

empowering choice and ensuring information is provided to enable informed choice for all service users; More connections highlights the MNVP priority to seek new connections, work with more communities and professional stakeholders within the city and ultimately, reach more service users.

The work plan was presented and ratified at the first MNVP meeting of the quarter.

4.8 Learning Disability Fun Day

This took place on 23 June 2023 at the RVI to celebrate learning disability week.

The Patient Experience Team had a stall asking staff, patients and visitors of their experience when coming into hospital with a learning disability. The team asked people what has previously worked well, and three things would they like to see improved. Most of the suggested improvements included:

- Better use of the Learning Disability Passport, including providing it as early as possible during a care journey and ensuring clinical staff take the time to read it.
- Use Easy Read information to explain health information and visits.
- Planning hospital visits with family and carers to manage expectations.

This feedback will be provided to the Learning Disability Steering Group to help drive forward improvements in the Learning Disability Passport and use of Easy Read information.

4.9 Communication Support for Patients with a Learning Disability

Meeting the communication needs of patients with a learning disability is a Trust legal obligation under the Equality Act 2010 and Accessible Information Standard.

The Patient Experience Team and Learning Disability Liaison Team are working closely with Skills for People to see how they can support the organisation in developing Easy Read information for patients. Skills for People is a local charity based in Byker supporting people with a learning disability and/or autism, and they have expertise in developing Easy Read information which is co-led by people with learning disability.

A charitable application will be submitted to support funding this important piece work.

5. SAFEGUARDING AND MENTAL CAPACITY ACT QUARTER ONE SUMMARY (Q1)

This summary provides a Q1 update of Safeguarding and Mental Capacity Act (MCA) activity throughout the Trust and includes references to activity, education and training, and audit and assurance.

5.1 Safeguarding and MCA Activity

Safeguarding activity for Q1 evidences the following key high-level points:

- In Adult Safeguarding, 1,052 referrals/cause for concerns were received in Q1 which is 100 more than the same period last year and an 11% increase in activity. Self-

neglect continues to be the most significant case for referral accounting for 513 of the concerns received in Q1. Recent investment into the team is in progress, and the impact will be closely monitored.

- The Safeguarding Children's team continue to see an increase in overall activity since the pandemic. In Q1, there has been over a 12% increase in activity in comparison to Q1 last year. Child self-harm/overdose/substance misuse, Neglect and Domestic Abuse all feature high in the categories of referral. Maternity activity remains relatively stable.
- Q1 there were 45 reported MCA enquiries, with 15 regarded as complex. 'Complex' can be where external legal advice has been required and/or have cases that have been put before the Court of Protection.
- Q1 numbers for Urgent DoLS applications received and sent to Local Authorities increases monthly which has been an ongoing trend since October 2022. DoLS numbers for May and June were significantly greater than those of any month since the DoLS dashboards were created.

5.2 Education and Training

Adults and Children, Level 1 and Level 2 training demonstrates good compliance with 97% and 94% respectively for both programmes. Whilst Level 3 compliance has improved over the last 2 quarters, it remains lower than expected at 81% in adults and 83% in Childrens. Work remains in progress to maximise compliance across all Clinical Boards and workforce groups.

In Q1, the Trust has embarked on a significant mandatory and best practice MCA training programme. This has been achieved through a level 1 MCA mandatory training for all clinical and patient facing staff. Compliance as of the 3 September sits at 89%. Regular updates have been provided to leaders across the Trust via the operational meetings to increase compliance.

Ongoing information sessions for clinical leaders and ward bite-sized training remains in place after it was commenced in April 2023. The bite-sized sessions appear to have been effective in that ward staff describe feeling more confident about the DoLS process with the clear increase in submission of Urgent DoLS and improvement in audit data demonstrating the importance of this education.

5.3 Audit and Assurance

A number of audit reports were presented to the Safeguarding Committee in Q1 for review and discussion. This included the following:

- An audit of Emergency Department (ED) Records provided evidence of good practice within the safeguarding Cause for Concern (CfC) process. The audit will be repeated in February 2024.
- The Safeguarding Children Clinical Supervision audit highlighted evidence of staff accessing supervision in a 1:1 structure and whilst staff generally preferred 1-1 supervision, many would be receptive to group supervision. Not all supervision sessions were documented within the patient's record and further training will be delivered to the 0-19 Service.

- In April and May all patients subject to DoLS were audited to understand if an assessment of capacity had been undertaken prior to DoLS application, which is the expectation as outlined in the policy. Compliance with process is increasing month on month with the most recent audit demonstrating 73% compliance. Work continues through education to improve compliance and a regular audit framework remains in place.

6. LEARNING DISABILITIES Q1 SUMMARY

6.1 Activity

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

The following activity trends are noted for Q1:

- In Q1 there were 783 referrals which is a slight increase in comparison to 763 in the previous quarter but a substantial 26% increase when compared to 623 in Q1 of 2022/2023.
- At time of report there were 68 patients which the team are involved with planning the admission to ensure safety and reasonable adjustments identified and implemented. A number of these cases are extremely complex, requiring input from the Mental Capacity Act Lead Practitioner and Legal Services.
- There have been 329 inpatients and 339 A&E attendances in Q1 demonstrating an increase of 41 from the previous quarter.

6.2 CQC Focused Inspection Update

In response to the CQC report highlighting concerns around record keeping for reasonable adjustments for people with a Learning Disability, a significant piece of work has commenced to ensure evidence of 'reasonable adjustment' is documented. The Learning Disability Liaison Team and the Digital Health Team worked at pace and implemented alterations to the triage and admission documentation for documenting the diagnosis of a learning disability and reasonable adjustments.

Audits have been undertaken since the changes in the e-record triage and admission documentation to assess compliance. Audit undertaken of patient notes in Adult and Paediatric ED and across in-patient areas just after implementation and education demonstrated low compliance in completing screening questions and documenting evidence of reasonable adjustments. Further changes have been made to the paediatric triage form in emergency care and the same process will commence in adult emergency care. Training continues to be delivered across the organisation to raise awareness. Re-audit is in progress. Case note review in the interim is demonstrating improved compliance with screening and the documentation of reasonable adjustments.

6.3 Training and Education

The Code of Practice (Health and Social Care Act 2008) consultation paper pertaining to mandated training on learning disability and autism has been released. The content is as expected and requires the following:

- All staff to undertake a 90min e-learning training. In the Trust we have implemented the Diamond Standard Training current compliance is 88%.

There are then two tiers that all staff will branch into:

- Tier 1 – the Consultation paper describes this for all staff who require general awareness and who do not come into contact with patients. This training will be a 60 minute virtual but live session.
- Tier 2 – for staff who need to provide care or have front of service interaction. This is a full day training face to face.

The Code of Practice (Health and Social Care Act 2008) consultation paper pertaining to mandated training on learning disability and autism has been released and an overview of the proposed requirement is provided within the report. The training proposal is very prescriptive to be led by a 'Trio' of three trained individuals – a facilitator, a person with lived experience of learning disability and a person with lived experience of autism. The consultation paper closed on 19 September.

The Trust has been asked by the A2A (a North and East and North Cumbria regional Learning Disabilities Network) to participate in a regional pilot to support the evaluation of the training to understand the potential barriers in achieving the proposed compliance. A Task and Finish Group has been developed to consider the implications of the pilot and further updates will be provided to the Trust Board in future reports.

7. FLU/COVID VACCINATION PROGRAMME

The Joint Committee on Vaccination and Immunisation (JCVI) advised that the Covid vaccination programme should be brought forward to begin in September 2023, in light of new variants and to maximise protection in those who are most vulnerable to serious infection ahead of the winter months. Recent government announcements have confirmed the eligible cohorts for this programme which includes health and social care workers. Winter influenza vaccines are also to be delivered in the autumn in line with the normal yearly vaccination programme.

In the 2022/2023 program, the uptake for the flu vaccine was 73% and the Covid Vaccine uptake was 66%. Regionally this was the highest uptake for Covid and second highest for Flu vaccinations and the highest nationally for both vaccines for trusts with greater than 10,000 frontline staff. The aim is to meet and surpass the targets previously achieved with particular focus on achieving maximum compliance in both vaccines.

At the time of writing, vaccine supply is still in the process of being finalised though it is expected that the vaccination programme will commence on the 25 September for both vaccines. The administration of both vaccines will be monitored daily and reported weekly

with high level data broken down to Clinical Board level and regular reporting to the Executive Team and Trust Board.

The Department of Health and Social Care (DHSC), together with Public Health England (PHE) have previously outlined their expectation to Trusts regarding Flu vaccine uptake. This included completion of a 'self-assessment checklist' published in Board papers at the start of the flu season. This has not been received this year, but the Trust has used previous versions to ensure all necessary preparations are in place.

8. RECOMMENDATION

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

Report of Maurya Cushlow
Executive Chief Nurse
26 September 2023

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

APPENDIX 1 - 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 leaders 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 medicines are stored	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 for ensuring medication is secure,	Matrons	B7 DS Leads B7 NBC Lead B7 Ward Leads B7 Team Leads Community	Compliant with mechanism for ongoing monitoring and reporting to ensure	Monthly medication and IV Fluid checklist, Home Birth bags monthly checklist.

Date	Areas for Improvement	Must/ Should	Action	Action Lead	Action Owner	Progress	Supporting Documents
	securely. Regulation 12 (1) (2) (g)		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.			embedded practice.	
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 for	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: 87.36% against a target of 96% Children's Safeguarding Level 3: 87.93%: against a target of 95% Core Competency Training: 67% against a target of 90%	

Date	Areas for Improvement	Must/ Should	Action	Action Lead	Action Owner	Progress	Supporting Documents
			Newcastle and the additional financial resource required.				
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 with a mechanism in place for monitoring and reporting.	
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	Director of Midwifery	Director of Midwifery, Matrons	Compliant with a mechanism in place for monitoring and reporting.	Evidence strengthened through documentary evidence of monitoring and reporting of Daily staffing vs Acuity and staff movement using action log.

Date	Areas for Improvement	Must/ Should	Action	Action Lead	Action Owner	Progress	Supporting Documents
			for additional assurance with regard to workforce planning and mitigation of risk.				
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	Maternity has now implemented e-obs from July 2023. This will enable a continuous process of review in relation to completion of MEOWS, and greater quality assurance through audit to ensure embedded practice.	Directorate Governance Team Quality & clinical effectiveness midwife	Risk Management Midwives, Team Leads, Shift Coordinators	Partially compliant pending audit of newly implemented system.	

Date	Areas for Improvement	Must/ Should	Action	Action Lead	Action Owner	Progress	Supporting Documents
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.	Directorate Management Team	Head of Security PN Matron	Compliant.	
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 revised to 05.11.23 in view of additional training requirements. 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 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
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 Report: The safety of maternity services in England must be implemented.	1.1	To fund maternity and neonatal services appropriately requires a multi-year settlement to ensure the workforce is enabled to deliver consistently safe maternity and neonatal care across England.	n/a Awaiting information on further funding
	1.2	Minimum staffing levels should be those agreed nationally, or where there are no agreed national levels, staffing levels should be locally agreed with the LMNS. This must encompass the increased acuity and complexity of women, vulnerable families, and additional mandatory training to ensure trusts are able to safely meet organisational CNST and CQC requirements.	Compliant
	1.3	Minimum staffing levels must include a locally calculated uplift, representative of the three previous years' data, for all absences including sickness, mandatory training, annual leave, and maternity leave.	Non- compliant (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

every maternity unit should be implemented.	1.7	All trusts must ensure all midwives responsible for coordinating labour ward attend a fully funded and nationally recognised labour ward coordinator education module, which supports advanced decision making, learning through training in human factors, situational awareness, and psychological safety, to tackle behaviours in the workforce.	Partial compliance (attendance ongoing, all LW coordinators scheduled to attend)
	1.8	All trusts to ensure newly appointed labour ward coordinators receive an orientation package which reflects their individual needs. This must encompass opportunities to be released from clinical practice to focus on their personal and professional development.	Compliant
	1.9	All trusts must develop a core team of senior midwives who are trained in the provision of high dependency maternity care. The core team should be large enough to ensure there is at least one HDU trained midwife on each shift, 24/7.	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.	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

If not resident there must be clear guidelines for when a consultant obstetrician should attend.	3.4	There must be clear local guidelines for when consultant obstetricians' attendance is mandatory within the unit.	Compliant
	3.5	There must be clear local guidelines detailing when the consultant obstetrician and the midwifery manager on-call should be informed of activity within the unit.	Compliant
4. Clinical Governance: Leadership: Trust boards must have oversight of the quality and performance of their maternity services. In all maternity services the Director of Midwifery and Clinical Director for obstetrics must be jointly operationally responsible and accountable for the maternity governance systems.	4.1	Members of the Trust Board must work together with maternity departments to develop regular progress and exception reports, assurance reviews and regularly review the progress of any maternity improvement and transformation plans.	Compliant
	4.2	All maternity service senior leadership teams must use appreciative inquiry to complete the National Maternity Self-Assessment Tool if not previously done. A comprehensive report of their self-assessment including governance structures and any remedial plans must be shared with their trust board.	Partial compliance
	4.3	Every trust must ensure they have a patient safety specialist, specifically dedicated to maternity services.	Compliant
	4.4	All clinicians with responsibility for maternity governance must be given sufficient time in their job plans to be able to engage effectively with their management responsibilities.	Partial compliance
	4.5	All trusts must ensure that those individuals leading maternity governance teams are trained in human factors, causal analysis, and family engagement.	Partial compliance
	4.6	All maternity services must ensure there are midwifery and obstetric co-leads for developing guidelines. The midwife co-lead must be of a senior level, such as a consultant midwife, who can drive the guideline agenda and have links with audit and research.	Compliant
	4.7	All maternity services must ensure they have midwifery and obstetric co-leads for audits.	Compliant
5. Clinical Governance – Incident investigation and complaints	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.	Compliant
	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

Incident investigations must be meaningful for families and staff and lessons must be learned and implemented in practice in a timely manner.	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	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

Staff should attend regular mandatory training. Rotas & Job planning need to ensure all staff can attend. Clinicians must not work on labour ward without appropriate regular CTG training and emergency skills training	7.3	All trusts must mandate annual human factor training for all staff working in a maternity setting; this should include the principles of psychological safety and upholding civility in the workplace, ensuring staff are enabled to escalate clinical concerns. The content of human factor training must be agreed with the LMS.	Compliant
	7.4	There must be regular multidisciplinary skills drills and on-site training for the management of common obstetric emergencies including haemorrhage, hypertension and cardiac arrest and the deteriorating patient.	Compliant
	7.5	There must be mechanisms in place to support the emotional and psychological needs of staff, at both an individual and team level, recognising that well supported staff teams are better able to consistently deliver kind and compassionate care.	Compliant
	7.6	Systems must be in place in all trusts to ensure that all staff are trained and up to date in CTG and emergency skills.	Compliant
	7.7	Clinicians must not work on labour wards or provide intrapartum care in any location without appropriate regular CTG training and emergency skills training. This must be mandatory.	Compliant
8. Complex Antenatal Care: Local Maternity Systems, Maternal Medicine Networks and trusts must ensure that women have access to preconception care. Trusts must provide services for women with multiple pregnancy in line with national guidance Trusts must follow national guidance for managing women with diabetes and hypertension in pregnancy	8.1	Women with pre-existing medical disorders, including cardiac disease, epilepsy, diabetes, and chronic hypertension, must have access to preconception care with a specialist familiar in managing that disorder and who understands the impact that pregnancy may have.	Compliant
	8.2	Trusts must have in place specialist antenatal clinics dedicated to accommodate women with multifetal pregnancies. They must have a dedicated consultant and have dedicated specialist midwifery staffing. These recommendations are supported by the NICE Guideline Twin and Triplet Pregnancies 2019.	Compliant
	8.3	NICE Diabetes and Pregnancy Guidance 2020 should be followed when managing all pregnant women with pre-existing diabetes and gestational diabetes.	Partial Compliance
	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	Compliant

		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).	
9. Preterm Birth: The LMNS, commissioners and trusts must work collaboratively to ensure systems are in place for the management of women at high risk of preterm birth. Trusts must implement NHS Saving Babies Lives Version 2 (2019)	9.1	Senior clinicians must be involved in counselling women at high risk of very preterm birth, especially when pregnancies are at the thresholds of viability.	Compliant
	9.2	Women and their partners must receive expert advice about the most appropriate fetal monitoring that should be undertaken dependent on the gestation of their pregnancies and what mode of delivery should be considered.	Compliant
	9.3	Discussions must involve the local and tertiary neonatal teams so parents understand the chances of neonatal survival and are aware of the risks of possible associated disability.	Compliant
	9.4	There must be a continuous audit process to review all in utero transfers and cases where a decision is made not to transfer to a Level 3 neonatal unit and when delivery subsequently occurs in the local unit.	Compliant
10. Labour and Birth: Women who choose birth outside a hospital setting must receive accurate advice with regards to transfer times to an obstetric unit should this be necessary. Centralised CTG monitoring systems should be mandatory in obstetric units	10.1	All women must undergo a full clinical assessment when presenting in early or established labour. This must include a review of any risk factors and consideration of whether any complicating factors have arisen which might change recommendations about place of birth. These must be shared with women to enable an informed decision re place of birth to be made	Compliant
	10.2	Midwifery-led units must complete yearly operational risk assessments.	Partial compliance
	10.3	Midwifery-led units must undertake regular multidisciplinary team skill drills to correspond with the training needs analysis plan.	Partial compliance
	10.4	It is mandatory that all women who choose birth outside a hospital setting are provided accurate and up to date written information about the transfer times to the consultant obstetric unit. Maternity services must prepare this information working together and in agreement with the local ambulance trust.	Partial compliance
	10.5	Maternity units must have pathways for induction of labour, (IOL). Trusts need a mechanism to clearly describe safe pathways for IOL if delays occur due to high activity or short staffing.	Compliant

	10.6	Centralised CTG monitoring systems must be made mandatory in obstetric units across England to ensure regular multi-professional review of CTGs.	Compliant
11. Obstetric Anaesthesia: A pathway for outpatient postnatal anaesthetic follow-up must be available in every trust to address 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.	11.1	Conditions that merit further follow-up include, but are not limited to, postdural puncture headache, accidental awareness during general anaesthesia, intraoperative pain, and the need for conversion to general anaesthesia during obstetric interventions, neurological injury relating to anaesthetic interventions, and significant failure of labour analgesia.	Compliant
	11.2	Anaesthetists must be proactive in recognising situations where an explanation of events and an opportunity for questions may improve a woman's overall experience and reduce the risk of long-term psychological consequences.	Compliant
	11.3	All anaesthetic departments must review the adequacy of their documentation in maternity patient records and take steps to improve this where necessary as recommended in Good Medical Practice by the GMC	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	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

all unwell postnatal women have timely consultant review. Postnatal wards must be adequately staffed at all times	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	Sep 23	Sep 23
Total Number of Recommendations (interim and final report combined)	97	100%	98 *	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	12	n/a
Compliant	46	54.1%	56	65.1%	61	71.0%	65	75.6%	66	76.7%	68	79.0%
Partial Compliance	36	41.4%	27	31.4%	23	26.7%	19	22.1%	18	20.9%	17	19.7%
Non-compliance	3	3.5%	3	3.5%	2	2.3%	2	2.3%	2	2.3%	1	1.1%

*additional IEA added following Insight Visit Feedback

APPENDIX 3

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
	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	Q9	Independent Senior Advocate Role to report to Trust and LMNS.	n/a Awaiting appointment

Women and Families	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
	Q25	Women with complex pregnancies (whether MMC or not) must have a named consultant lead.	Partial Compliance

	Q26	Early specialist involvement and management plans must be agreed where a complex pregnancy is identified.	Compliant
	Q27	Demonstrate compliance with all five elements of the Saving Babies' Lives care bundle (SBLCBv.2)	Compliant
	Q28	Continuation of Q25: mechanisms to regularly audit compliance.	Partial Compliance
	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.	Compliant
	Q31	Risk assessment must include ongoing review of the intended place of birth.	Partial Compliance
	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.	Partial Compliance
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
	Q40	Accurate evidence-based information for maternity care is easily accessible, provided to all women and MVP quality reviewed.	Compliant
	Q41	Enable equal participation in all decision-making processes and Trust has method of recording this.	Partial Compliance
	Q42	Women's choices following a shared & informed decision-making process must be respected and evidence of this recorded.	Partial Compliance
	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.	Partial Compliance

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

The Newcastle upon Tyne Hospitals NHS Foundation Trust

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 other professions.	✓	Partially compliant: Progressing		
	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. 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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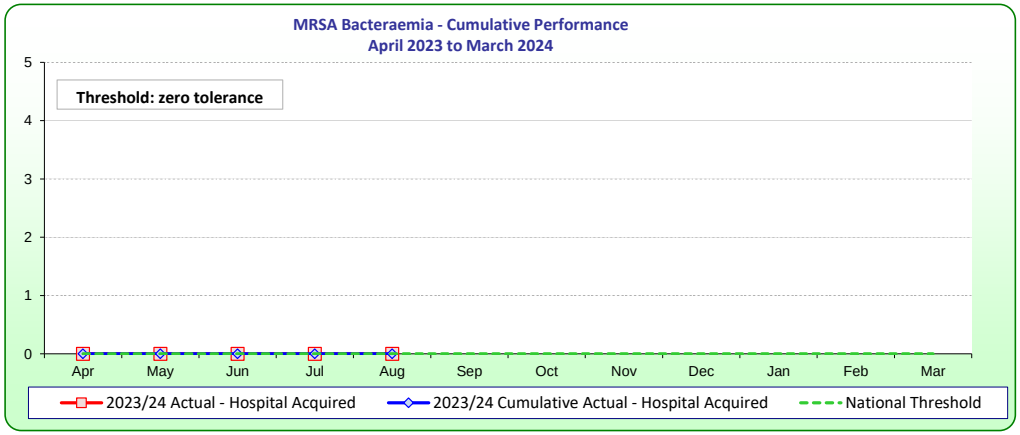
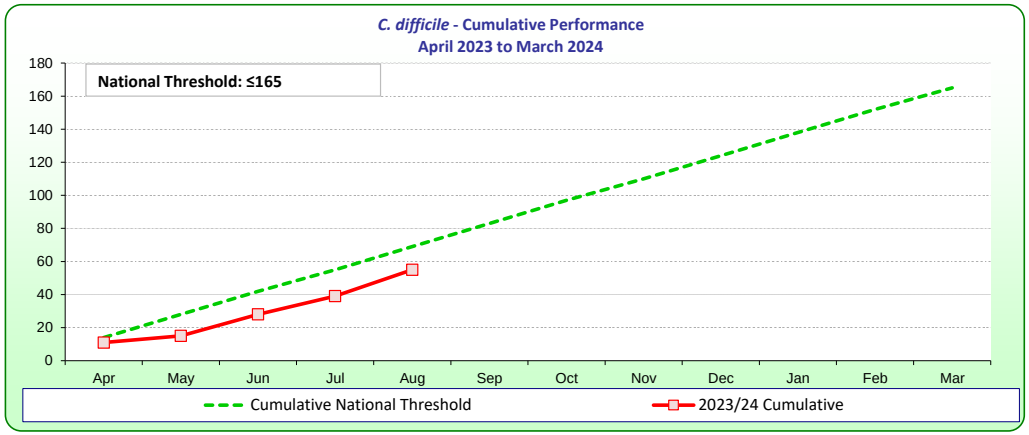
The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Healthcare-Associated Infections Report
August 2023


MRSA Bacteraemia - Cumulative Performance
April 2023 to March 2024
Threshold: zero tolerance
0
1
2
3
4
5
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
2023/24 Actual - Hospital Acquired
2023/24 Cumulative Actual - Hospital Acquired
National Threshold


