The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	30 November 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]	SO1.4 [high quality safe care] Ensuring the Trust is sufficiently staffed to meet the demands of the organisation.						
Reports previously considered by	Consultant Appointments are submitted for information in the month following the Appointments Panel						

CONSULTANT APPOINTMENTS

1. APPOINTMENTS COMMMITTEE – CONSULTANT APPOINTMENTS

1.1. Appointments Committees were held between 10 September 2023 and 13 October 2023 and by unanimous resolution, the Committees were in favour of appointing the following:

Appointed	Job title	Start Date
Miss Jane Kerby	Consultant Cleft Surgeon	30-Oct-23
Dr. Rania Showeil	Consultant Cellular Pathologist	11-Dec-23
Dr. Andrea Glover	Consultant Orthodontist	01-Jan-24
Dr. Laurentiu Craciunas	Consultant in Reproductive Medicine and Gynaecology	08-Jan-24
Dr. Laura Proctor	Consultant Cellular Pathologist	28-Feb-24
Dr. Matthew Kerr	Consultant Paediatric Anaesthetist	01-May-24
Miss Andrea Pujol Nicolas	Consultant Orthopaedic Surgeon - Foot & Ankle	01-Aug-24
Dr. Hannah Billett	Consultant in Palliative Medicine	06-Jan-25

2. RECOMMENDATION

1.1 – For the Board to receive the above report.

Report of Andy Welch
Medical Director
30 November 2023

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	30 November 2023						
Title	Emergency Preparedness, Resilience & Response (EPRR) Annual Report						
Report of	Andy Welch, Accountable Emergency Officer						
Prepared by	Michael Clark, Head of Emergency Preparedness, Resilience & Response (EPRR)						
Status of Report	Public		Private		Internal		
	☒		☐		☐		
Purpose of Report	For Decision		For Assurance		For Information		
	☐		☒		☐		
Summary	NHS England requires NHS organisations, and providers of NHS-funded care, to provide annual assurance of readiness against the Core Standards for Emergency Preparedness, Resilience & Response (EPRR). The content of this report outlines the Trust's position regarding the annual EPRR Core Standards self-assessment and progress with the EPRR Work Programme.						
Recommendation	The Board of Directors is asked to: i) Note progress made over the last year on the EPRR Work Programme in planning, training and exercising as well as the successful response to incidents as detailed within this paper; ii) to be cognisant of significant change to this year's EPRR Core Standards assurance process and the accept the assessment of 'Partially Compliant', with an action plan to achieve Full Compliance; and iii) support the Head of EPRR in addressing the priority areas requiring action as outlined in Section 7.3 of this report.						
Links to Strategic Objectives	Putting patients first and providing care of the highest standard focussing 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. The Trust is required to meet legislative duties set out in the Civil Contingencies Act 2004.						
Reports previously considered by	The EPRR Report and Core Standards Self-Assessment is submitted annually to Trust Board.						

EMERGENCY PREPAREDNESS, RESILIENCE & RESPONSE (EPRR) ANNUAL REPORT – APRIL 2022 TO SEPTEMBER 2023

1. INTRODUCTION

The Civil Contingencies Act 2004 (CCA) (UK Government, 2004) imposes a statutory duty on Newcastle Upon Tyne Hospitals NHS Foundation Trust (the Trust) to have in place arrangements to respond to incidents and emergencies. Under the terms of the CCA the Trust is a Category 1 Responder. This places a statutory duty upon the Trust to be able to respond to internal or external disruptive events that might impact on the Trust's ability to deliver its services.

The CCA also places other duties on Category 1 responders, including the requirement to:

- Assess the risk of emergencies occurring and use this knowledge to inform contingency planning.
- Ensure emergency plans and business continuity management arrangements are in place.
- Communicate with the public to ensure they are warned, informed and advised in the event of an emergency.
- Share information and cooperate with other local responders to enhance co-ordination and efficiency.

The NHS Emergency Preparedness, Resilience and Response (EPRR) Guidance (NHS England, 2015) requires the Trust to:

- Have suitable and up-to-date incident response plans which set out how the Trust would respond to and recover from a major incident (MI)/emergency which is affecting the wider community or the delivery of services; and
- Have business continuity plans that enable the Trust to maintain or recover the delivery of critical services in the event of a disruption.

The minimum requirements which the Trust must meet regarding EPRR are set out in the NHS England Core Standards for EPRR (Core Standards). These standards are in accordance with the CCA 2004 and the NHS Act 2006 (as amended). The standards are published annually, and the Trust undertakes a self-assessment against these standards as part of the annual national assurance process and submits results to the Board for approval along with a summary of EPRR activities in the preceding 15 