C. difficile - Cumulative Performance
April 2023 to March 2024
National Threshold: ≤165
0
20
40
60
80
100
120
140
160
180
Apr
May
Jun
Jul
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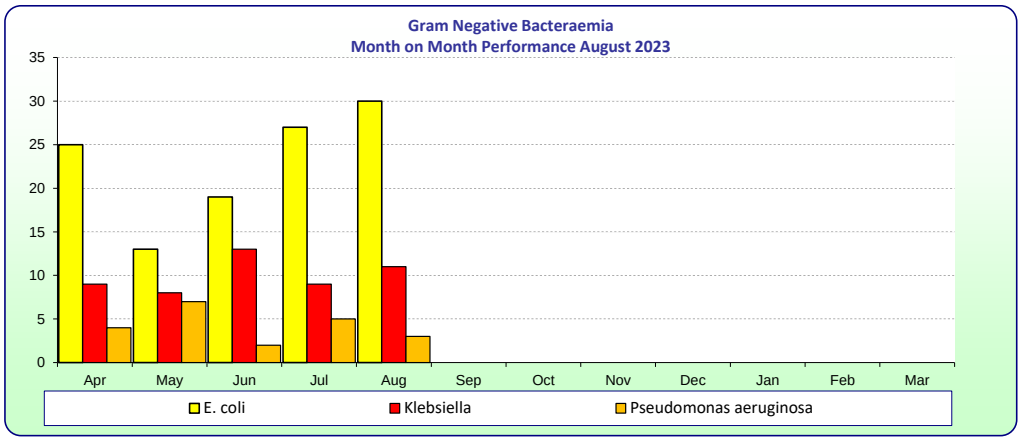
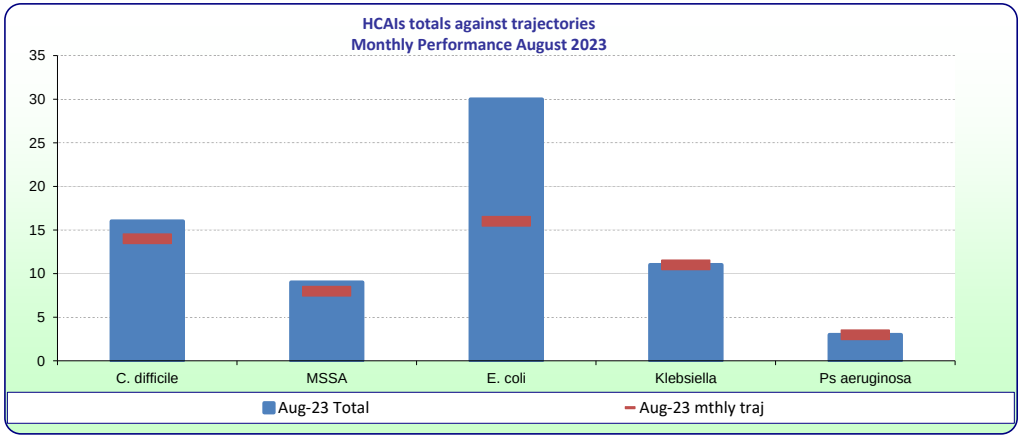
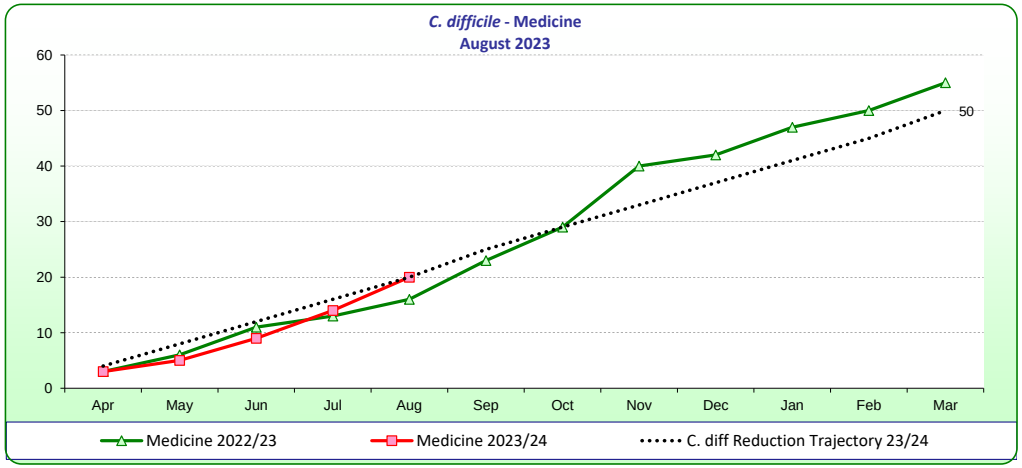
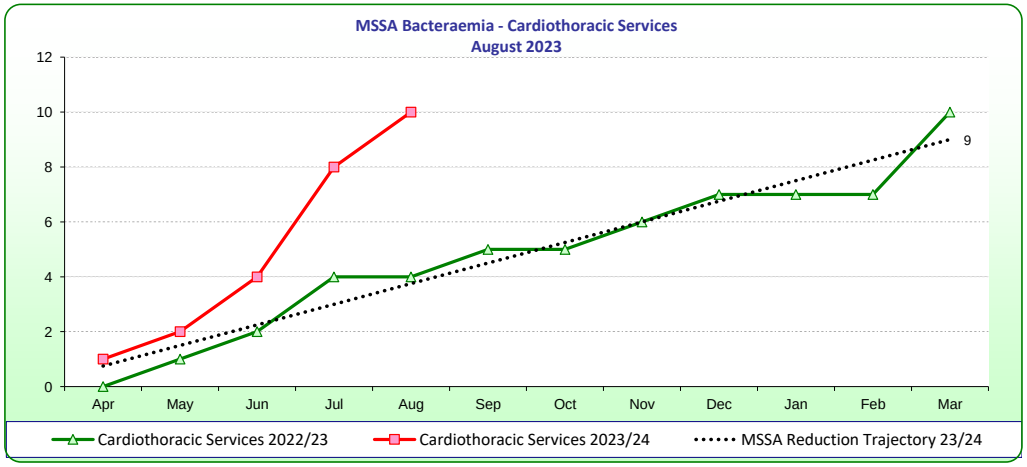
Feb
Mar
Cumulative National Threshold
2023/24 Cumulative


Gram Negative Bacteraemia
Month on Month Performance August 2023
0
5
10
15
20
25
30
35
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
E. coli
Klebsiella
Pseudomonas aeruginosa

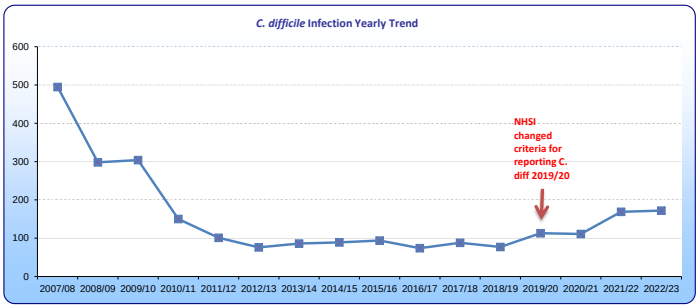

HCAIs totals against trajectories
Monthly Performance August 2023
0
5
10
15
20
25
30
35
C. difficile
MSSA
E. coli
Klebsiella
Ps aeruginosa
Aug-23 Total
Aug-23 mthly traj

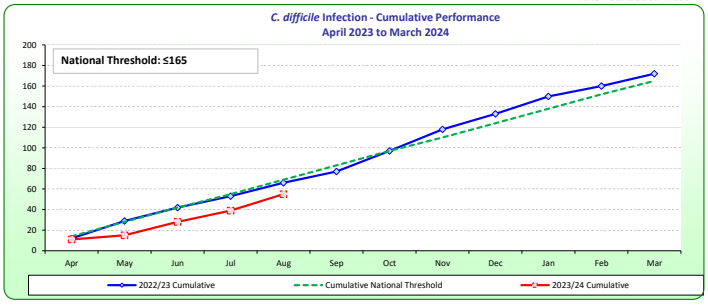

C. difficile - Medicine
August 2023
0
10
20
30
40
50
60
50
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Medicine 2022/23
Medicine 2023/24
C. diff Reduction Trajectory 23/24

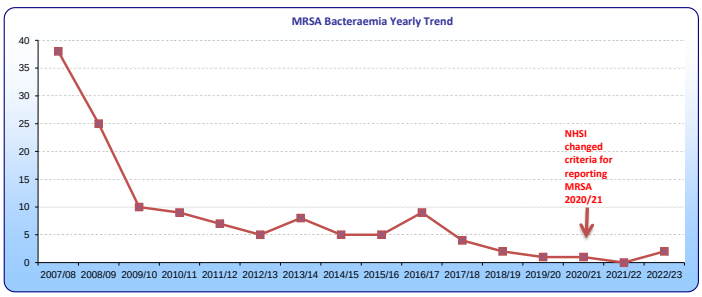

MSSA Bacteraemia - Cardiothoracic Services
August 2023
0
2
4
6
8
10
12
9
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Cardiothoracic Services 2022/23
Cardiothoracic Services 2023/24
MSSA Reduction Trajectory 23/24

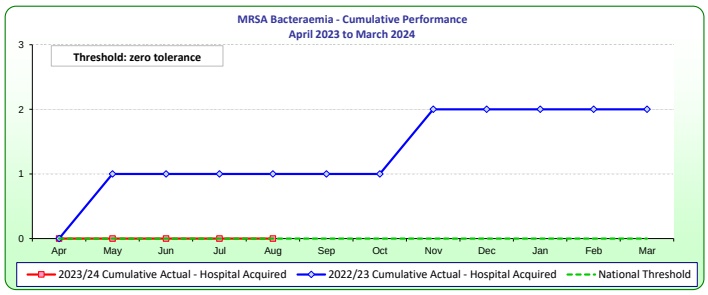
Healthcare-Associated Infection Report August 2023

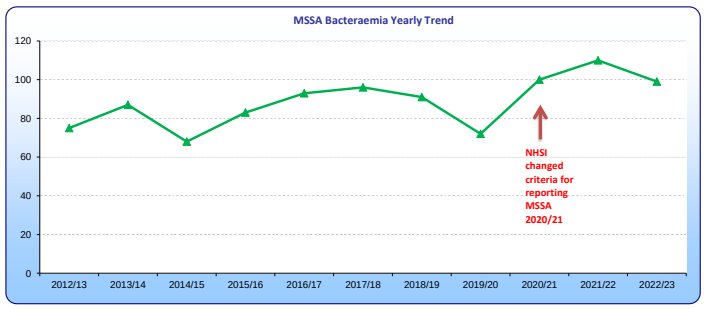
The Newcastle upon Tyne Hospitals NHS Foundation Trust

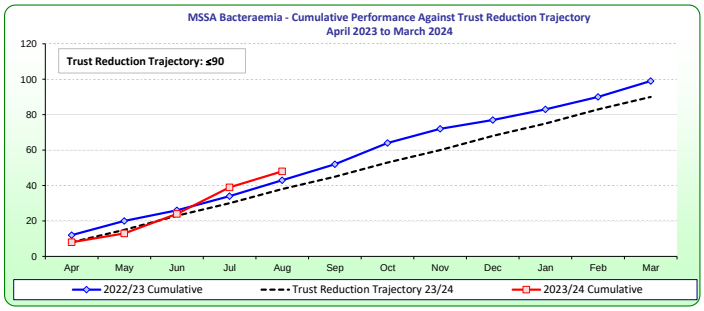


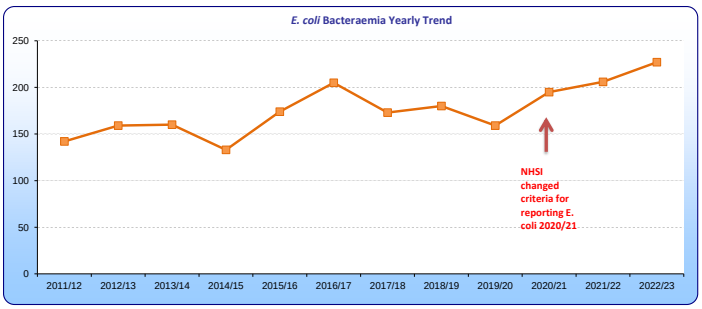


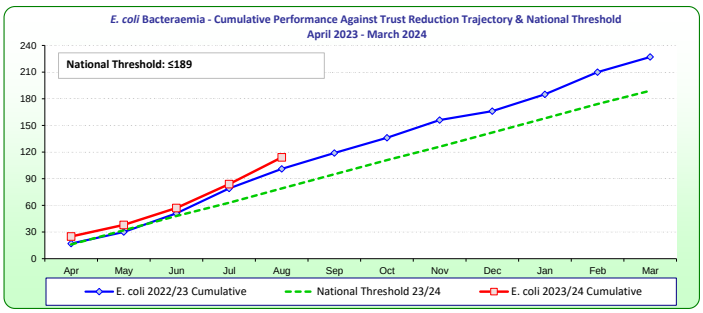


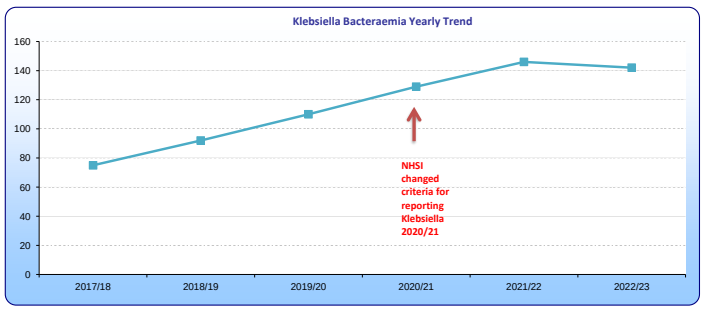


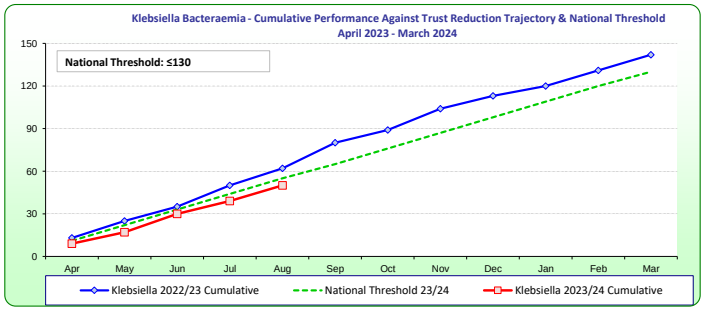


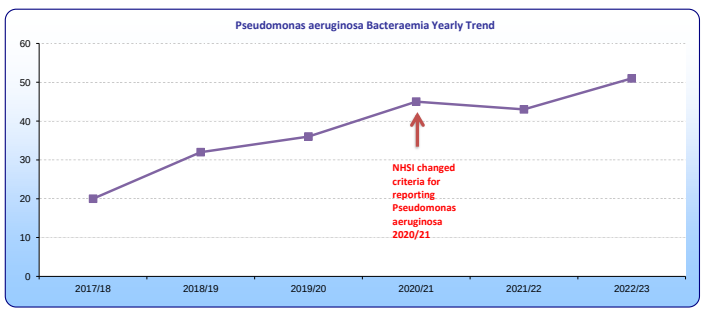


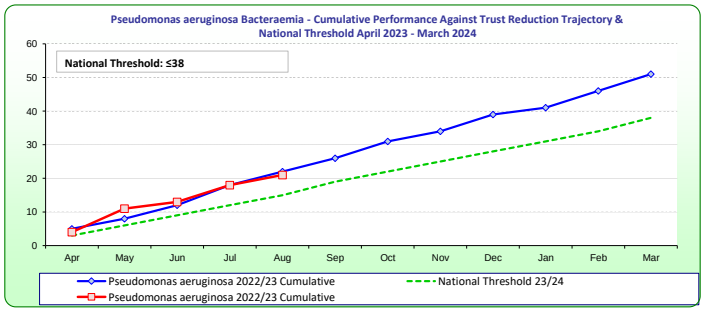












The Newcastle upon Tyne Hospitals NHS Foundation Trust

Bacteraemia / Infections

IPC indicators (reported to DH)	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Cumulative
MRSA Bacteraemia - non-Trust	0	0	2	0	1								3
MRSA Bacteraemia - Trust-assigned (objective 0)	0	0	0	0	0								0
MSSA Bacteraemia - Healthcare Associated (local objective ≤90)	8	5	11	15	9								48
E. coli Bacteraemia - Healthcare Associated (National Threshold ≤189)	25	13	19	27	30								114
Klebsiella Bacteraemia - Healthcare Associated (National Threshold ≤130)	9	8	13	9	11								50
Pseudomonas aeruginosa Bacteraemia - Healthcare Associated National Threshold ≤38)	4	7	2	5	3								21
C. diff - Hospital Acquired (national threshold ≤165)	11	4	13	11	16								55
C. diff related death certificates	2	0	1	0	0								3
Part 1	2	0	1	0	0								3
Part 2	0	0	0	0	0								0

Periods of Increased Incidence (PIIs)	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Cumulative
C. diff - Hospital Acquired	0	2	2	2	1								7
Patients affected	1	2	6	2	2								13
COVID-19 - Hospital Acquired	1	1	1	0	5								8
Patients affected	2	3	2	0	11								18

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 associated (8-14 days post admission)	23	8	6	1	30								68
Hospital onset Definite HC associated (≥15 days post admission)	39	20	7	0	32								98

Outbreaks	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Cumulative
Norovirus Outbreaks	2	1	0	0	0								3
Patients affected (total)	18	8	0	0	0								26
Staff affected (total)	4	7	0	0	0								11
Bed days lost (total)	126	3	0	0	0								129
Other Outbreaks	0	0	1	0	0								1
Patients affected (total)	0	0	18	0	0								18
Staff affected (total)	0	0	6	0	0								6
Bed days lost (total)	0	0	51	0	0								51
COVID Outbreaks	8	2	1	0	8								19
Patients affected (total)	38	18	4	0	63								123
Staff affected (total)	0	4	0	0	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	12:09	12:41								
Laboratory Turnaround Time	03:23	03:08	02:55	01:53	02:10								
Total to Result Availability	17:10	17:03	14:48	14:02	14:51								

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

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%	94%	97%								96%
Standard IPC Precautions (incl HH, ANTT, PPE) Community only Total	100%	100%	100%	100%	100%								100%
Invasive Device Care Audit Community only Total	78%	100%	100%	100%	100%								96%
Matron Checks (OP/Community/Dental) Community only Total	100%	100%	100%	100%	89%								98%

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%	95%								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%	67%	NYA								66%

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.

August 2023 re ANTT in the Learning Lab - TEL team have advised there have been some updates to the way ANTT is assigned. It has now been assigned as a 3 year renewal to anyone who also has Adult Resus Level 2 assigned to them. The Power BI dashboard has now been updated to include this 3 year renewal ANTT certification, which replaces the old one, but currently only 36 staff are compliant, making the compliance rate less than 1% therefore August's total is not recorded here

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	26 September 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 July 2023: • Charity Committee – 10 August 2023; • People Committee – 22 August 2023; • Quality Committee – 19 September 2023; and • Finance Committee – 25 September 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 July 2023.

UPDATE FROM COMMITTEE CHAIRS

1. CHARITY COMMITTEE

A meeting of the Charity Committee took place on 10 August 2023. During the meeting, the main areas of discussion included:

- The Charity finance reports were received and discussed.
- The Committee discussed the summary of investments to 30 June 2023 including the quarterly summary investment reports from:
  - Newton's; and
  - CLLA.
- The draft Charity Annual Accounts were provided.
- The Charity Director provided a general charity update including the draft festive funding programme and the draft interim position of funding salaries.
- The Arts Programme proposal was received and discussed.
- The following grants were approved which totalled £267,757.47:
  - Clinical Haematology, Funding of Haematology Fellow - £121,802;
  - Trust Wide, Safe fatigue risk management - power naps for staff - £76,620;
  - Dental, Orthodontics and Child Dental Health Waiting Room Refurbishment - £40,573.47; and
  - Patient Services, Continuation of Long Covid Service - £28,762.
- The Committee received the dashboard of operational Key Performance Indicators (KPI's), the Charity Risk Statement and the Committee Annual Review including the Terms of Reference and Schedule of Business.

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

2. PEOPLE COMMITTEE

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

- People matters arising from the Care Quality Commission (CQC) inspection were discussed.
- An industrial action update was provided.
- The Head of Corporate Risk and Assurance presented the People Committee Risk Report.
- The Associate Director of Sustainability and Environment presented the Sustainability Annual Report.
- An Education and Training update including appraisal compliance was received and discussed.
- The Chief People Officer provided an update on the People Priorities Delivery including the national workforce plan and staff engagement.
- An Employee Relations update was provided.
- A comprehensive update in relation to Health and Wellbeing was received.
- The Gender Pay Report was received and discussed.

- The Head of Human Resources presented the Equality and Diversity update.
- The People and Culture Dashboard was provided.
- The proposed People Committee dates for 2024 were received.

The next formal meeting of the Committee will take place on 17 October 2023.

3. QUALITY COMMITTEE

A meeting of the Quality Committee took place on 19 September 2023. During the meeting, the main areas of discussion included:

- The Quality Committee Risk Report was received.
- The Committee considered the following management group reports:
  - Patient Safety Group Annual Report;
  - Clinical Outcomes and Effectiveness regular report;
  - Patient Experience Group regular report; and
  - Compliance and Assurance Group regular report.
- The Director of Infection, Prevention and Control, the Deputy Director of Quality and Safety and the Chief Operating Officer presented the quality and performance elements of the Integrated Board Report.
- An update was provided in relation to the Trust's response to the recent CQC inspections.
- The Committee received and discussed three quarter one reports:
  - Safeguarding and Mental Capacity Act;
  - Learning Disability; and
  - Mortality/Learning from Deaths.
- A Maternity update was received and discussed including an Ockenden update report and a CNST Quarterly report.
- The Health and Safety Annual Report was provided.
- An update was provided in relation to Clinical Research.
- The Committee received a legal update and an update on leadership walkabouts / spotlight on service.
- An update with regards to outpatient appointments was received.
- The proposed Quality Committee dates for 2024 were received.

The next meeting of the Committee will take place on 21 November 2023.

4. FINANCE COMMITTEE

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

- The Head of Corporate Risk and Assurance presented the Finance Committee Risk Report.
- The Chief Finance Officer provided an update on the month 5 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 including a Deep Dive into Cancer Performance.
- The Executive Director of Business, Development and Enterprise presented a proposal for managing share holdings and provided an update on the Community Diagnostic Centre.
- Tenders and Business Cases were presented for approval.

The next meeting of the Committee will take place on 29 November 2023.

5. RECOMMENDATIONS

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

Report of Lauren Thompson
Corporate Governance Manager / Deputy Trust Secretary
15 September 2023

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	26 September 2023						
Title	Committee Annual Review, including 2023/24 Schedule of Business and updated Terms of Reference						
Report of	Teri Bayliss, Charity Director Caroline Docking, Assistant Chief Executive						
Prepared by	Amanda Waterfall, Charity Operations Manager						
Status of Report	Public	Private	Internal				
	☒	☐	☐				
Purpose of Report	For Decision	For Assurance	For Information				
	☒	☐	☐				
Summary	The purpose of this report is to provide assurance to the Trust Board that Charity Committee met their key responsibilities for 2022/23, in line with their Terms of Reference. The Committee Annual Review outline overall achievements throughout the year and action points for continuing development during the coming year. The Annual Review has been considered at the relevant Committee meetings. The Committee Terms of Reference (ToR) and 2023/24 Schedules of Business have been discussed at each respective Committee meetings. Changes have been made to the ToRs to update role titles and to reflect in guidance and regulations.						
Recommendation	The Trust Board is asked to: i) Approve the Committee Annual Review, outlining 2022/23 work undertaken and note the key areas to revisit during 2023/24; and ii) Approve the updated Terms of Reference and 2023/24 Schedule of Business.						
Links to Strategic Objectives	Performance – Being outstanding, now and in the future.						
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☐	☒	☒	☐	☐	☒	☐
Link to Board Assurance Framework [BAF]	Risk 4050 - CQC 'Well Led' – potential impact on 'outstanding' rating for NHS Trusts.						
Reports previously considered by	Annual review.						

ANNUAL REVIEW OF THE NEWCASTLE HOSPITALS CHARITY COMMITTEE 2022/23

EXECUTIVE SUMMARY

The report includes:

- A summary of the committee's purpose and responsibilities;
- The committee membership and meeting attendance during 2022/23;
- An overview of the work of the Charity Governance Working Group;
- The key achievements in 2022/23;
- The grants approved in 2022/23, with those exceeding £100,000 outlined;
- Financial management and controls reporting arrangements;
- Governance, internal controls and risk management;
- Progress areas for 2023/24; and
- The priority actions for the coming year.

The Committee is asked to approve this report outlining 2022/23 work undertaken and note the key areas and priority actions to revisit during 2023/24.

ANNUAL REVIEW OF THE NEWCASTLE HOSPITALS CHARITY COMMITTEE 2022/23

1. PURPOSE

The purpose of this report is to provide assurance to the Trust's Board of Directors (BoD) that the Charity Committee has met its key responsibilities for 2022/23, in line with its terms of reference.

The following sections outline overall achievements throughout the year. The report also outlines action points for continuing development during the coming year.

2. COMMITTEE RESPONSIBILITIES

The Charity Committee is a statutory committee established by the BoD to manage, on behalf of the BoD, all charitable funds of which the Trust is Corporate Trustee, and to ensure that the management of the charity is compliant with the regulations set out by the Charity Commission (CC) for England and Wales and the Fundraising Regulator.

The key purpose of the Charity Committee is to:

- Ensure that there is a robust process in place to consider the application of the Charity's funds in accordance with their respective governing documents and ensure that funds are used in accordance with the charity's objectives – all with the budget, priorities and spending criteria determined by the Trust Board as trustees and consistent with the Charities Act 2022 and the Charities (Protection and Social Investment) Act 2016 (the 'PSI Act 2016');
- Provide oversight to ensure that the Charity's funds are managed in accordance with statutory requirements of the Charity Commission, the Fundraising Regulator, the Department of Health & Social Care guidance and that the Trust's Standing Orders, Reservation of Powers to the Board and Delegation of Powers, the Scheme of Delegation and Standing Financial Instructions are appropriate in this context; and
- Make decisions, on behalf of the Corporate Trustee, involving the sound investment of charity funds in a way that both preserves their capital value and produces a proper return consistent with prudent investment and ensures compliance with the Trustees Act 2000, the Charities Act 2022, the PSI Act 2016 and CC regulations.

The committee fulfils this responsibility through the receipt of assurances from management, investment managers, and other sources.

3. COMMITTEE MEMBERSHIP AND MEETINGS

The Committee is appointed by the Board and consists of five members of the BoD with a quorum being three members, with at least one Executive Director (ED) and one Non-Executive Director (NED) in attendance.

Four ordinary meetings were held between 1 April 2022 and 31 March 2023. Attendance was as follows:

	Attendance at ordinary meetings
Jill Baker, NED and Committee Chair	4 of 4
Jonathan Jowett, NED*	0 of 1
Graeme Chapman, NED	4 of 4
Andy Welch, Medical Director and Deputy Chief Executive	2 of 4
Angela Dragone, Finance Director**	1 of 1
Caroline Docking, Assistant Chief Executive	4 of 4
Bill Macleod, NED***	3 of 3
Jackie Bilcliff, Chief Finance Officer****	2 of 2

* Jonathan Jowett left the committee in May 2022
** Angela Dragone left the Trust in July 2022
*** Bill Macleod joined the committee in September 2022
**** Jackie Bilcliffe joined the Trust in September 2022

It was agreed in year 2022/23 that additional meetings were required to consider grant applications and therefore, a further four grant-only meetings were held between 1 April 2022 and 31 March 2023. Attendance was as follows:

	Attendance at grant only meetings
Jill Baker, NED and Committee Chair	4 of 4
Graeme Chapman, NED	4 of 4
Andy Welch, Medical Director and Deputy Chief Executive	3 of 4
Angela Dragone, Finance Director	0 of 1
Caroline Docking, Assistant Chief Executive	2 of 4
Bill Macleod, NED	3 of 4
Jackie Bilcliff, Chief Finance Officer	3 of 4

The Committee met the minimum number of four meetings per year and other attendees at the meetings included:

- The NHC Director;
- The Financial Accountant – NHC;
- The Deputy Finance Director;
- The Associate Director of Finance;
- The Arts Programme Manager – NHC;
- The Deputy Trust Secretary;

- The Operations Lead – NHC;
- The Data & Operations Manager – NHC;
- The Head of Corporate Risk and Assurance; and
- The Head of Grant Programmes – NHC.

The Charity Operations Manager acted as the Committee Secretary.

4. CHARITY GOVERNANCE WORKING GROUP

The Governance Working Group (CGWG) met over a twelve-month period and the final meeting took place in June 2022. The actions agreed by the CGWG are now the responsibility of the Charity Committee. The main findings included:

- The understanding of the Corporate Trustee of the work of the Charity is to continue to be strengthened;
- Work was required to improve NHC's financial operating model within the Trust;
- The decision was made not to pursue charity independence at this time. but to further solidify the Charity's position within the Trust;
- The grant making policy/approach has been considered and is under review by the Charity Committee;
- Investment Strategy review underway.

The committee was kept up to date with CGWG developments at each meeting until the activity of the CGWG concluded.

5. KEY ACHIEVEMENTS

During 2022/23, the following matters were considered by the committee:

- The Charity Director provided a comprehensive update at each of the meetings in relation to progress against the Charity Strategy; namely fundraising and retail, communications and engagement, charity operations and the arts programme. Further to this:
  - At the May 2022 meeting, the results of a charity operations benchmarking exercise were received and discussed.
  - At the September 2022 meeting, an update on the Charity's conflict of interest process was received.
- The Committee received the Charity Risk Statement in May 2022 and February 2023.
- The Committee received a Charity Dashboard, outlining progress against operational KPIs and communications, at the May 2022 meeting. An update was provided on progress at each subsequent meeting.
- The Committee received and considered the Charity Audit Strategy Memorandum.
- The final Charity Annual Report and Accounts were received in November 2022.
- The Committee continued to receive finance reports at each meeting and throughout the year, considered its approach to unrealised gains and received a summary of bank accounts, signatories, and delegated authorities.
- The Committee regularly received summary investment reports from Newton's and CCLA and in February 2023, a presentation was delivered from investment

management firms relating to the development of the charity's approach to its investment strategy more broadly.

- Grant applications were presented for the consideration of the Committee at each meeting. These are outlined in section 6. In addition, a report of recent grant making activity was presented at each meeting which included the festive funding programme, an overview of the grant making approach within NHC, as well as summaries of grants under £25,000 agreed between meetings.
- The first major seven figure personal philanthropic gift was received in January 2023 and aligned to a Trust priority.
- The Committee received the first annual grant-making Impact Report in 2022/23 for year 2021/22.
- The Committee considered an options appraisal for alternative financial systems in November 2022 and a review of the operational management of Charity finance in in February 2023. This referenced work undertaken to date, a review of current systems and staffing, and priority actions to take forward to improve financial operations.
- The Committee received a paper relating to the Charity's capacity to deliver the Charity Strategy to 2026 in November 2022 which identified the need to further grow fundraising, event and volunteering capacity. This was approved.
- The first Charity Forum with external charities took place in January 2023 and was very well received.
- An update on the success and potential of the arts programme was received in February 2023.
- Overall Charity income of £8,431,222.08 was received in 2022/23.

6. GRANT APPROVALS

During 2022/23, the Committee considered grant applications for approval. The following grants of over £100,000 were approved:

- Support staff for the Enhanced Recovery programme in Abdominal Transplantation - £107,019.00.
- Clinical Specialist Physiotherapist in Childrens Cancer - £190,842.
- Training Posts for the Sir Bobby Robson Cancer Trials Research Centre - £302,811.
- Establishing Effective Transition from Children's to Adult Services and Develop an 'Outreach' Service for Young People (YP) out with GNCH - £265,241.75.
- Socioeconomic inequalities in lung cancer treatment: unravelling the deprivation gap in the North East of England - £129,059.
- NCCC Complementary Therapies October 2022 - March 2026 - £353,158.
- Robotic Programme Expansion - £1,857.526.
- Radiotherapy treatment equipment - £600,000.
- Citizen's Advice Gateshead - A Helping Hand: Social Welfare Advice for Trust Staff, 3 years - £188,422.
- Citizen's Advice Gateshead - Direct Access to Social Welfare Advice for families at The Great North Children's Hospital - £188,422.

Applications that exceed £1m were required to be considered and agreed by the BoD in advance of committee approval.

7. FINANCIAL MANAGEMENT, CONTROL & REPORTING

At the request of the CGWG, a charity financial review has been undertaken to review the following objectives:

- The simplification of the current financial accounting processes.
- Management and resourcing of the Charity finance function.
- The development of financial reporting to the Charity Committee and the Charity's senior management team.
- Full cost recovery from NHC for the Trust.

A financial process action plan will be developed and presented to the May Committee Meeting.

A review of investment management had been agreed by the Charity Committee and was underway.

The committee continued to receive regular reports from the Trust's Investment Fund Managers, CCLA and Newton's, as well as the charity's own financial report.

8. GOVERNANCE, INTERNAL CONTROL AND RISK MANGEMENT

Three areas of strategic risk were outlined in the charity risk statement presented through the year. These were:

- Governing principles (relating to the Charity Commission);
- Financial Strategies; and
- Potential impact on fundraising as a result of the pandemic.

The risk appetite for each risk area was considered and agreed and would continue to be reviewed in light of developments. Additional controls in place were also outlined.

The committee had a schedule of business for 2022/23 and utilised a rolling programme and action log to track committee actions.

There were no matters arising during the course of the year that required reporting to the Charity Commission.

9. PROGRESS FOR 2023/24 & REVIEW OF EFFECTIVENESS

Key areas to be revisited during 2023/24 are:

- Performance against the key areas of focus in the charity strategy for 2023/24 continue to roll forward. This includes the need to ensure that the committee are kept abreast of any areas of potential risk to this and where strategic aims are unlikely to be achieved.
- A clear framework/grant programme to be developed, agreed and approved by the Committee.

- The ongoing role of research and its relationship to the committee, and the process by which it is managed, is currently being reviewed and will be agreed by the committee.
- The outputs from the financial management review are to be implemented.
- Continued progress with NHC recruitment and confirmation of co-location.
- Strengthen and develop the model of charity forums taking place throughout the year.
- A robust review of the terms of reference for the committee to continue, following the conclusion of the work undertaken by the CGWG. This will include a review of the committee membership, as well as executive lead arrangements.
- The development programme for committee members to continue for agreement by the Committee.

The Committee will be required to receive assurances regarding the activities outlined above.

10. RECOMMENDATION

The Committee is asked to approve this report outlining 2022/23 work undertaken and note the key areas and priority actions to revisit during 2023/24.

Teri Bayliss
Charity Director

Amanda Waterfall
Charity Operations Manager
5 July 2023

TERMS OF REFERENCE – CHARITY COMMITTEE

1. CONSTITUTION OF THE COMMITTEE

The Charity Committee is a statutory Committee established by the Board of Directors to manage, on behalf of the Board, all charitable funds of the trust charity, considering the requirements and regulations of the Department of Health and Social Care and the Charity Commission for England and Wales.

2. PURPOSE AND FUNCTION

2.1 The Committee does not diminish in any respect the overall responsibility of the Board of Directors in terms of trusteeship and accountability, and the Charity Committee is responsible for scrutiny and providing assurance to the Trust Board on key issues allocated to them by the Trust Board.

2.2 Agendas are set to enable the Trust Board in its capacity as Corporate Trustee of the charity to be assured that robust processes are in place to enable statutory duties to be discharged, to enable the Trust's strategic objectives to be met and to address and mitigate risk.

2.3 The purpose and function of the Committee is to:

2.3.1 ensure that there is a robust process in place to consider the application of the Trust's charitable funds in accordance with their respective governing documents and ensure that funds are used in accordance with the charity's objectives – all with the budget, priorities and spending criteria determined by the Trust Board as trustees and consistent with the Charities Act 2011 and the Charities (Protection and Social Investment) Act 2016 (the 'PSI Act 2016');

2.3.2 provide oversight to ensure that the Trust's charitable funds are managed in accordance with statutory requirements of the Charity Commission, Department of Health & Social Care guidance and the Trust's Standing Orders, Reservation of Powers to the Board and Delegation of Powers, the Scheme of Delegation and Standing Financial Instructions; and

2.3.3 make decisions, on behalf of the Corporate Trustee, involving the sound investment of charitable funds in line with the approved investment strategy and ensures compliance with the Trustees Act 2000, the Charities Act 2022, the PSI Act 2016 and Charity Commission regulations.

3. AUTHORITY

The Committee is:

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

3.2 authorised by the Board of Directors to investigate any activity within its Terms of Reference, to seek any information it requires from any officer of the Trust, and to invite any employee to provide information by request at a meeting of the Committee to support its work, as and when required; and

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

3.4 In line with the Trust's Standard Financial Instruction's, the Chief Finance Officer has prime responsibility for:

- treasury management and Trust banking services;
- cash management;
- investment strategy of the Trust (including Charity), and oversight of Charity investments;
- overall accountability for the Charity Annual Accounts;
- ensuring all receipts relating to the Charity are credited to the proper accounts.

3.5 The Assistant Chief Executive has prime responsibility for the Trust's Charitable Funds with the specific powers, duties and responsibilities delegated to the Assistant Chief Executive being:

- to adopt and ensure a professional approach to the administration of all charitable funds;
- preparation of the Charity Annual Report and Accounts;
- line management of the Charity Director.

3.6 The specific powers duties and responsibilities delegated to the Charity Director are:

- provision of policy, process and guidelines, and ensure the appropriate treatment of, donations, legacies and bequests, fundraising and trading income;
- provision of secure and appropriate receipting arrangements for donations, legacies and bequests;
- where necessary, obtain grant of probate, or make application for grant of letters of administration, where this organisation is the beneficiary;
- be empowered, on behalf of this organisation, to negotiate arrangements regarding the administration of a will with executors and to discharge them from their duty;
- lead and manage all arrangements for fund-raising; and
- preparation of reports to the Trust Board including the Charity Annual Report and Accounts.

4. MEMBERSHIP AND QUORUM

Membership

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

4.02 The Committee's membership will comprise:

- three Non-Executive Directors;
- the Assistant Chief Executive;
- the Medical Director/Deputy Chief Executive; and
- the Chief Finance Officer.

4.03 One of the Non-Executive members will be appointed by the Trust Board of Directors as the Chair of the Committee.

4.04 A further Non-Executive member of the Committee shall be appointed as Vice-Chair, likewise by the Trust Board of Directors.

4.05 The Assistant Chief Executive shall act as the Executive Lead for the Committee.

4.06 The Charity Director and the Financial Accountant (Charitable Funds) will attend the Committee. Other non-Committee members may be invited to attend and assist the Committee from time to time, according to particular items being considered and discussed.

4.07 The Chair of the Board of Directors will not be a member of the Committee but may be in attendance.

4.08 Other than as specified above, only members of the Committee have the right to attend Committee meetings. Alternate, or substitute, members may be agreed in advance with the Chair for a specific meeting but not for more than one.

4.09 In the absence of the Committee Chair, the Vice-Chair shall chair the meeting. Members are expected to attend all meetings and will be required to provide an explanation to the Chair of the Committee if they fail to attend more than two meetings in a financial year.

4.10 Members are able to attend Committee meetings in person, by telephone, or by other electronic means. Members in attendance by these means will count towards the quorum.

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

4.12 The Council of Governors may nominate up to two governors to attend one meeting of the Committee annually to observe proceedings. The observation of Board assurance committees by governors shall be subject to conditions agreed by the Board of Directors. The Chair of the Committee may, in exceptional circumstances, exclude governors from being present for specific items.

4.13 The Charity Operations Manager will act as the Committee Secretary or their designated deputy.

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

Quorum

4.15 The quorum necessary for the transaction of business will be three members, including at least one member of the Executive Team and one Non-Executive Director.

4.16 Members unable to attend a meeting of the Committee may nominate a deputy to attend on their behalf, agreed with the Chair of the Committee. Nominated deputies will not count towards the quorum.

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

5. DUTIES

5.1 Financial management and control

The Committee will:

5.1.1 ensure that a process is in place to review the arrangements for the registration of funds with the Charity Commission and ensure that all -funds comply with the objects of the charity and the existing registrations;

5.1.2 ensure that all funds within the Charity umbrella are properly managed through the implementation of sound financial controls in accordance with the Standing Financial Instructions and meet the requirements of H.M. Revenue & Customs;

5.1.3 ensure that funds are effectively managed and utilised in accordance with the objects of the charity and where stipulated, purposes for which they are given by the donors;

5.1.4 agree banking arrangements;

5.1.5 provide assurance that protocols are in place for the receipt of all income due to the Charity;

5.1.6 provide assurance that all expenditure and grants are properly authorised and reviewed through established procedures in accordance with delegated levels;

5.1.7 seek assurance that processes are in place for assets funded by the Charitable Funds to be recorded on the Trust asset log to ensure that the location of any assets purchased with Charity funds is known; and

5.1.8 ensure a process is in place to review the usage of funds in accordance with their objects, and subsequently rationalise funds within the powers granted by the Charity Commission where the original objects have failed or are no longer relevant.

5.2 Fundraising and investment

The Committee will:

5.2.1 agree a fundraising- strategy for the Charity;

5.2.2 oversee the strategy for liaising with benefactors/donors with regard to potential sources of income and how it is applied;

5.2.3 establish and regularly review an investment strategy including the appointment of specialist advisors; and

5.2.4 agree the basis for apportioning of dividends/interest from investments and administrative charges.

5.3 Financial reporting

The Committee will:

5.3.1 review quarterly financial statements including Statement of Financial Activities and Balance Sheet: analysis of income; Investment reports; target spend and reserves; and schedule of all grants made in accordance with the Scheme of Delegation;

5.3.2 request/review any report on an ad-hoc basis, which the Committee feel is necessary;

5.3.3 ensure that the Charity Annual Report & Accounts are produced in accordance with the latest accountancy practice and policy as laid down by the Charity Commission for England and Wales; and

5.3.4 review the Charity Annual Report and Accounts prior to submission to the Trust Board for approval and adoption and subsequent circulation to the Charity Commission and other agencies (as required).

5.4 Governance, risk management and internal control

The Committee will:

5.4.1 agree and approve Audit (Internal/External) services provided to the Charity;

5.4.2 liaise with the Charity Commission on all matters affecting the governance of charitable funds and takes advice from supporting agencies (e.g. Association of NHS Charities) and appropriate legal advice where necessary;

5.4.3 agree Terms of Reference for the Great North Children's Hospital and Sir Bobby Robson Foundation(s). To consider the minutes of aforesaid meetings and review / approve recommendations. Maintain general oversight of these groups.;

5.4.4 ensure that the Annual Return required by the Charity Commission in respect of all charitable funds held by the Charity is completed;

5.4.5 confirm agreement of the overall structure of the Charity team, as advised by the Assistant Chief Executive and Charity Director, and agree annual management and administrative charges levied by the Trust;

5.4.6 establish a Risk strategy for the Charity, covering all potential areas of risk and agree controls aimed at mitigating such risks. To review/agree on an annual basis;

6. REPORTING AND ACCOUNTABILITY

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

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

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

7. COMMITTEE ADMINISTRATION

7.1 The Committee will meet a minimum of four times a year and at such other times as the Chair of the Committee, in consultation with the Committee Secretary, will require allowing the Committee to discharge all of its responsibilities.

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

7.3 The agenda will be set in advance by the Chair and Charity Director, reflecting an integrated cycle of meetings and business, which is agreed each year for the Board and its Committees, to ensure it fulfils its duties and responsibilities in an open and transparent manner.

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

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

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

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

7.8 The Committee will, at least once a year, review its own performance, using a process agreed for all Board committees by the Board of Directors.

Procedural control statement: [X] June 2023
Date approved: [TBA] [Charity Committee] and [TBA] [Board]
Approved by: Charity Committee and Trust Board
Review date: [TBA]

Committee / Group:	**Charity Committee**
Chair:	**Jill Baker**
Annual Cycle Covered:	**2023/24**

	Lead	Authors / contacts of the report	May-23	Aug-23	Nov-23	Feb-24	Notes
Standing Business Items							
Apologies for absence	Jill Baker		✓	✓	✓	✓	
Declaration of interests	Jill Baker		✓	✓	✓	✓	
Minutes and matters arising	Jill Baker	Teri Bayliss/Amanda Waterfall	✓	✓	✓	✓	
Action log	Jill Baker	Teri Bayliss/Amanda Waterfall	✓	✓	✓	✓	
KPI and Communication Dashboard	Teri Bayliss	Chris Ham	✓	✓	✓	✓	
Committee minutes: - Great North Children's Foundation - Sir Bobby Robson Foundation - Charlie Bear	Jill Baker	Teri Bayliss/Amanda Waterfall	✓	✓	✓	✓	
Charity Strategy & Governance							
Charity Director's Update	Teri Bayliss	Teri Bayliss	✓	✓	✓	✓	
Charity Risk Report	Natalie Yeowart	Natalie Yeowart/Amanda Waterfall					Review annually as a minimum
Charity Risk Statement	Natalie Yeowart	Natalie Yeowart/Amanda Waterfall	✓	✓	✓	✓	
Committee Terms of Reference, Committee Review and Schedule of Business	Teri Bayliss	Amanda Waterfall	✓				Deferred from May Meeting as Terms of Reference not finalised.
Grant Applications & Recommendations from Grants Panel	Head of Grants	Head of Grants	✓	✓	✓	✓	
Summary of Grants agreed since last meeting	Head of Grants	Head of Grants	✓	✓	✓	✓	
Charity Commission Checklist	Teri Bayliss	Teri Bayliss/Amanda Waterfall	✓				
KPI and Communication Dashboard	Teri Bayliss	Chris Ham	✓	✓	✓	✓	

Policies and Procedures	Teri Bayliss	Teri Bayliss/Amanda Waterfall					As and when required
Impact Report	Teri Bayliss	Graham Stokoe			✓		
Finance							
Finance Report - to include SoFA, Target Spend Report, & Income Report	Jackie Bilcliff	Graham Bowers	✓	✓	✓	✓	
Summary of Investment Performance/Investment Reports	Jackie Bilcliff	Graham Bowers	✓	✓	✓	✓	
Annual Report and Accounts	Teri Bayliss	Graham Bowers/Graham Stokoe		✓(Draft)	✓(Final)		Prior to Board approval
Investment Management Review	Teri Bayliss/Jackie Bilcliff	Teri Bayliss/Jackie Bilcliff			✓		As and when required
Annual Investment Benchmarking			✓				
Review of Bank Accounts						✓	

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	26 September 2023						
Title	Integrated Board Report						
Report of	Angela O'Brien- Director of Quality and Effectiveness.						
Prepared by	Gavin Snelson- Quality Assurance Lead, 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 July 2023, there has been an increase in the total number of Trust onset MSSA Bacteraemias (n= 15) and the total number of Trust Onset E. coli Bacteraemias (n=27).
2. There has been a sustained reduction in July of inpatient acquired pressure ulcers (n=70) since April 2023.
3. There was a slight increase of 8 in falls across the Trust in July (n=224) following the lowest number of falls reported in June for an 18-month period.
4. There were 22 serious incidents in August 2023. The Duty of Candour process has been initiated for all cases.
5. There were two Never Events reported in August 2023.
6. In 2023-24 the Trust has opened a total of 193 formal complaints up to the end of August 2023 (167 with identified patient clinical activity).
7. The 2022-23 Health and Safety Annual Report highlighted a 28% increase in physical assaults from the previous year.
8. There were no moderate or serious incidents reported in Maternity in August 2023.
9. Staff turnover has decreased from 16% in June 2022 to 11.46% in August 2023, against a target of 8.5%.
10. As at month 5, the Trust is reporting an adverse variance of £10.9 million against the agreed financial plan.

The Board is asked to receive the report.

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Integrated Board Report

Quality, People and Finance

September 2023

Healthcare at its best
with people at our heart

Executive Summary

Purpose

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

Current Operating Environment

Operational pressures have picked up in August, mainly due to an increase in bed occupancy. Patients continue to be delayed in accessing assessment and packages of care, we are experiencing some long delays for patients needing to access mental health beds and the volume of patients admitted with incidental COVID is on the rise (approximately 50 patients mid-August). COVID is being managed as any other infection, but when at a higher volume, it does add to the logistical challenge in the use of beds; having to utilise cubicles and turnaround bed cleans. Even with this pressure directly impacting on the flow of patients out of the Emergency Department, performance overall remains above the revised national standard of 76%. There remains good management of ambulance handovers.

There are still ongoing periods of Industrial Action (IA) by Junior doctors and Consultants with action taking place throughout July and into August and these continue to adversely impact on the elective programme. There is a significant amount of planning required to ensure safety and to prioritise clinically urgent patients. In between IA dates teams are spending their time rescheduling patients who have had to be cancelled as a result. To date there has been an overall loss of activity (approximately 5.5%). It has been more challenging to retain elective activity during the summer due to annual leave and less staff around to provide cover. Teams are already planning for confirmed IA dates in September and October. The Theatre and ward refurbishment programmes are underway on both main sites. Teams are having to relocate, and theatre sessions be re-allocated, but the impact on activity has been limited to date.

Report Highlights

1. Throughout the month of July 2023, there has been an **increase in the total number of Trust onset MSSA Bacteraemias (n= 15) and the total number of Trust Onset E. coli Bacteraemias (n=27).**

2. There has been a **sustained reduction in July of inpatient acquired pressure ulcers (n=70) since April 2023.**

3. There was a **slight increase of 8 in falls across the Trust in July (n=224) following the lowest number of falls reported in June for an 18-month period.**

4. There were **22 serious incidents in August 2023.** The Duty of Candour process has been initiated for all cases.

5. There were **two Never Events reported in August 2023.**

6. In 2023-24 the Trust has opened a total of **193 formal complaints up to the end of August 2023 (167 with identified patient clinical activity).**

7. The **2022-23 Health and Safety Annual Report highlighted a 28% increase in physical assaults** from the previous year.

8. There were **no moderate or serious incidents reported in Maternity in August 2023.**

9. **Staff turnover has decreased from 16% in June 2022 to 11.46% in August 2023**, against a target of 8.5%.

10. As at month 5, the Trust is reporting an **adverse variance of £10.9 million against the agreed financial plan**.

Contents: September 2023

Quality

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

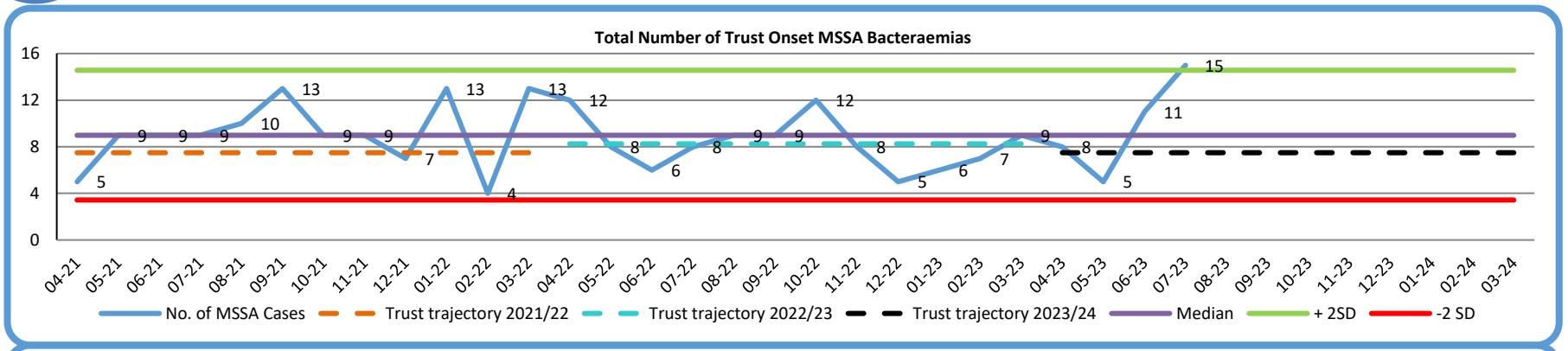
People

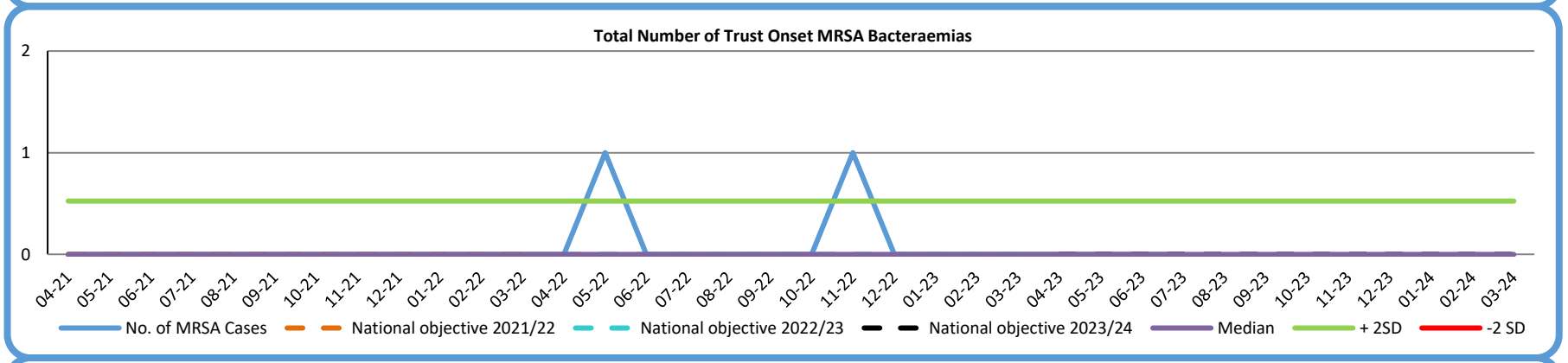
- Sickness Absence (including COVID-19)
- Equality and Diversity
- Sustainable Workforce Planning
- Excellence in Education & Training

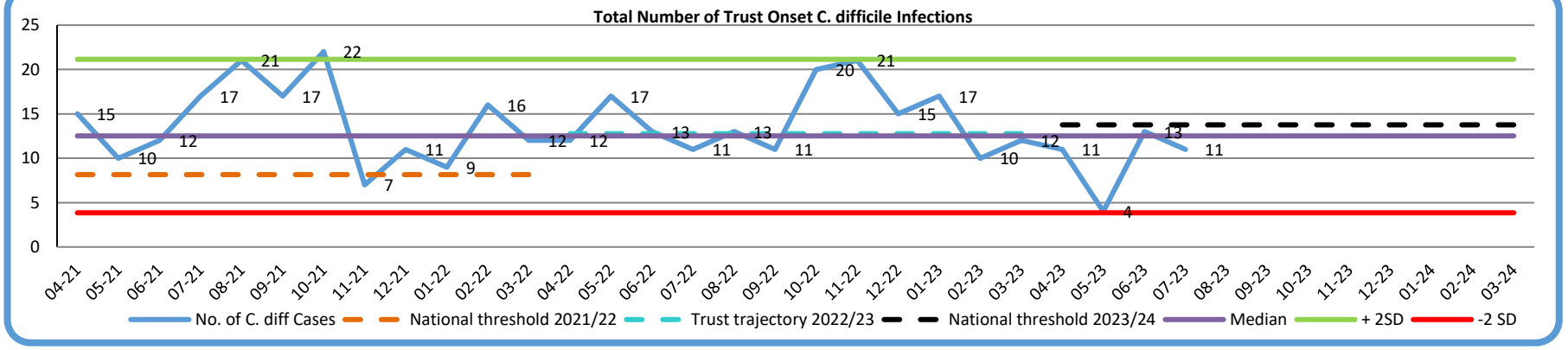
Finance

- Overall Financial Position

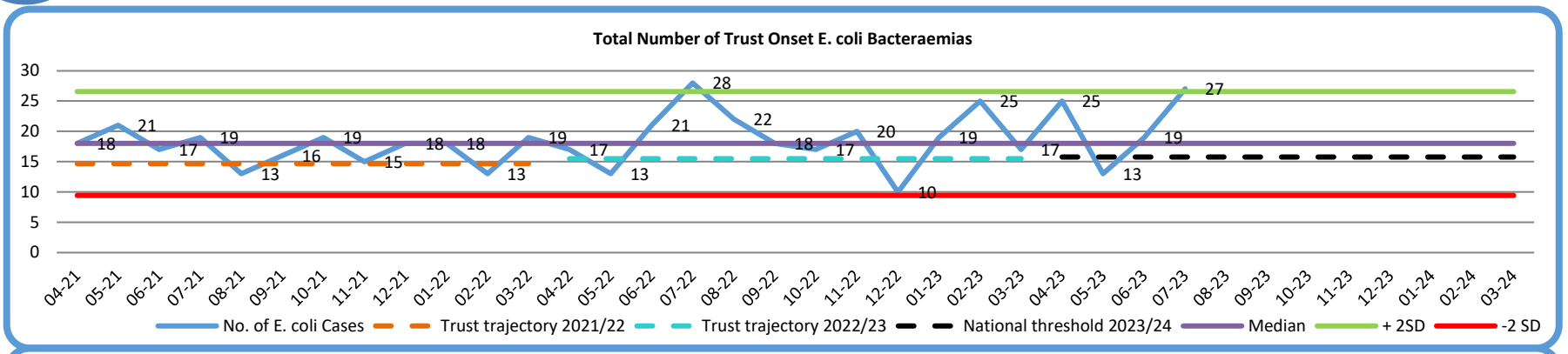
Quality: Healthcare Associated Infections 1/2

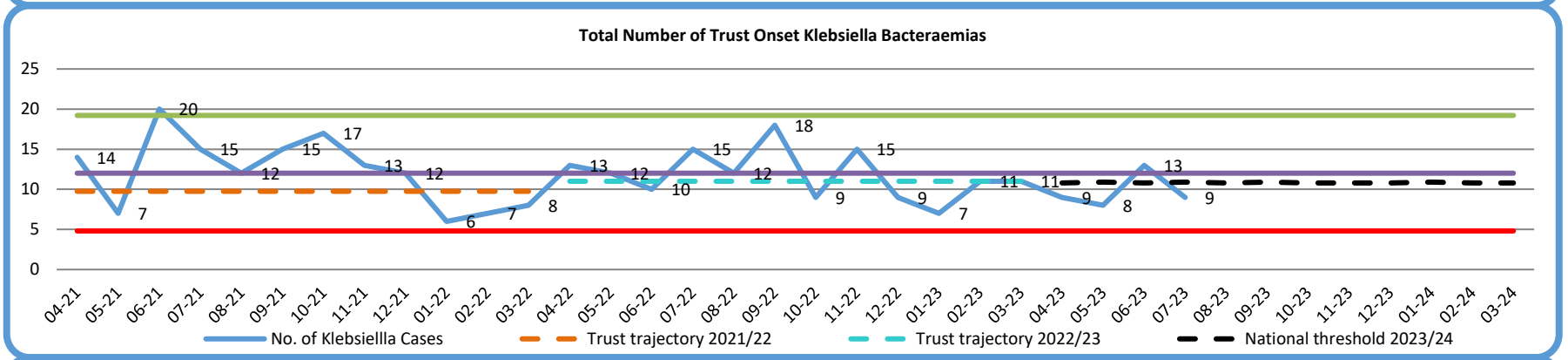


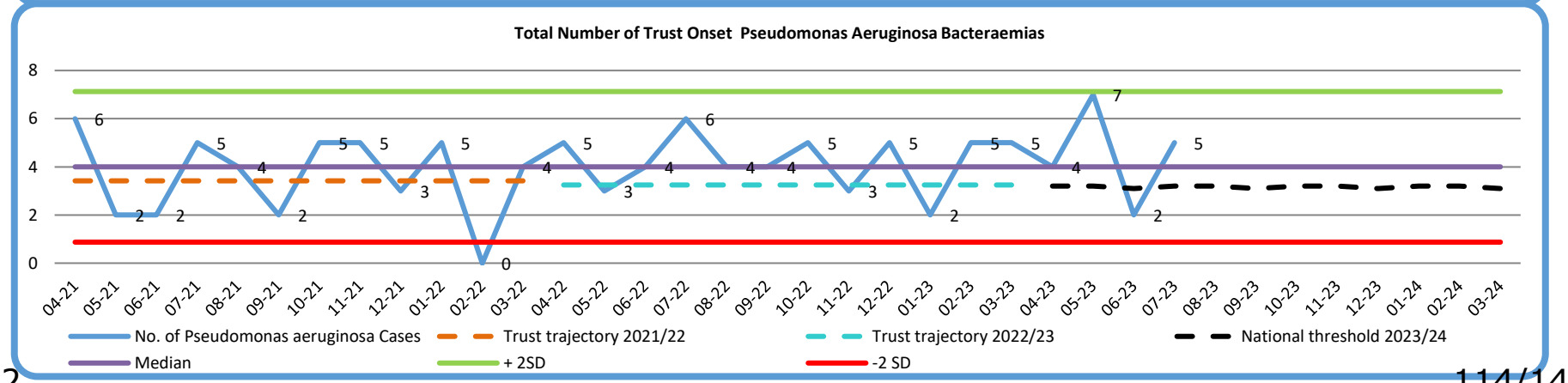




Quality: Healthcare Associated Infections 2/2







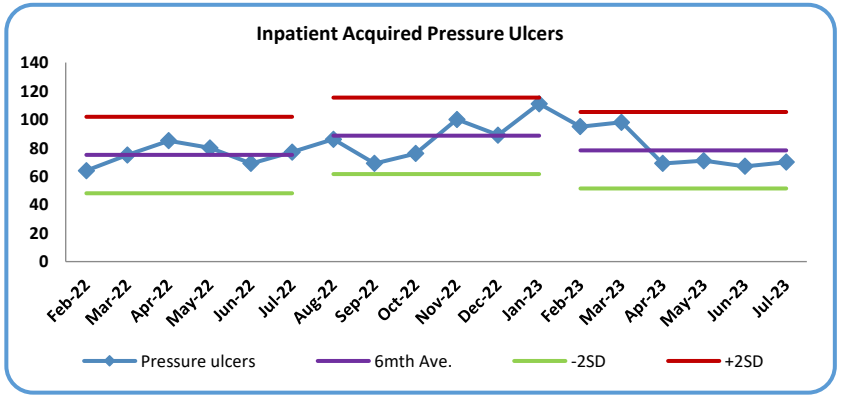
Quality: Harm Free Care – Pressure Damage

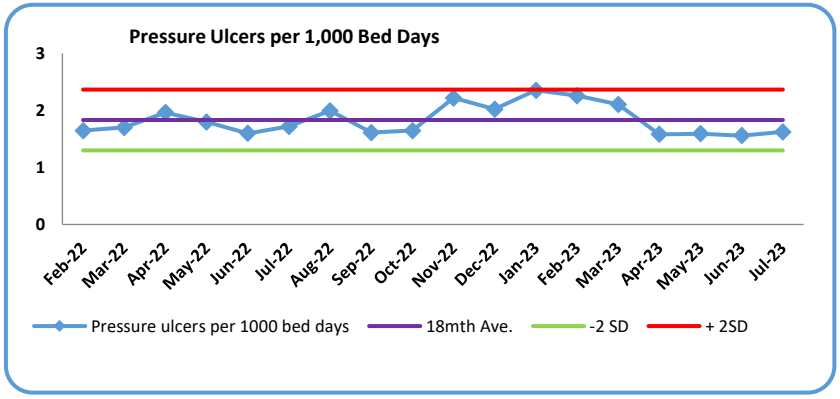
Analysis of data has demonstrated the following key points:

- There was a peak of inpatient acquired pressure ulcers in January 2023 at 111 cases. This was both in terms of total numbers and per 1,000 bed days. In comparison to the same period last year, there has been an increase in the average from 75 cases last year to 78 this year, with the 12-month data reflecting a 5% increase overall. However, since April there has been a sustained reduction, which continues to be monitored in the coming months.
- In July, 93% of acquired pressure ulcers reported were Category II damage, graded low/minor harm. The remaining 7% were graded as Category III damage, and therefore are identified as serious incidents, requiring a root cause analysis (RCA) which has been undertaken.
- No Category IV or above damage has been reported in the last year, with a comparison to 1 last year in June.
- There has been a 49% reduction in acquired pressure damage of Category III and above between April and July 2023 compared to the same time period in 2022.
- Between January and June this year there has been a 2% increase in patients presenting to the Trust with significant existing damage compared to the same period last year. These patients are at a higher risk of developing further pressure damage or deterioration of existing damage.

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. All areas (excluding GNCH) were given a 20% improvement trajectory for 2022-23. Those wards who achieved or exceeded the 20% pressure ulcer reduction trajectory, RVI 16, 31, 36, 42, 43 and FH 17, 27, 30, 33, 35, 38 have been issued with Certificates of Achievement.
- 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.
- A pilot commenced in January (on wards FH8, RVI23 and then FH13) 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. The results from this pilot demonstrating good utilisation of the tool, although skin assessment completion has been variable. Work is ongoing to learn and improve this with education provided to ward leaders. Discussions are in place to trial this in critical care and maternity areas.





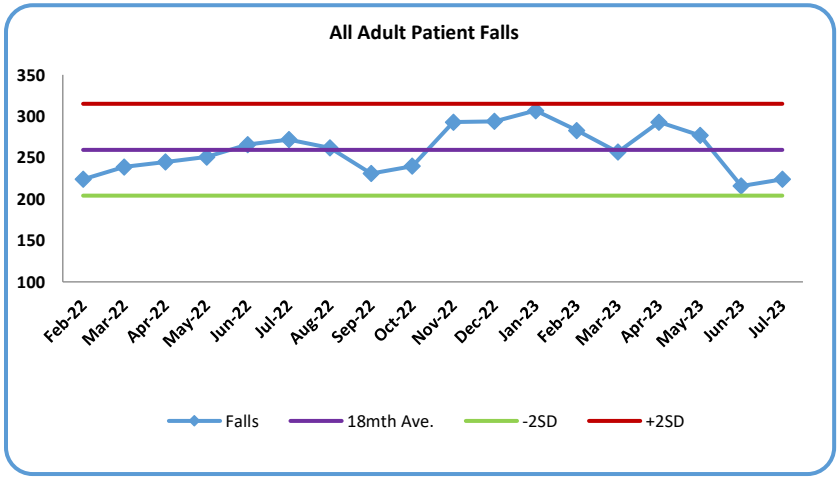
Quality: Harm Free Care - Falls

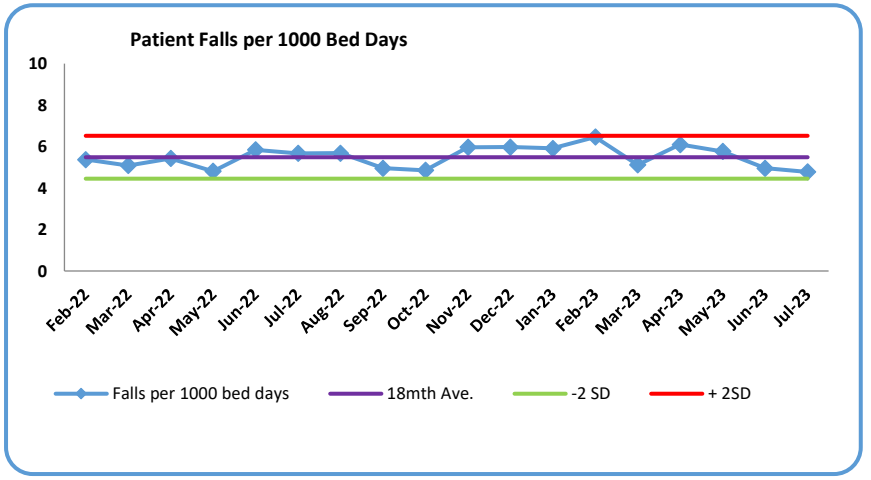
Analysis of data has demonstrated the following key points:

- June saw the lowest number of falls across the Trust over and 18-month period, with a slight rise by 8 in July 2023.
- This downward trend is reflected in adult in patient falls with falls per 1,000 bed days being at its lowest point in July.
- 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.

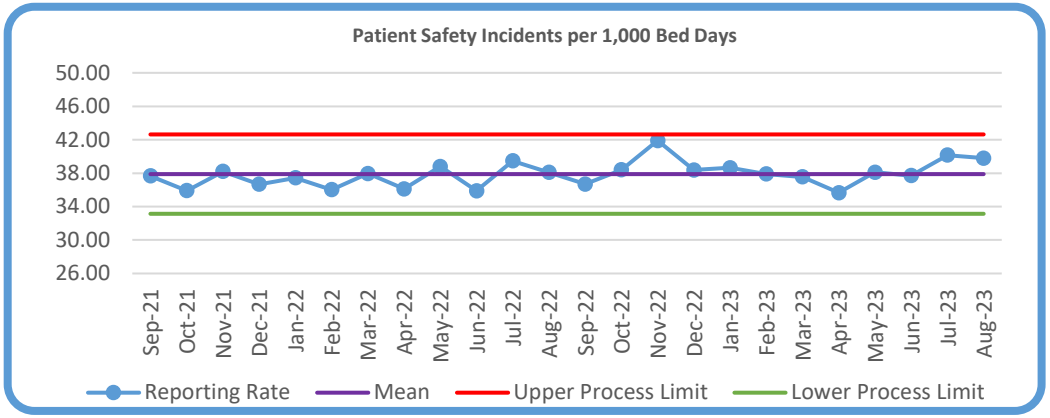
Current actions in place:

- 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.
- In line with Trust assurance measures, focused auditing has taken place to monitor compliance with the Trust's Enhanced Care Observations(ECO) 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 highlighted the requirement for further focused education to take place in some areas. Work continues on a rolling programme across the organisation.
- The Falls Prevention Coordinator is continuing work to improve compliance with patients over 65 years of age have a lying and standing blood pressure completed during their hospital stay. On Freeman Wards 20 and 35 and RVI 48 compliance has been audited and will pilot an improvement project. Re-audit will take place following implementation to measure impact .
- In 2022-23 all inpatient areas (including GNCH) were given a 20% reduction trajectory in falls. 13% achieved a 20% reduction (FH1,FH23, FH37, GNCH1B, GNCH12, RVI32, RVI37, RVI47) with 6% exceeding this (FH27, FH33, GNCH8, RVI33) and 13% demonstrating no falls.

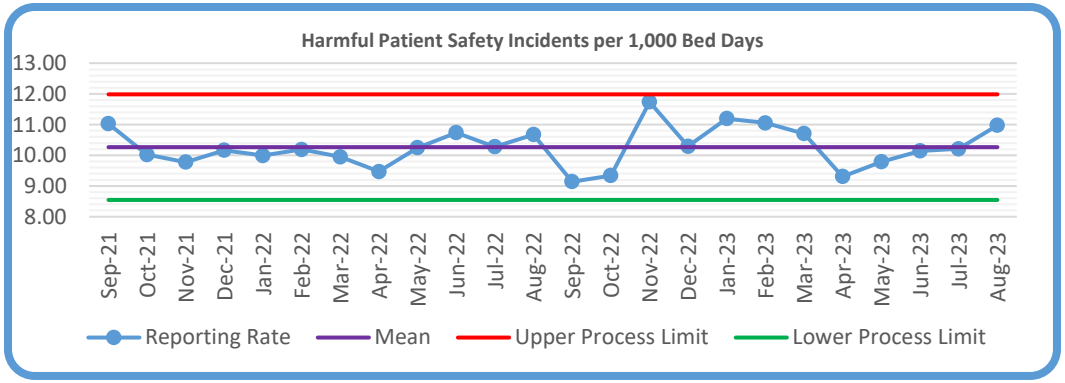




Quality: Incident Reporting

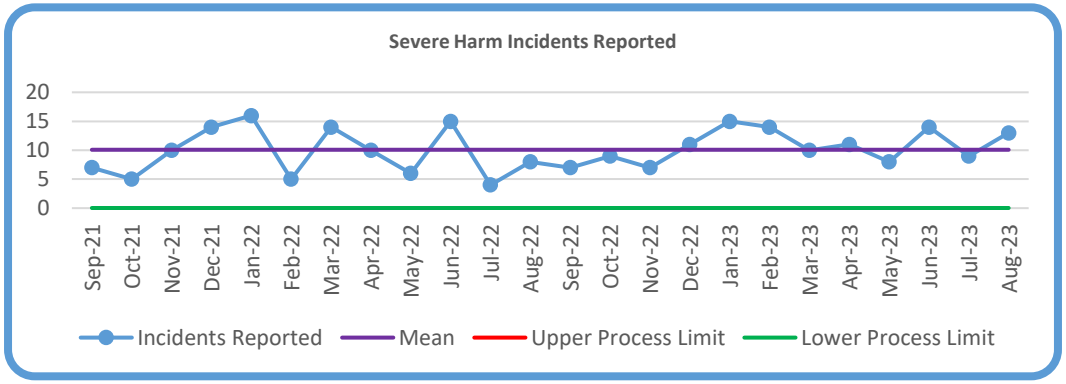


All patient incidents: In August 2023 the number of patient safety incidents reported per 1000 bed days has remained above the mean but is still within the expected common cause variation.



Harmful incidents: The number of *harmful patient safety incidents per 1,000 bed days has risen above the mean in August 2023 for the first time since April. The number is similar to that of March 2023, but lower than November 2022 and well within the expected common cause of variation. Severity grading of reported incidents may be modified following investigation and is therefore subject to change in future reports.

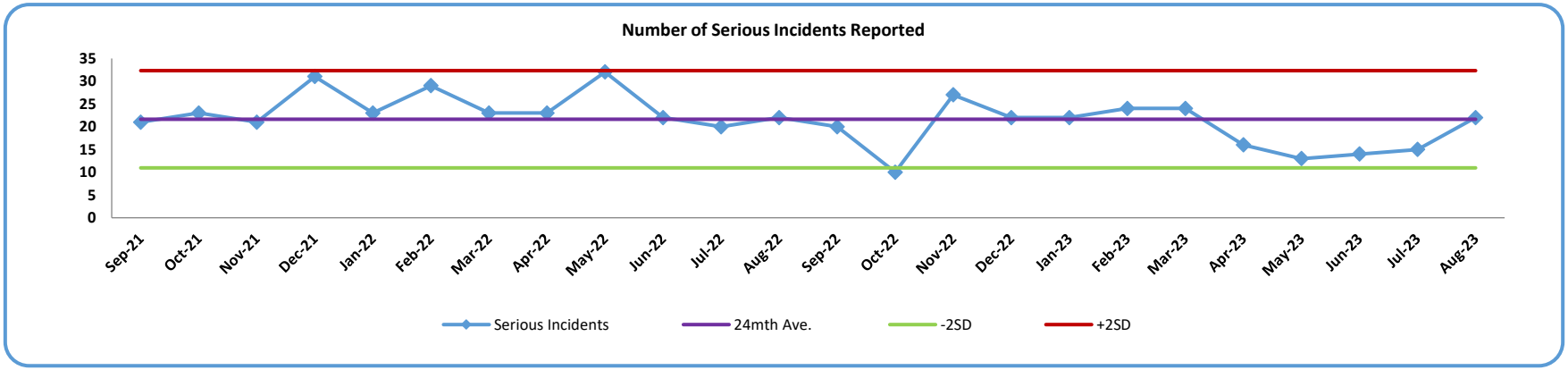
**includes all levels of harm from minor to catastrophic. Excludes patient safety incidents that resulted in no patient harm.*



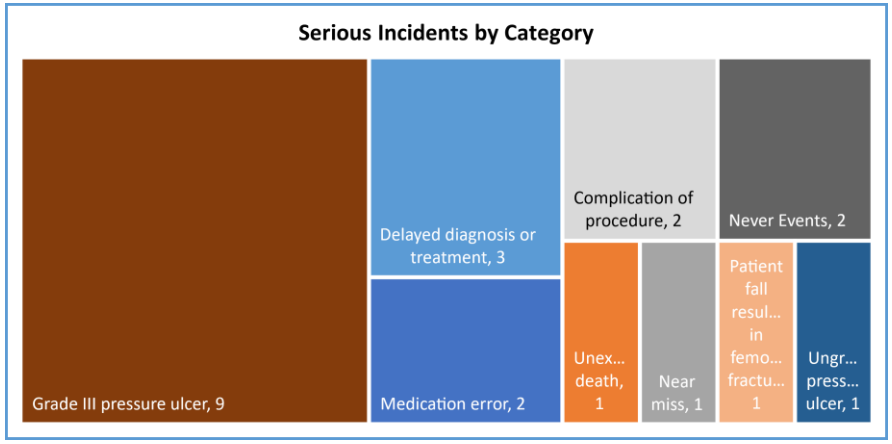
Severe harm incidents: There were 13 patient safety incidents reported that resulted in severe harm in August 2023, which is 4 more than July but 1 less than June.

Severity grading of reported incidents may be modified following investigation and is therefore subject to change in future reports.

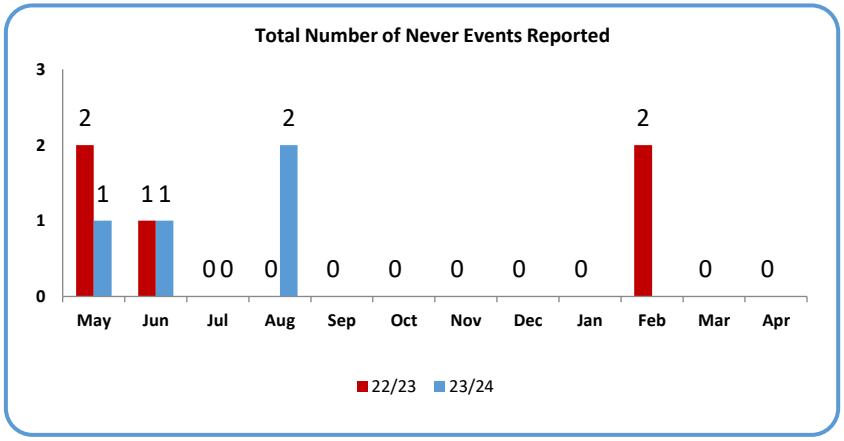
Quality: Serious Incidents and Never Events



There were 22 Serious Incidents (SIs) reported in August 2023, which means there has been a gradual upward trend towards the mean since May, making the number similar to that of August 2022. However, this is still within the accepted common cause for variation. The statutory requirement Duty of Candour (DoC) applies to patient safety incidents that occur when providing care and treatment that results in moderate, severe harm or death and requires the Trust to be open and transparent with patients and their families. The DoC process has been initiated for all cases reported in August 2023.



The categories of reported SIs for August 2023 are displayed in the table above. The highest number of SIs relate to Grade III pressure ulcers.



There were 2 Never Events were reported in August 2023, bringing the total so far for 2023/24 to 4.

Quality: Serious Incident Lessons Learned (1/3)

Learning identified from Serious Incident (SI) & Never Event (NE) investigations completed between 01.05.2023 – 31.08.2023

The following section outlines key learning from the 29 SI investigations completed between 1st May 2023 to 31st August 2023. This data excludes information on falls, pressure ulcers, deaths as a result of definite or probable hospital acquired Covid-19 and any SI cases subsequently de-registered during this period.

Maternity reportable cases – 2 cases

- Dissemination of recently updated local guidance on 'Management of vulnerable infants' to ensure staff are aware of appropriate processes to follow when caring for an unwell neonatal patient.
- Education and training provided to support the implementation of Neonatal Early Warning Score alongside the Neonatal Risk Assessment, both of which are now embedded in Badgernet.
- Education and training provided to staff to ensure that parents receive clear information advising them what to do if they have concerns for their baby.
- Feedback from family provided to organ donation team about sensitivities and timing of organ donation conversations relating to maternal deaths.

Other maternity cases – 2 cases

- Review and strengthen the triage system to include timescales and guideline for escalation in line with national triage tool.
- Strengthen the use of formalised SBAR handover for use in emergency situations.

Internal referral – 1 case

- Clinical Boards to review and agree an SOP to and strengthen existing processes for sending and receiving, acknowledging and acting upon internal referrals.

Lost to follow up – 1 case

- Processes for monitoring waiting list patients reviewed and strengthened to allow more robust oversight of the highest priorities.
- Failsafe officers now monitoring the patient database to ensure high risk patients who require more frequent review are offered timely appointments.

External correspondence related incident – 2 cases

- Processes for sending out discharge letters from the Trust reviewed and strengthened.
- Revisit processes for listing patients and reviewing local and national transplant lists reviewed and strengthened.

Quality: Serious Incident Lessons Learned (2/3)

Missed/delayed diagnosis or treatment – 8 cases

- Internal referral triage system reviewed and strengthened.
- Processes for patient appointments improved to ensure there is an appropriate balance between face to face and telephone appointments to allow for more robust review of patient treatment.
- Agreed processes to ensure critical functions of wards are covered when staff are engaged with unanticipated challenging patients in order to continue to provide urgent care to other patients.
- Ensure staff wellbeing is adequately supported following unexpected and/or distressing events.
- Patient pathway reviewed and updated to prompt the correct action to support clinical decision making.
- Guidance for the treatment of patients on disease modifying medication reviewed and updated. Education provided across the Trust through local governance meetings and CRG (Clinical Risk Group).
- Initiation of Trust-wide quality improvement project to review and strengthen the management of abnormal results, to ensure timely clinical care, treatment, and follow-up of patients.
- Local processes improved to ensure lead consultant is aware of abnormal radiology results so that a timely diagnosis can be made.
- Local handover processes for medical staff and nurse practitioners reviewed to ensure robust sharing of information between shifts.
- Processes for documenting falls and agreed standardised assessment proforma reviewed and amended with local agreement.
- Local protocol to manage repeat attendees in ED developed and agreed in order to ensure patients have a senior medical review.
- SOP developed and agreed to ensure paediatric patients are routinely weighed during ED assessments in order to easily identify paediatric patients that are failing to thrive.

Quality: Serious Incident Lessons Learned (3/3)

Medication related incidents – 6 cases

- Education provided on processes for completion of discharge documentation to ensure information is clear, accurate and that actions are written in the designated section of the discharge document.
- Processes reviewed and strengthened to ensure patients are not discharged to another ward prior to senior medical and pharmacy review.
- Targeted enhanced pharmacists support for wards.
- VTE assessment guidance revised with improved education for foundation doctors and improved communication during handover and ward rounds.

Complication of treatment – 3 cases

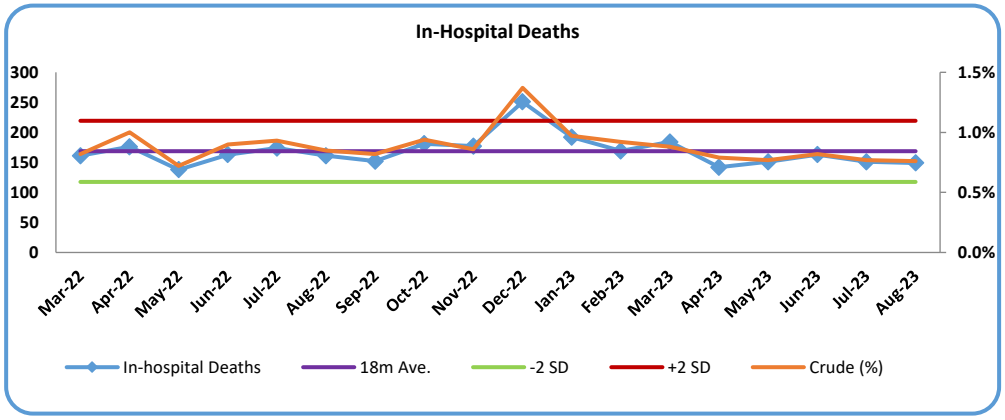
- Local education and training delivered in relation to invasive line management, with specialist critical care focus.
- Trustwide training and alert circulated to highlight best practice.

Complication of surgery – 4 cases

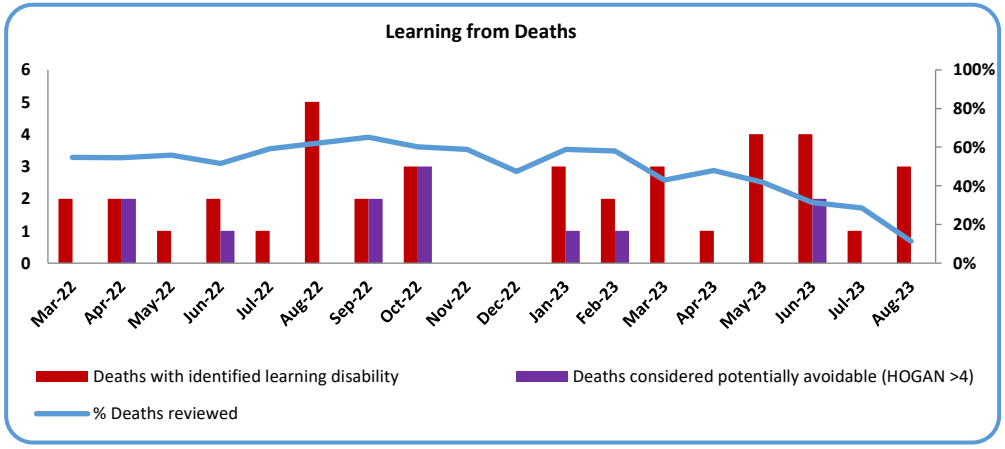
- Develop more robust processes for the management of patients on pooled patient lists.
- Process for taking consent reinforced to include allowing patients time to consider treatment options before making a decision about their treatment.
- Local review of devices involved in surgical procedures leading to an agreed decision to amend practice.
- Training and education provided locally regarding count processes and keeping contemporaneous documentation, shared across all theatres.
- National guidelines reviewed and local practice amended to include 'Prep, Stop, Block' posters.

Quality: Mortality Indicators (1/2)

In-hospital Deaths: In total there were 149 deaths reported in August 2023, which is lower to the amount reported 12 months previously (n=161). The crude death rate is 0.76%. Nationally the deaths were high in December 2022, with influenza reported to be the main cause of death.

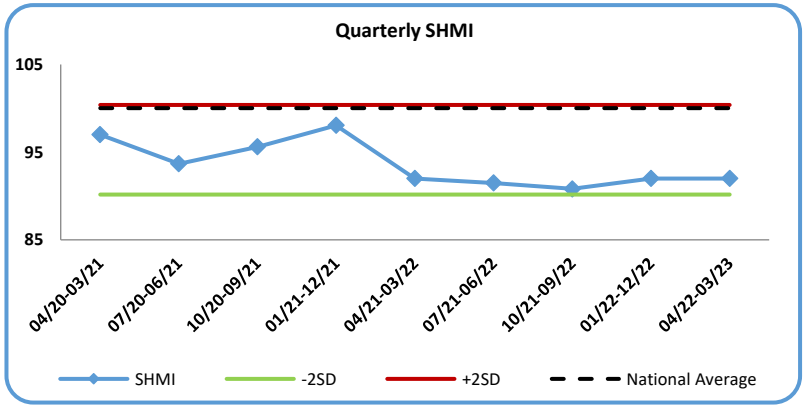


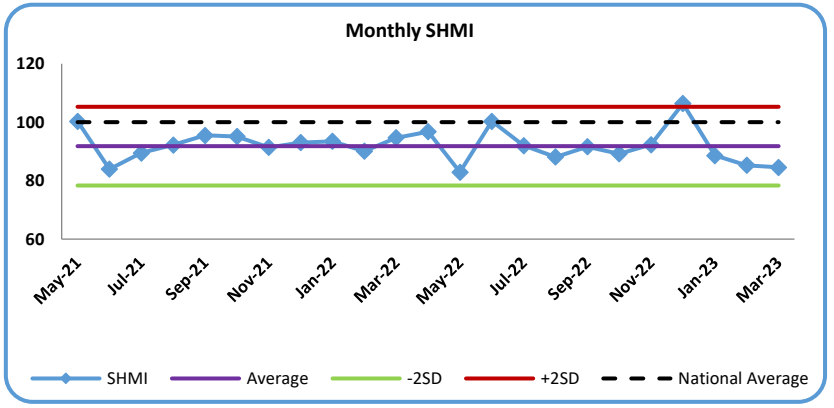
Learning from Deaths: Out of the 149 deaths reported in August 2023, 17 patients have, to date, received a level 2 mortality review. However, these figures will continue to rise due to ongoing M&M meetings held over the forthcoming months. All figures will continue to be monitored and modified accordingly. Three patients had an identified learning disability.



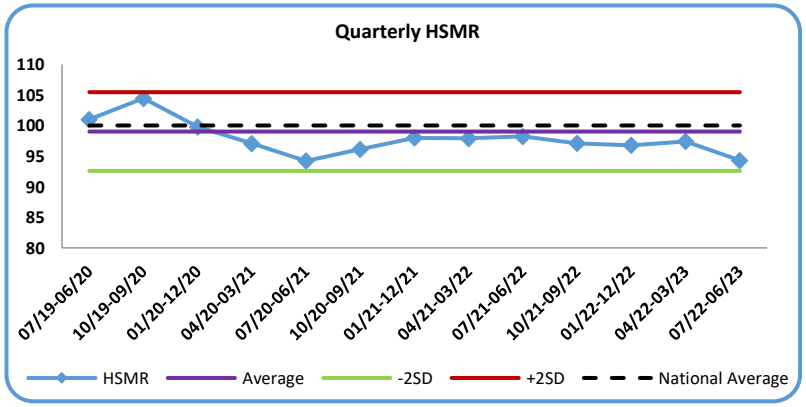
Quality: Mortality Indicators (2/2)

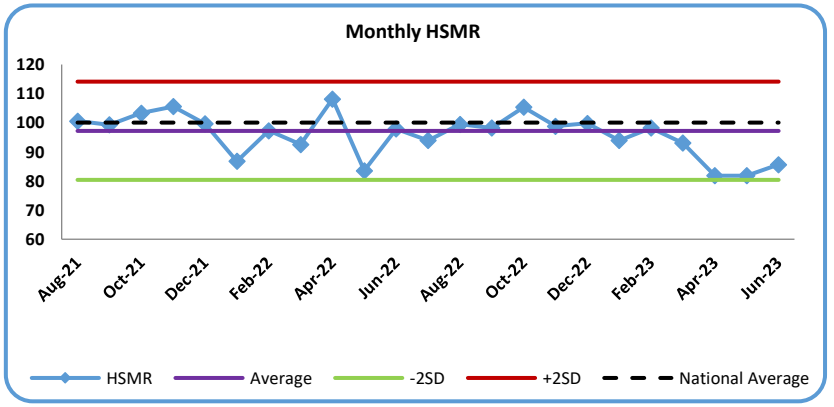
SHMI: The latest published SHMI quarterly data from NHS England shows the Trust has scored 92 from months April 2022 to March 2023. This is below the national average and is within the "as expected" category. Monthly SHMI data is published up to March 2023 and shows the Trust to be below the national average. 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, with data published up to June 2023. This is showing just below the national average and within "as expected" levels. Monthly data is published up to June 2023 and is showing well below the national average and within "expected limits". 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: Mortality Indicators (2/2)

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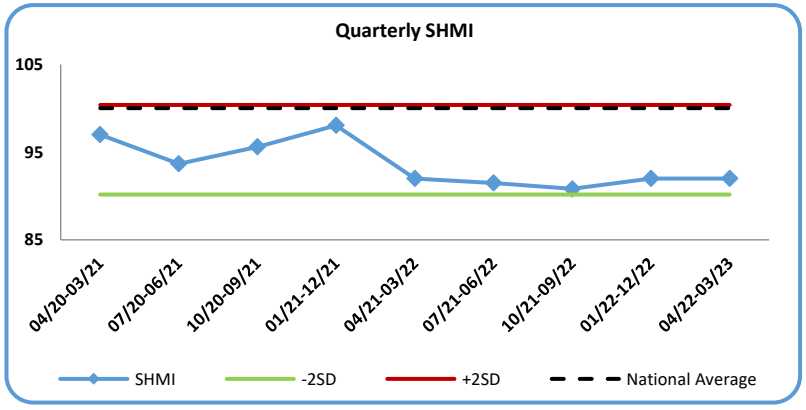

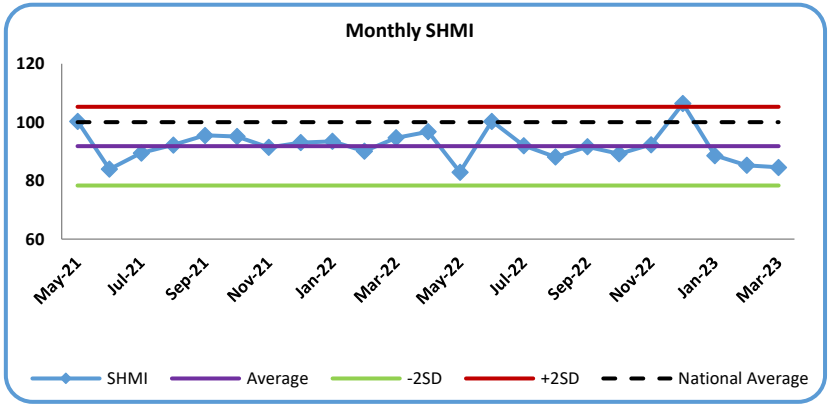

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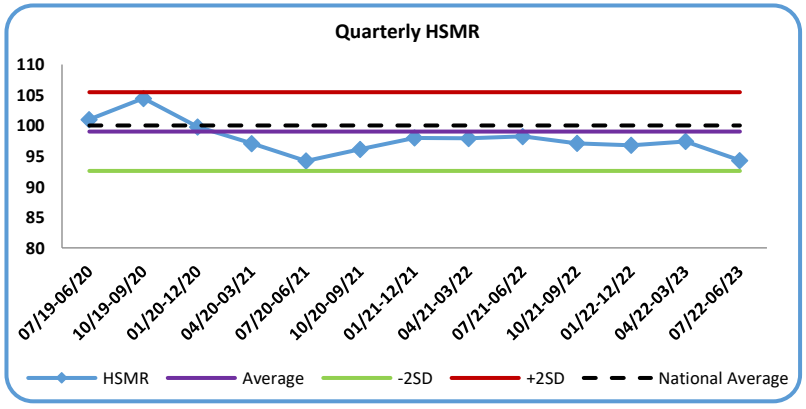
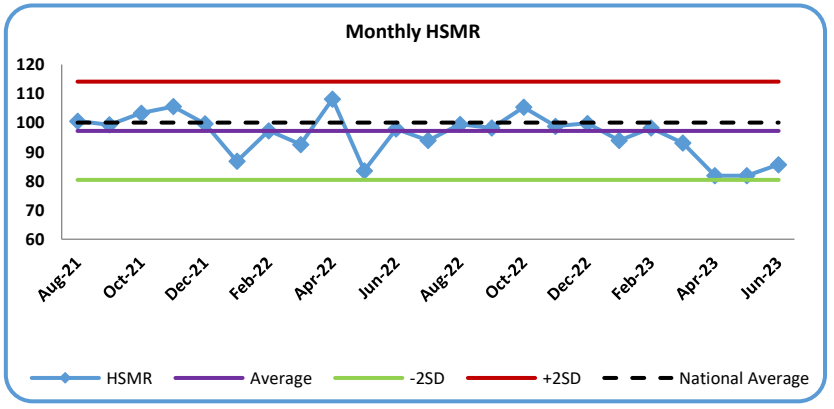
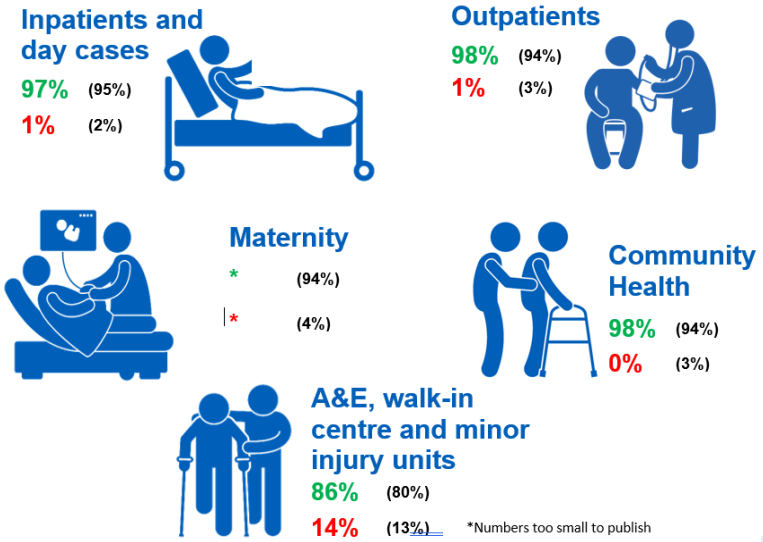




Quality: FFT and Complaints



Friends and Family Test

There were 2,209 responses to the Friends and Family test from the Trust in June 2023 compared to 2,079 in the previous month.

The infographic shows the proportion of patients who give a positive or negative rating of the care they received. The national average results are shown in brackets for comparison and the national technical issue which delayed reporting from February onwards is now resolved.

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 193 formal complaints up to the end of August 2023 (167 with identified patient clinical activity).

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 0.06% (6 per 10,000 contacts). The lowest complaint percentages are with Cancer Services and ePOD with 0.01% (1 per 10,000 contacts).

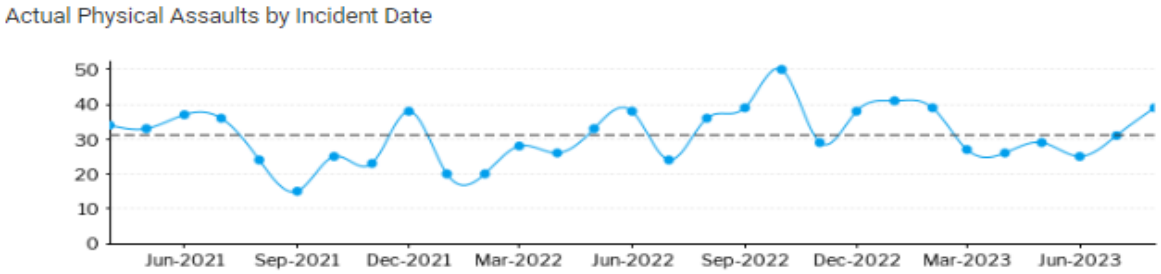
	Complaints and Activity (April – August 2023)				
Directorate*	Complaints	Activity	Patient % Complaints	Ratio (YTD)	22-23 Ratio (Full year)
Cancer Services	7	87237	0.01%	1:12462	1:8154
Cardiothoracic Services	12	46789	0.03%	1:3899	1:3974
Childrens Services	9	30686	0.03%	1:3410	1:2137
Dental Hospital And Oral Surgery	7	38910	0.02%	1:5559	1:15521
ePOD	24	162210	0.01%	1:6759	1:8802
Internal Medicine	17	57009	0.03%	1:3353	1:2780
Medicine (ED)	24	71523	0.03%	1:2980	1:5184
Musculoskeletal Services	8	41485	0.02%	1:5186	1:3883
Neurosciences	15	36374	0.04%	1:2425	1:3280
Periop and Critical Care	4	12197	0.03%	1:3049	1:3167
Renal and Urology	12	27152	0.04%	1:2263	1:2926
Surgical Services	16	27467	0.06%	1:1717	1:1845
Women's Services	15	58530	0.03%	1:3902	1:3304
Trust (with activity)	167	697569			1:3759

*Note the directorate structure of this table will be updated in future reports to reflect the new clinical boards.

Quality: Health and Safety (1/2)

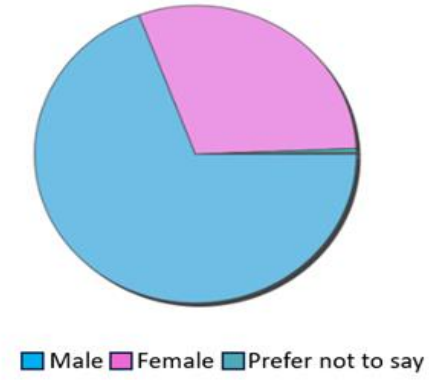
Staff Safety: Violence and Aggression (Thematic Review)

Violence and Aggression incidents: The 2022-23 Health and Safety Annual Report highlighted a 28% increase in physical assaults from the previous year. The Emergency Department continue to report the highest levels of physical assault; however, there's a relatively wide spread of reported assaults across a varied range of disciplines and specialities. Staff feedback highlights the negative impact this type of behaviour has on morale, absence and retention rates, etc.

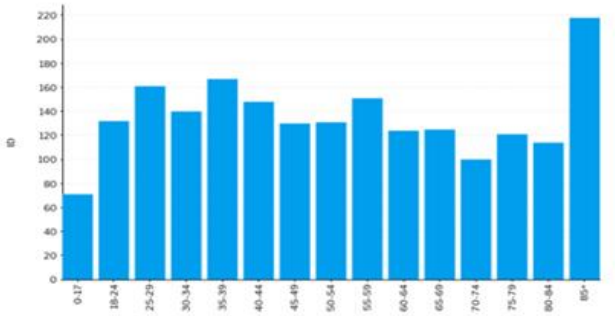


The above chart shows the sustained rate of incidents reported over a longer period. Incident forms submitted this calendar year, show that mental health, alcohol, dementia and delirium make up 52% of the recorded contributory factors. Over the same period, males are recorded as the perpetrators in 69% of incidents.

Perpetrator of Violence and Aggression by Gender



Perpetrator of Violence and Aggression by Age



Quality: Health and Safety (2/2)

National Initiatives:

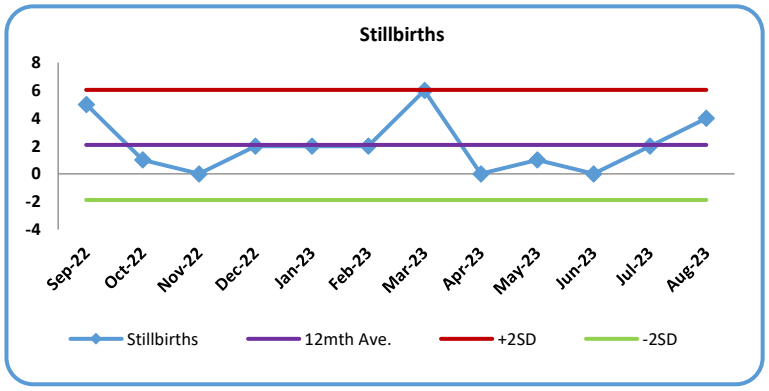
There is a nationally recognised workstream for organisations to use the Public Health model to reduce violence and aggression. Newcastle Hospitals are reviewing this model and using incident data and staff feedback to help develop Trust wide and localised reduction plans, which will need to be monitored over a period of time. The contributory factors are not always under our control and the Public Health model promotes a multi-agency approach to violence reduction. For example, the Trust are soon to deploy Emergency Department Navigators. Following extensive trials in Scotland, this evidence-based approach to dealing with challenging behaviour, looks to introduce social prescribing and support to those more likely to be either the victim or perpetrator of violence and aggression.

All organisations with NHS contracts are now expected to meet National Violence Reduction Standards. Newcastle Hospitals compare well against these standards and to help with this, we have recently approved the Trust Violence Reduction Strategy and improved our ability to determine whether those with protected characteristics are the victims of this type of behaviour. Our recent CQC inspection highlighted a focus around the use of restrictive interventions such as physical restraint. The main reason for the use of physical restraint is in the management of violence and aggression. We therefore look to use primary initiatives to prevent the use of physical restraint, which would include for example: improving patient experience, better environments, mutual expectations, reduction of boredom and sleep hygiene.

Trust Initiatives:

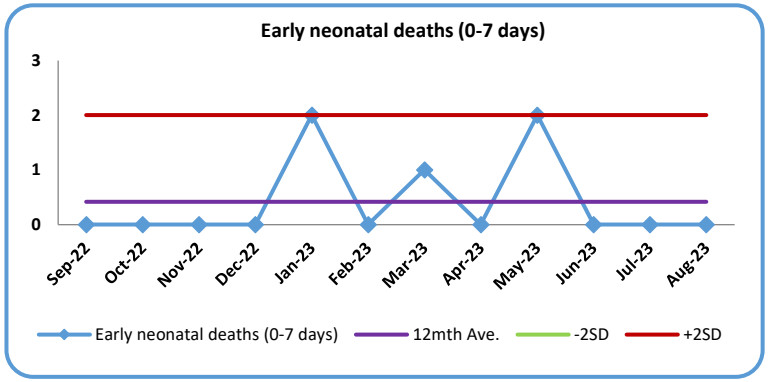
- CGARD (Health and Safety Team) are re-evaluating ward / department-based risk assessments using a comprehensive risk assessment tool for higher risk / higher frequency areas.
- Specific staff-based violence reduction surveys are currently being planned on Ward 23 RVI and Ward 47 RVI. The aim is to use the results of these surveys to develop localised violence reduction plans, using recognised quality improvement tools. This will be extended to other areas within the current financial year.
- Offering staff a range of training opportunities covering primary (We Can Talk, MH Awareness, etc), secondary (de-escalation skills) and tertiary (hands on) skills depending on role. Further discussion is taking place to seek ongoing funding for breakaway training, which has recently been re-introduced and is covered on the Trust training needs analysis.
- Improve the reporting culture across the organisation to ensure we have an accurate record of actual activity and work closely with those areas where tolerance to violence and aggression is deemed to be too high. As this work progresses it's probable the number of incidents will increase before plateauing and then reducing over time.
- Working closely with other agencies to ensure violence and aggression is addressed holistically e.g. work progressing with Northumbria Police Violence Reduction Unit to partially fund ED Navigators.
- Review the Exclusion from Treatment of Violent or Abusive Patients Policy and align this to a re-formatted 'Violent Patient Marker' group.
- Provide lone worker devices to those staff working in the community.
- Continued support for staff who have been the victims of violence and aggression at work.

Quality: Maternity (1/3)



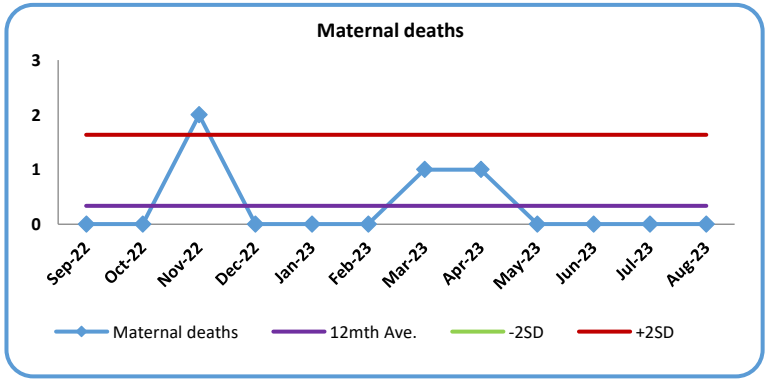
Stillbirths

As Newcastle Hospitals is a tertiary referral Fetal Medicine Unit, complex cases are often referred to the Trust from other units within the region, with women opting to deliver here rather than return to their local unit. This data includes termination for fetal anomalies > 24 weeks gestation. 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 four stillbirths in August.



Early Neonatal Deaths

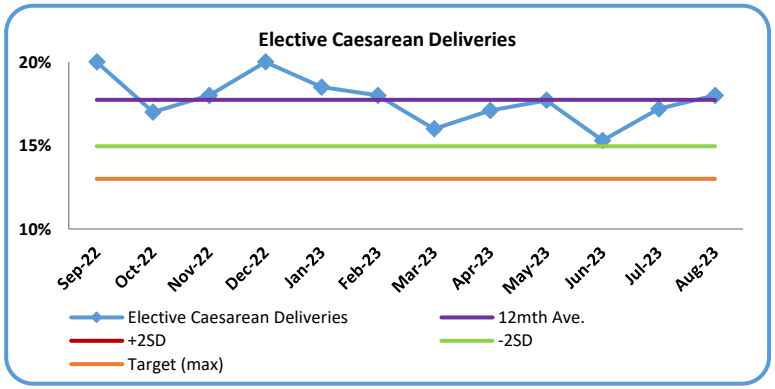
These figures are for term infants (born between 37 and 41 weeks) who delivered at the Trust but sadly died within the first week of life. These deaths are reported to the Child Death Review panel (as are all neonatal deaths regardless of gestation) who will have oversight of the investigation and review 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 August 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 and was aggravated by pregnancy.
Early maternal deaths are also reported to HSIB, investigation is dependent on certain criteria. There were no cases reported in August.

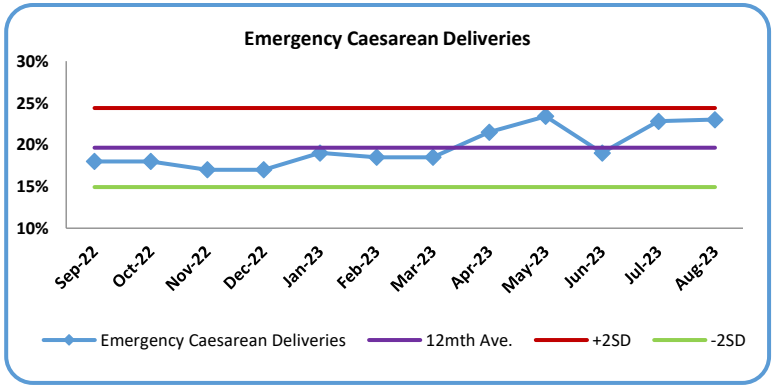
Quality: Maternity (2/3)



Elective Caesarean section

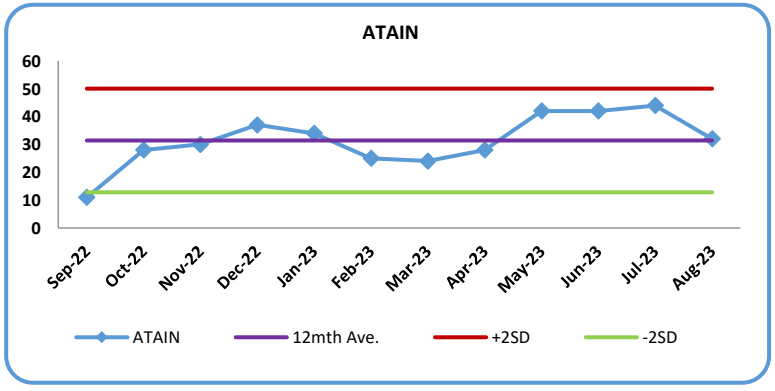
Maternity at the Trust is an outlier for elective Caesarean section compared to other UK Trusts. However, the rates are comparable to that of other tertiary centres in the UK.

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

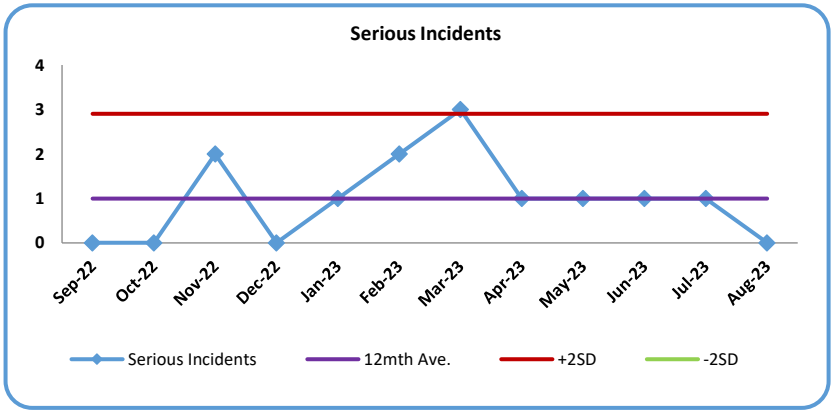
The emergency Caesarean section rate is comparable to other Trusts. Maternity is a consultant led service with dedicated consultant presence on Labour Ward 8am-10pm daily, consultant led multi-disciplinary ward rounds occur twice daily. The majority of obstetric consultants remain onsite overnight, from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



ATAIN

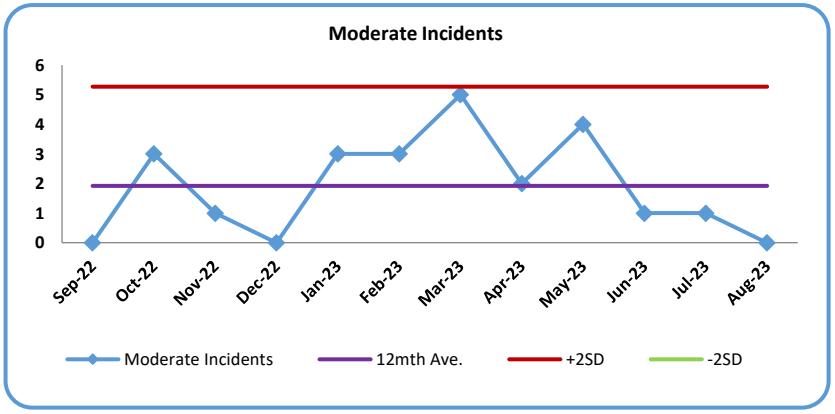
All unplanned admissions of term babies (37 – 41 weeks) into the neonatal unit are reviewed at a weekly multi-disciplinary meeting and a quarterly report is produced and shared. Following review, some cases will be investigated in more detail if they have been identified as a Serious Incident. Analysis for April/May/June 2023 shows a reduction in avoidable admissions from 9% (previous quarter) to 5%. There were 32 term admissions for August, analysis to determine how many avoidable admissions there were is not yet complete.

Quality: Maternity (3/3)



Serious Incidents

There have been 12 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 have been no Serious Incidents in August.



Moderate incidents

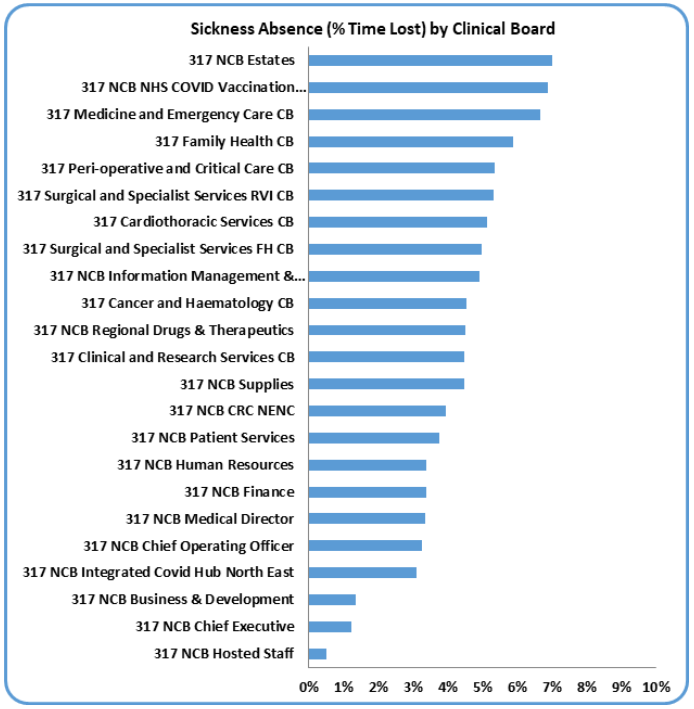
There were no moderate (and above) incidents reported in Maternity this month. All incidents are carefully reviewed by the Maternity Governance team and are graded appropriately after completion of a rapid review (48hr report). In the past 12 months, the majority of the moderate graded incidents were 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.

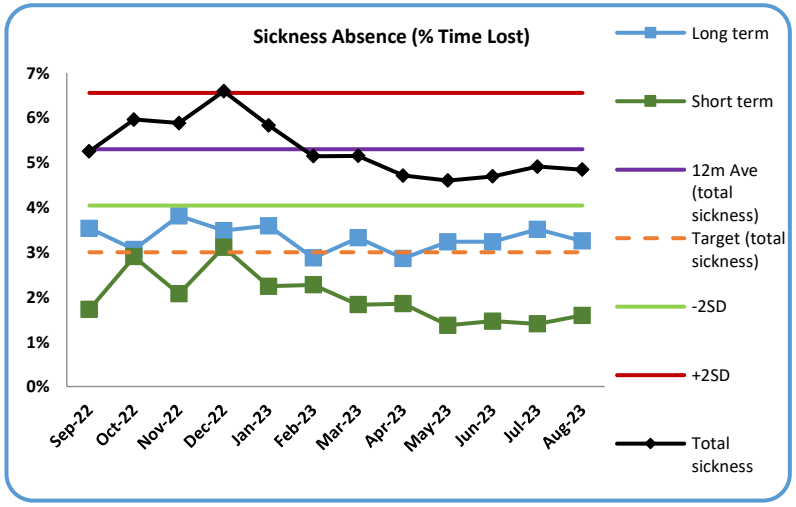
People: Sickness Absence 1/2

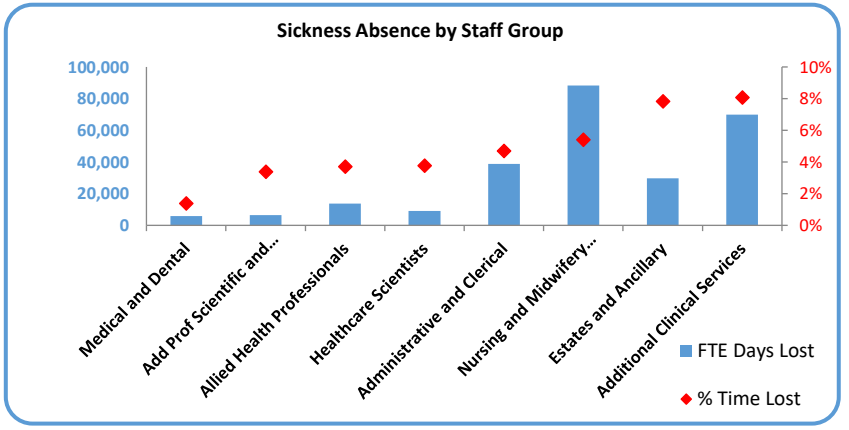
- Year to year comparison for sickness absence (including COVID-19 related sickness (rolling 12 months):

	Aug-22	Aug-23	
Long-term	3.65%	3.49%	↓
Short-term	1.80%	1.81%	
Total	5.44%	5.30%	↓

- 264,715 FTE working days were lost due to sickness (including COVID-19 related sickness) in the year to August 2023, compared to 322,268 for the previous year.
- Overall sickness absence (including COVID-19 related sickness) is 5.30%, which is down from end of August 2022 position of 5.44%% (% 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.

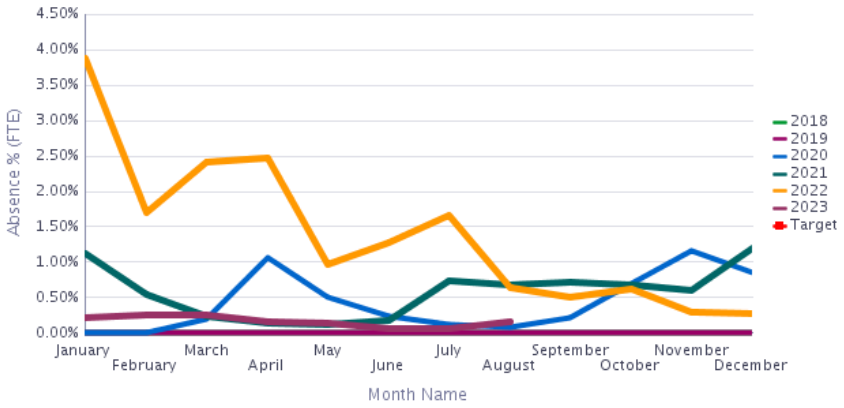




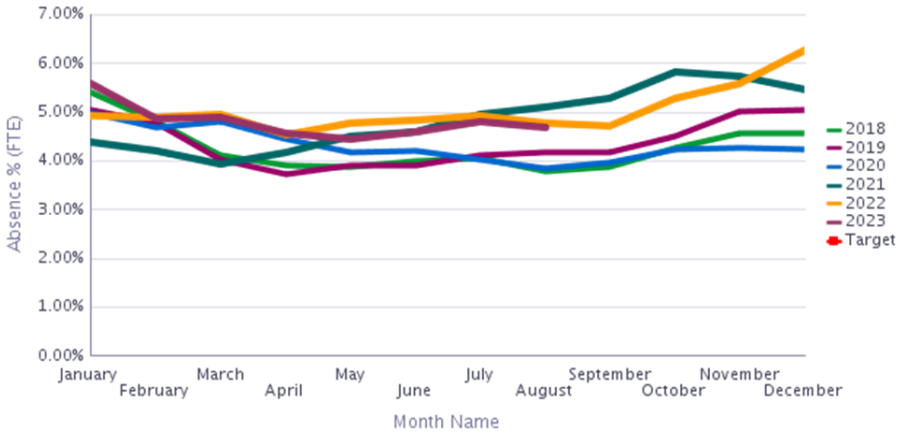


People: Sickness Absence 2/2

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

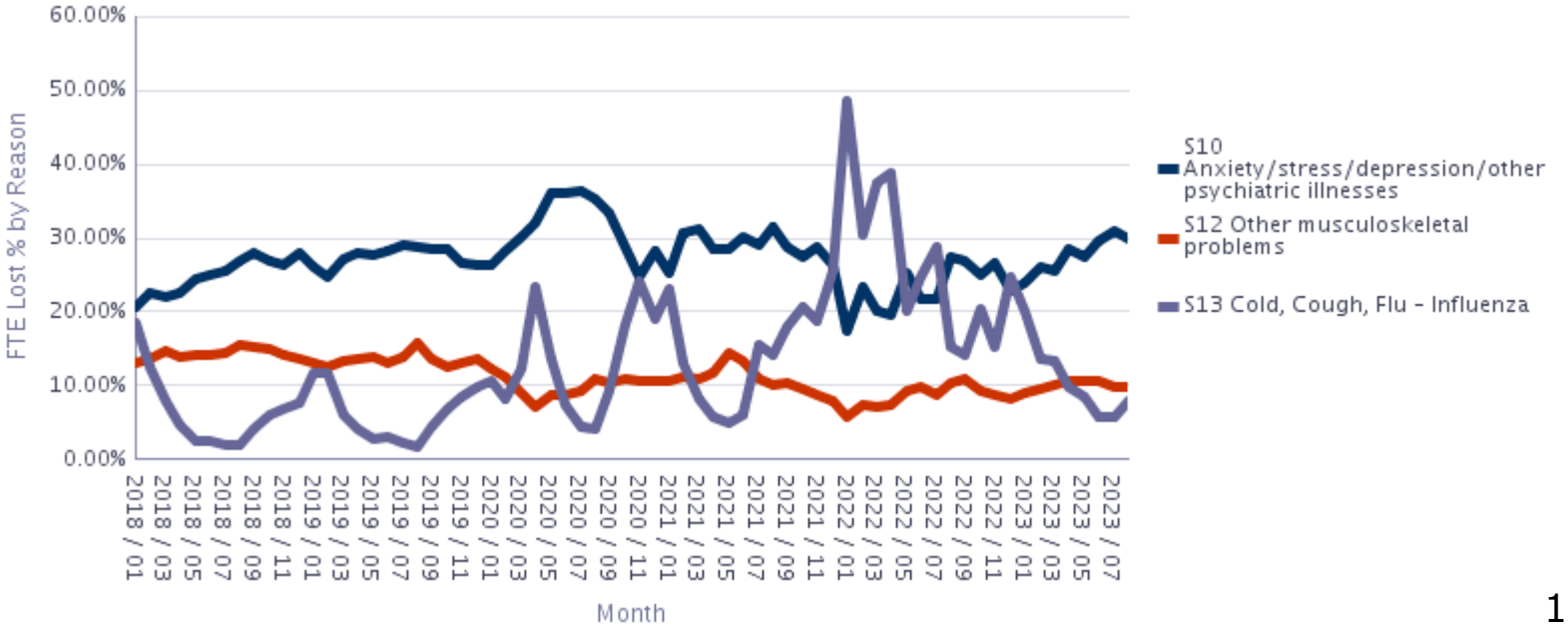


Non-COVID-19 Related Sickness Jan 2018 – August 2023 (%FTE)

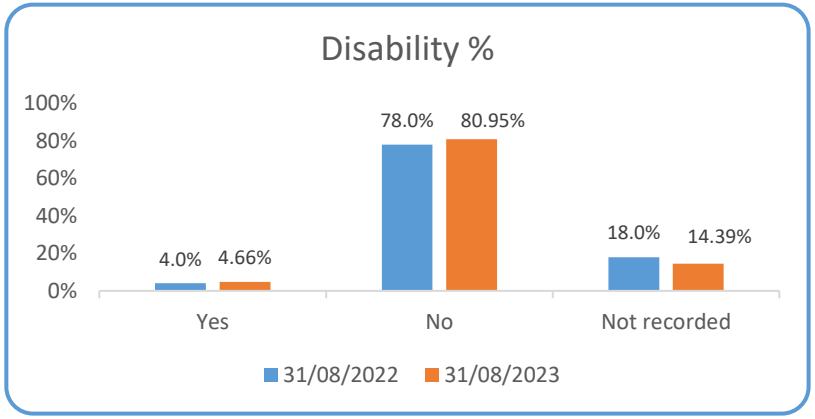


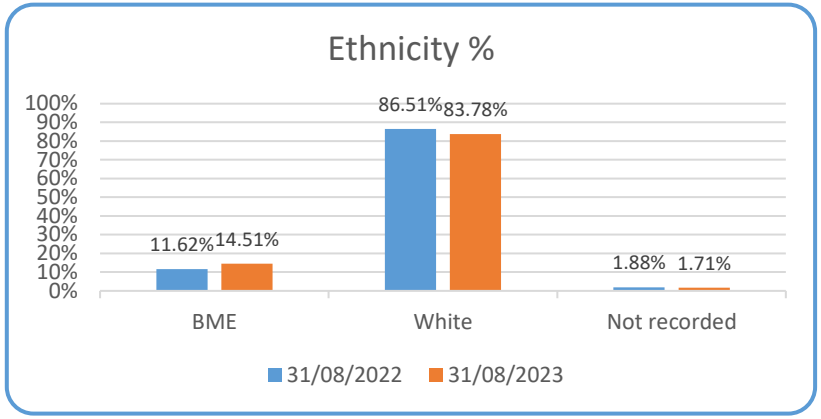
Top 3 Sickness Reasons Jan 2018 - August 2023 (%FTE)

S13 includes Covid sickness

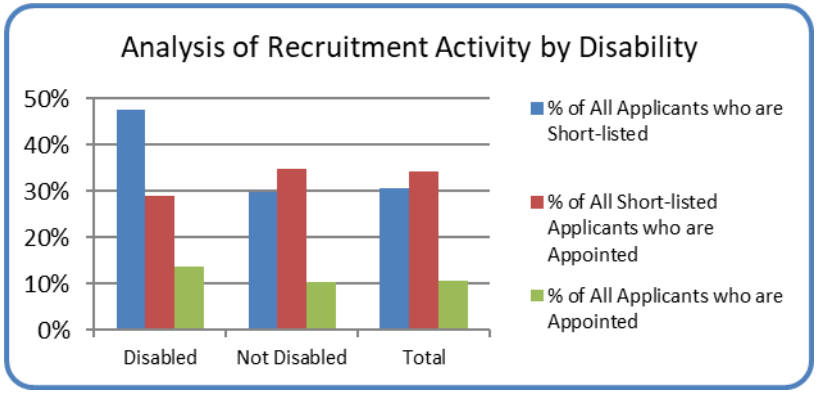


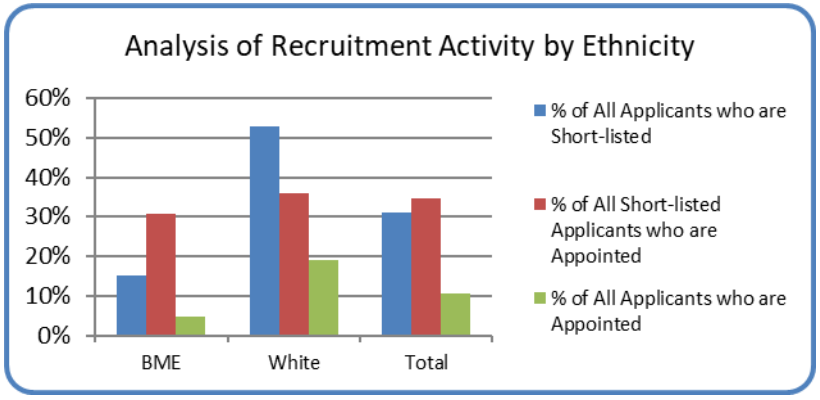
People: Equality and Diversity





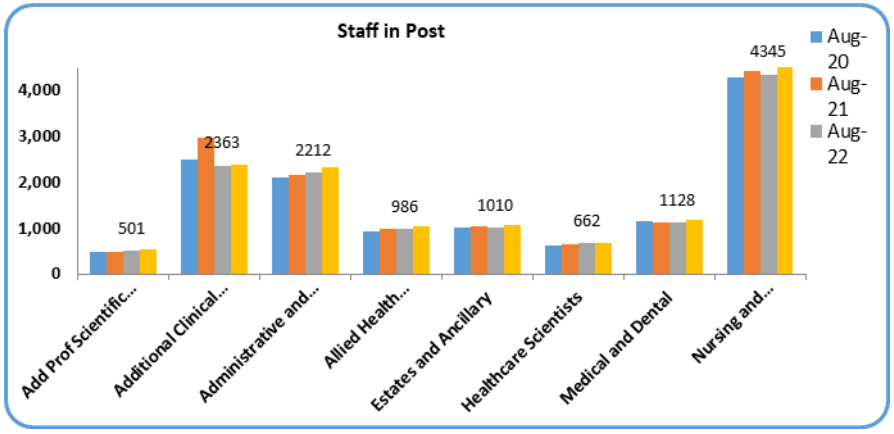
- The graphs above identify, by disability and ethnicity, the recruitment outcome of applicants during the twelve months ending August 2023.

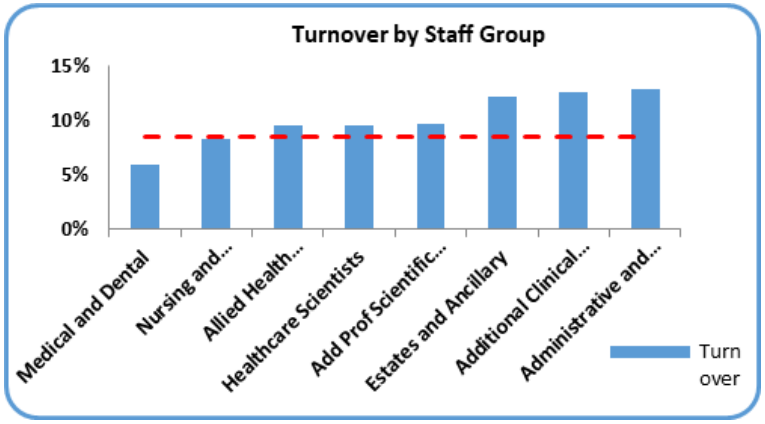


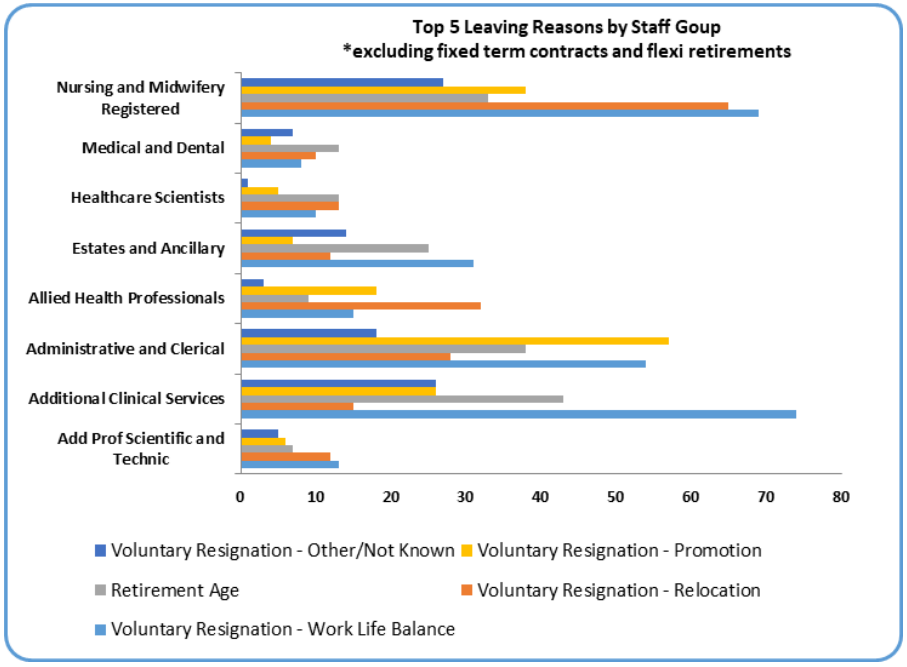


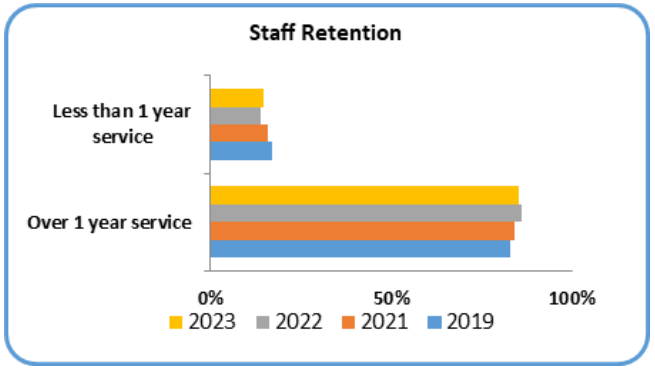
- The graphs above identify, by headcount, the percentage of staff in post in August 2022 and August 2023 by disability and ethnicity. The percentage of staff employed disclosing a disability has increased from 3.98% to 4.66% and the percentage of BAME staff has increased from 11.62% to 14.51%.

People: Workforce 1/3









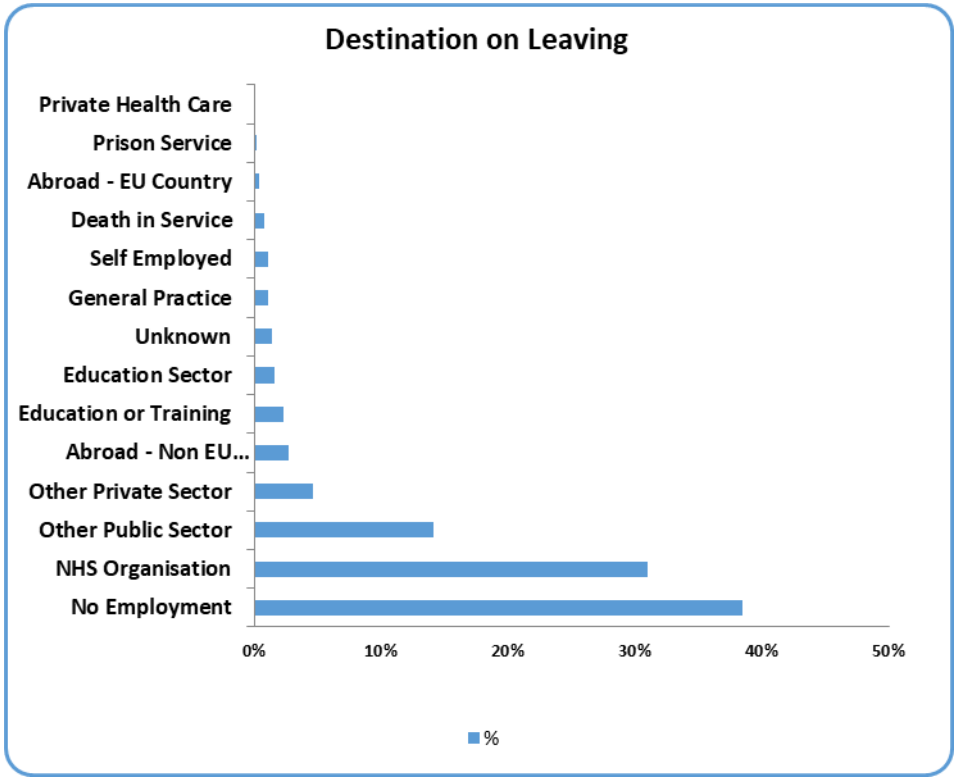
- Staff in post has increased by 5.10% since August 2020. The staff groups with the largest increase are Add Prof Scientific and Technic and Allied Health Professionals.
- Staff turnover has decreased from 16% in June 2022 to 11.46% in August 2023, against a target of 8.5%.
- The total number of leavers in the period September 2022 to August 2023 was 1,584.
- Retention for staff over 1 year service is 85.2%, a decrease from 86.6% in June 2022.

People: Workforce 2/3

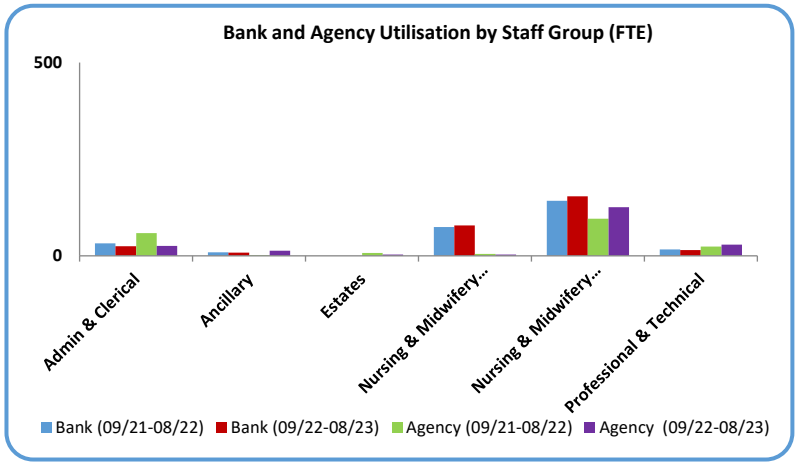
Turnover by Clinical Board

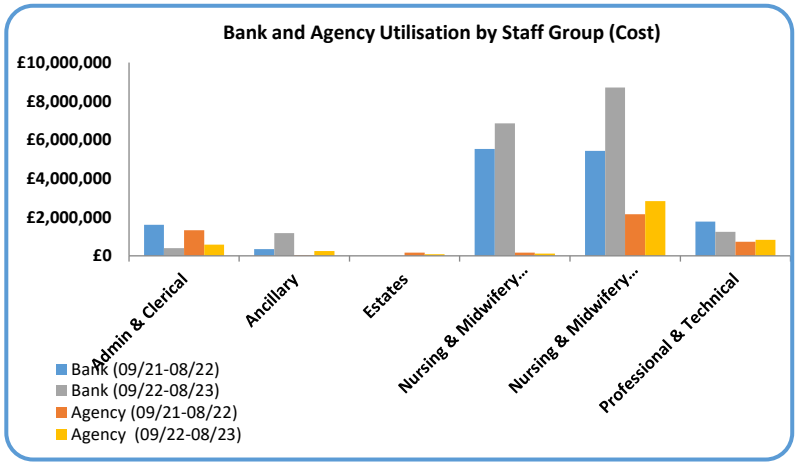
Clinical Board	Turnover
317 NCB CRC NENC	5.97%
317 Cancer and Haematology CB	7.93%
317 Peri-operative and Critical Care CB	8.36%
317 NCB Regional Drugs & Therapeutics	8.45%
317 Surgical and Specialist Services FH CB	8.96%
317 Surgical and Specialist Services RVI CB	9.90%
317 Medicine and Emergency Care CB	11.44%
317 Clinical and Research Services CB	11.60%
317 NCB Chief Operating Officer	12.12%
317 Cardiothoracic Services CB	12.17%
317 NCB Estates	12.32%
317 NCB Patient Services	12.78%
317 NCB Information Management & Technology	12.96%
317 NCB Chief Executive	13.04%
317 Family Health CB	13.08%
317 NCB Business & Development	13.33%
317 NCB Supplies	13.84%
317 NCB Finance	15.25%
317 NCB Medical Director	16.90%
317 NCB Human Resources	17.18%
317 NCB NHS COVID Vaccination Programme	30.99%
317 NCB Integrated Covid Hub North East	31.82%
Trust Total	11.46%

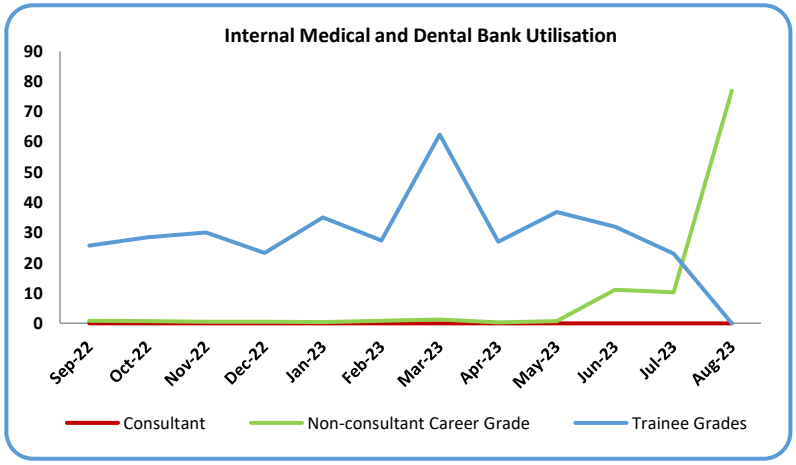
- Only 31% of leavers across the Trust disclosed they were going to another NHS organisation.



People: Workforce 3/3

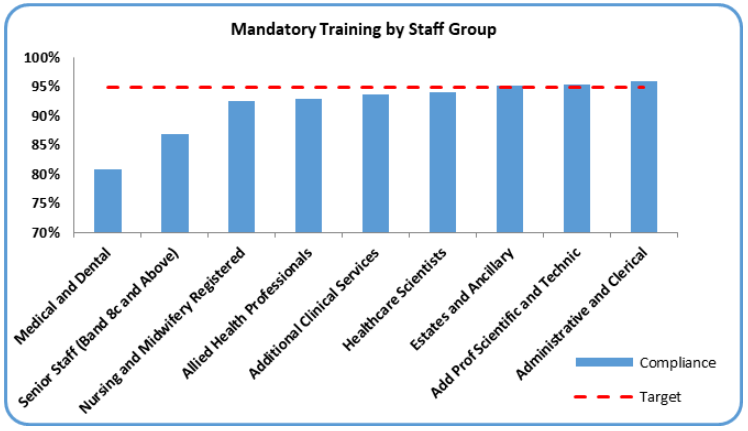


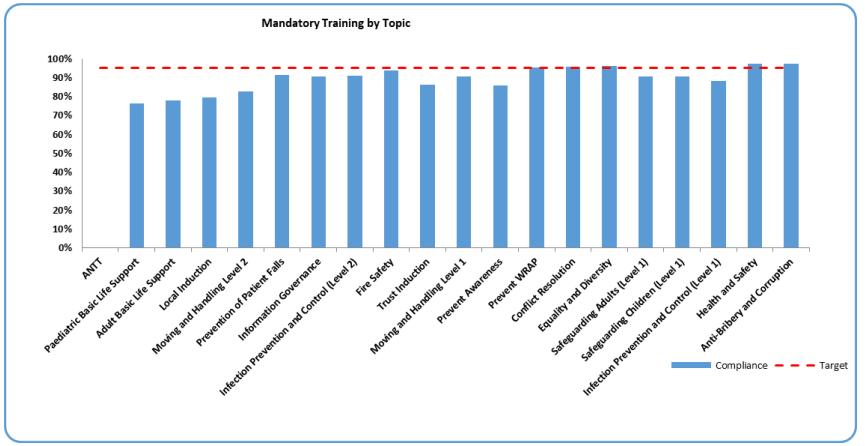


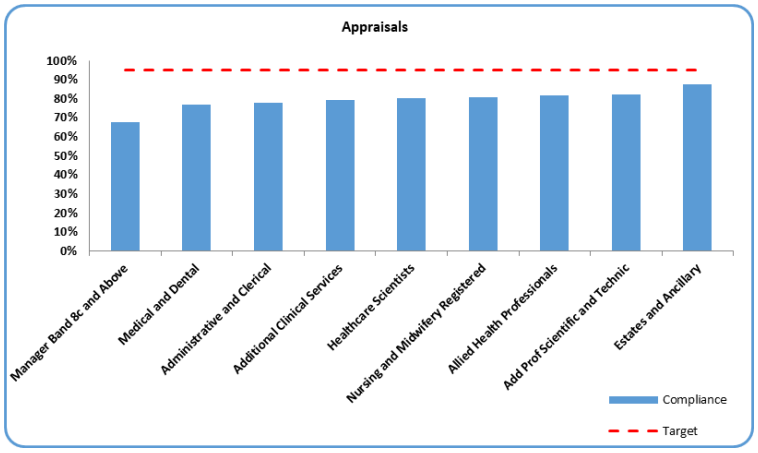


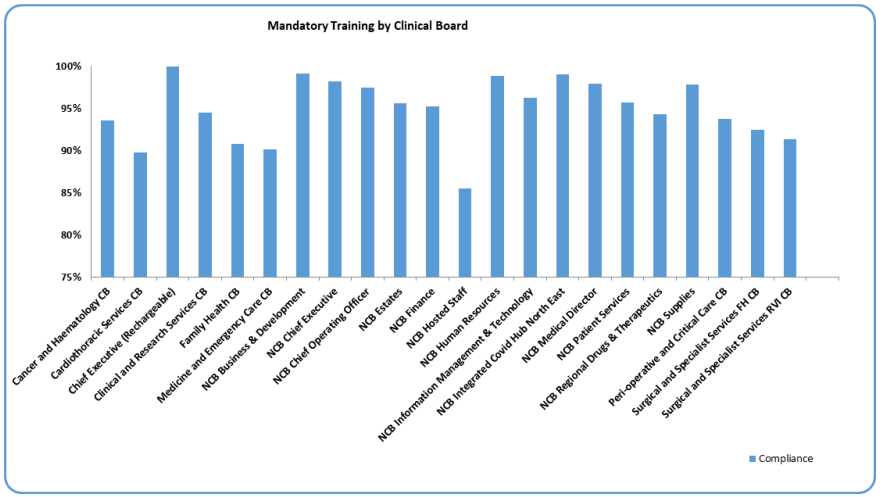
Comparing the periods September 2021 – August 2022 to September 2022 – August 2023, overall bank utilisation increased from 274 wte to 279 wte and agency utilisation has increased from 191 wte to 199 wte.

People: Delivering Excellence in Education & Training







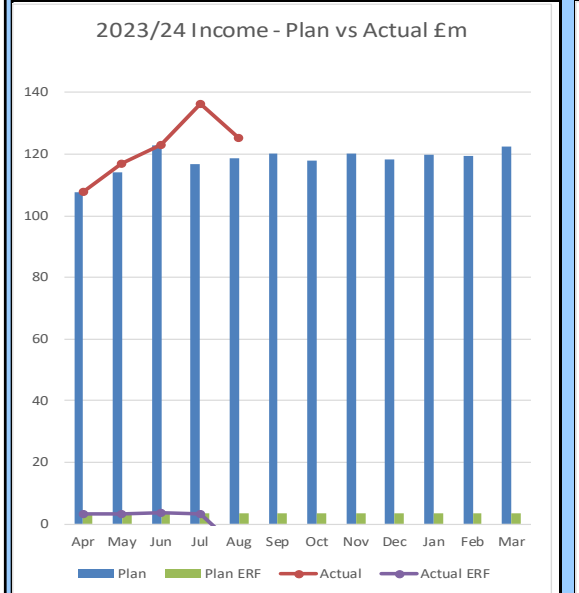


- Mandatory training compliance stands at 92% at end of August 2023, against an end of year target of 95%. The June 2022 position was 87.96%.
- Medical and Dental are the staff group with the lowest training compliance at 80.89% in August 2023 compared to 71.6% in June 2022.
- Appraisal compliance stands at 80.33%, 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.

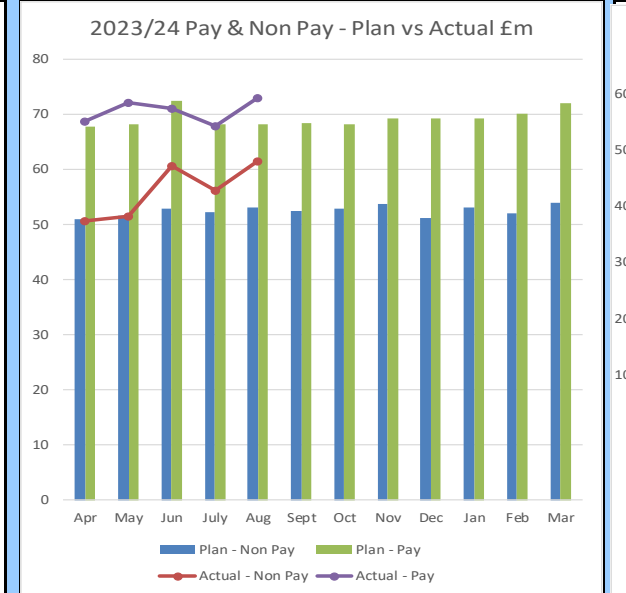
Finance: Overall Financial Position

Financial Overview as at 31st August 2023

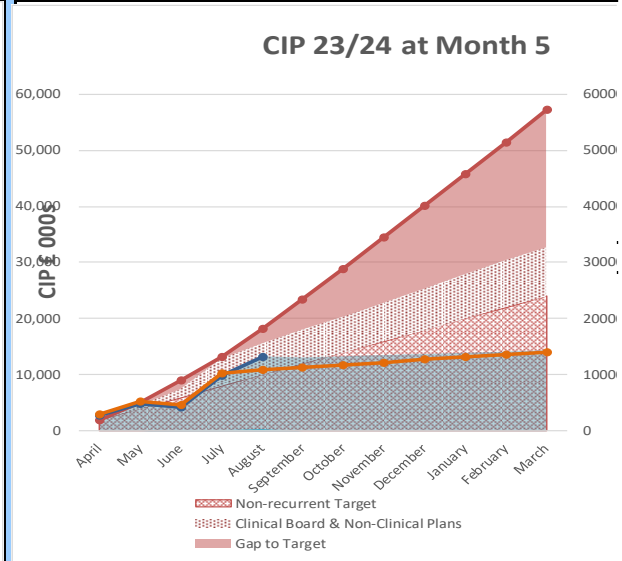
Income



Expenditure



Cost Improvement Analysis



Commentary

This page summarises the financial position of the Trust for the period ending 31st August 2023. The Trust has agreed a Financial Plan for 2023/24 with a break-even position. As at Month 5 the Trust is reporting an adverse variance of £10.9 millions against the agreed Financial Plan. This mainly relates to the financial impact of industrial action that is apparent within the spend trajectory and the impact of showing the adverse effect on delivering the against the ERF. The Trust incurred expenditure of £633 million and received income of £615 million, leaving a deficit of £18.3 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 August is £16.8 million and the year to date expenditure is £6.5 million creating a variance of £10.8 million to date. This is expected to catch up.

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	26 September 2023						
Title	Fit for the Future Programme Update						
Report of	Mr Martin Wilson						
Prepared by	Mrs Kelly Jupp, Trust Secretary						
Status of Report	Public		Private		Internal		
	☒		☐		☐		
Purpose of Report	For Decision		For Assurance		For Information		
	☐		☒		☒		
Summary	In October 2022, following a year long period of engagement and consultation, the Board of Directors approved plans to redesign the clinical management structure within Newcastle Hospitals to ensure the organisation is 'Fit for the Future'. This briefing summarises the progress made up until July 2023.						
Recommendation	The Trust Board is asked to receive the report and note the content.						
Links to Strategic Objectives	Aligned to all strategic objectives.						
Impact (Please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☒	☐	☒	☒	☐	☐	☐
Link to Board Assurance Framework [BAF]	Risk 4050 - CQC 'Well Led' – potential impact on 'outstanding' rating for NHS Trusts.						
Reports previously considered by	New report.						

FIT FOR THE FUTURE PROGRAMME UPDATE

EXECUTIVE SUMMARY

In October 2022, following a year long period of engagement and consultation, the Board of Directors approved plans to redesign the clinical management structure within Newcastle Hospitals to ensure the organisation is 'Fit for the Future'.

In April 2023 we moved from 21 directorates to 8 clinical boards.

This briefing summarises the progress made up until July 2023 and covers:

- Coordination and oversight;
- Recruitment;
- Governance and accountability;
- Monthly Performance Reviews (MPRs);
- Corporate department wrap around support to Clinical Boards; and
- Next steps.

The Trust Board is asked to receive the report and note the content.

Fit for the Future Update
August 2023

1. Introduction

In October 2022, following a year long period of engagement and consultation, the Board of Directors approved plans to redesign the clinical management structure within Newcastle Hospitals to ensure the organisation is 'Fit for the Future'.

In April 2023 we moved from 21 directorates to 8 clinical boards, the purpose being to ensure Newcastle Hospitals are led and organised in the best way to:

- Enhance quality and safety by improving clinical efficiency to provide more planned care and better deal with variation in emergency demand.
- Allow us to work more closely with partners in the health and social care system, in primary and secondary care, to meet care needs earlier, reduce duplication and improve safety.
- Help embed the leadership behaviours that staff say matter to them, namely:
    - More autonomy, control and flexibility over workload - to work smarter, not harder.
    - To feel better involved, included, listened to and engaged in decisions.
    - Physical and psychological safety - to feel safe and supported.
- Enable us to work differently, with a focus on transformation not growth.
- Create development opportunities for talented managers and clinical leaders.

This briefing summarises the progress made up until July 2023.

2. Coordination and oversight

The Fit for the Future process has been carefully managed to support staff and maximise organisational stability during this period of change. 2023/24 is a year of transition as Clinical Boards take on their new roles whilst ensuring the organisation as a whole still delivers on its expectations.

The Implementation of Fit for the Future has been led by the Chief Operating Officer (COO) and the wider Executive Team supported by Margaret Gray, Deputy Chief Operating Officer (DCOO) for Special Projects, overseeing the work. Arrangements included:

- Weekly Project Board meetings to provide executive oversight.
- Weekly Project Team meetings to coordinate and support the co-design of the Clinical Boards.
- Participative workshops to identify key strengths, opportunities, weakness and potential threats in joining together as clinical boards.
- Workshops with senior leaders, supported by Newcastle Improvement, for staff to come together and commence co-designing each clinical board.
- Consultation with operational management staff and opportunities for all directly affected staff to have a 1-1 meeting (as well as group sessions).

3. Recruitment

Appointments have been made to the triumvirate roles in each clinical board, being the Clinical Board Chair (CBC), the Director of Operations (DOps) and the Head of Nursing (HoN).

CBCs were appointed internally to ensure that the right wider clinical leadership structure is in place for the delivery of clinically led patient care that is of exceptional quality with safety paramount.

DOps have been appointed through open external recruitment process with seven of the eight posts appointed internally, reflecting the high calibre of management talent already in the organisation. The DOps took up their roles in April / May 2023.

The HoNs were appointed in June following a consultation with Matrons and the wider senior nursing team led by the Deputy Chief Nurse. The posts were recruited to internally and postholders will formally take up the roles in August.

The wider assimilation of operational managers has been completed successfully. Job descriptions were aligned to ensure consistency across the Trust and some new role titles introduced to ensure clarity and better alignment with peers in other NHS Trusts.

4. Governance and accountability

As part of the restructure the Trust has taken the opportunity to review and refresh its clinical managerial governance structures and to document these in a new Performance and Accountability Framework which has been well received. It sets out the overarching approach to performance management and the accountability arrangements including the hierarchy of meetings, terms of reference for key groups, explains the role of the Trust Board, Governors the CEO and Executive Team and the Clinical Board senior leadership teams. The Performance and Accountability framework will be regularly reviewed with Board oversight.

5. Monthly Performance Reviews (MPRs)

This is the primary means by which the Executive Team holds each Clinical Board and corporate directorate to account for progress against their business plans. They also provide a forum for Clinical Board and corporate directorates to escalate issues to and seek support from the management executive.

The MPRs are chaired by the COO and are attended by executive directors, the CBC, the Dops, the HoN, as well as the finance, information, performance and workforce leads. MPRs focus on five priorities (including any risks associated with each): Quality and safety, People, Performance, Finance and Fit For the Future transition.

The outcomes of each round of MPRs are reported to the Executive Team and at least twice per year to the Board.

6. Corporate department wrap around support to Clinical Boards

All corporate services that provide wraparound support to the CBs are completing a programme of work that will see a different way of working with the operational services. The models of support have been developed in partnership with Clinical Boards through a series of workshops and engagement events. In Summary:

a. People Directorate

The Leadership development programme will be widened out with the intention to offer the CBCs a programme of education that supports their development.

A series of workshops are planned from September 23 led by the People team with support from Newcastle Improvement. The initial aims being to i) support the development of the Clinical Board workforce plans to ensure that they understand their workforce requirements (numbers and skills), where the likely gaps might be with a clear training and recruitment plan; and ii) to conduct a stocktake of current people activities within the Clinical Board against the 7 people promises and utilise this 'base line assessment' to shape future engagement/deliverables.

b. Finance

A significant amount of work has been undertaken with regards to Financial Management and reporting to ensure that budgets are realigned to Clinical Boards (CBs) along with the associated interfaces.

To facilitate the CB's to manage their financial plans work is underway to refresh financial management information, update financial governance documentation (e.g. the Scheme of Delegation) and ensure appropriate alignment of finance staffing resource to the CBs.

c. Business and Development and Enterprise (BD&E)

BD&E have reviewed their structures in order to realign themselves to the CB's and are liaising with each CB to provide clarity on support, capacity and expectations, review meeting and reporting requirements and to support the success of the MPR cycle.

The Enterprise team are keen to improve integration and understanding of how the CB's can be supported to explore opportunities for commercial investments.

d. Information Management and Technology (IM&T)

In preparation for the introduction of the Fit For the Future management restructure IM&T have undertaken a significant amount of work in the background to understand what the system requirements for each of the CB's will be in the initial development phase in 23/24 and the next 5 years.

A workshop will be held in September with the key leaders in each board along with the digital team and the clinical champions, this will feed into a further piece of work regarding the Optimisation of the Electronic Patient Record, which is key to supporting the transformation and improvement of patient pathways and outcomes.

e. Quality and Safety (Q&S) Governance Framework

The Associate Medical Director (AMD) for Q&S Gus Vincent and Angela O'Brien, Director of Quality and Effectiveness, have undertaken a comprehensive piece of work to ensure that the Q&S governance structures in the Trust are realigned and fit for purpose. This included holding a workshop in June with key stakeholders to co-design how Q&S would be structured in the CB's and then escalated through the overarching governance structure and developing a Quality Oversight Framework for CBs which provides a standardised approach to Q&S (covering four main areas, being Patient Safety, Clinical Effectiveness, Patient Experience and Quality Improvement).

7. Next steps

The Fit for the Future Project will continue throughout 2023/24 as the new clinical management structure is embedded.

In August 2023 Margaret Gray will retire and her responsibilities for supporting the COO in overseeing implementation and assuring progress will be taken on by Kelly Jupp, Trust Secretary as part of her governance remit.

The project will continue to be monitored with regular reporting to the Executive Team as well as updates to the Trust Board. In addition regular Project Team and Executive Oversight Group arrangements will continue until the CBs are fully embedded/operating as 'business as usual'.

Margaret Gray, Deputy Chief Operating Officer – Special Projects
Martin Wilson, Chief Operating Officer
11th Aug 2023

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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
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			19.09.23 - Discussed at the Well Led meeting on 14 July 2023 and briefing document shared in the Trust Board Teams Group. Propose close action.
103	27 July 2023	PUBLIC	23/14 STRATEGIC ITEMS a. Digital People Story	Mrs Bromley queried if the Trust collates data from the project to demonstrate a positive impact in reducing the number of infections. The ECN confirmed that this is part of the process and the project has been highlighted in recent learning and sharing events. She agreed to share the data/information available [**ACTION01**].	MC			19.09.23 - Information included in the Chair and NED update email circulated on 22 September 2023. Propose close action.
104	27 July 2023	PUBLIC	23/14 STRATEGIC ITEMS c. Partnerships: Partnerships update	Mr Jowett queried what services sit under 'quaternary' to which the COO confirmed that he will share a breakdown of the tertiary and quaternary services. He noted that 20% of beds are occupied by tertiary and quaternary services **[ACTION02].**	MW			19.09.23 - KJ circulated to the Non-Executive Directors on 18 August 2023 as part of the weekly NED update. Propose close action.
105	27 July 2023	PUBLIC	23/14 STRATEGIC ITEMS c. Partnerships: Partnerships update	The CEO suggested that the Collaborative Newcastle plan be discussed in more depth at a future Board Development Workshop [**ACTION03**].	MW/KJ			19.09.23 - MW and KJ to agree which Board Development session date will be the most appropriate for the Collaborative Newcastle plan discussion (pencilled in for the December session).
106	27 July 2023	PUBLIC	23/14 STRATEGIC ITEMS d. Performance: Performance Report	The COO confirmed that he will share a breakdown of services provided by Community Services or bring members of the Family Health Clinical Board to a future Board/Board Development session to provide a service overview [**ACTION04**].	MW/VMR			19.09.23 - KJ circulated to the Non-Executive Directors on 18 August 2023 as part of the weekly NED update. Propose close action.
107	27 July 2023	PUBLIC	23/14 STRATEGIC ITEMS e. People: Industrial Action	Miss Smith said that it would be useful to see examples of learning from the periods of industrial action, potentially at a future Board Development session. The MD/DCEO confirmed that the Trust is actively reviewing lessons learned and it was agreed that feedback in relation to lessons learned would be circulated in a short briefing to the Board members [**ACTION05**].	AW			19.09.23 - Propose to discuss as part of a future Board Development session (date to be agreed).
108	27 July 2023	PUBLIC	23/15 BUSINESS ITEMS a. Medical Directors report	Ms Baker sought clarification with regards to the timeline for the Mental Health strategy production. The MD/DCEO advised that a timeline is currently being established taking into account the extent of the staff and patient input required and agreed to share the timeline separately [**ACTION06**].	AW			19.09.23 - AW confirmed that the strategy is currently under development and will be available by the end of the year (the operational strategy draft will be produced by the end of October 2023). Propose close action.
109	27 July 2023	PUBLIC	23/15 BUSINESS ITEMS c. Director of Quality & Effectiveness CNST Quarterly report	The ACE advised that a fully updated report against the new CNST requirements will be presented at the September Quality Committee and Board meetings [**ACTION07**].	KJ			19.09.23 - CNST report added to the September Quality Committee and Public Trust Board agendas. Propose close action.

Log No.	BOARD DATE	PRIVATE / PUBLIC	AGENDA ITEM	ACTION	ACTION BY	Previous meeting status	Current meeting status	Notes
110	27 July 2023	PUBLIC	23/16 ITEMS TO APPROVE a.Standards of Business Conduct including fit and proper persons statement	The ACE referred to the Disclosure and Baring Checks (DBS) which are carried out once on appointment within Newcastle Hospitals. She highlighted that discussions are taking place nationally in relation to the guidance regarding the frequency of undertaking such checks and the ACE and CPO will meet to discuss further and to ensure all guidance is being considered [**ACTION08**].	CD/CB			19.09.23 - Meeting held between the CPO and ACE. Fit and Proper Persons Test Framework report added to the agenda for the September Public Board meeting. Propose close action.

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.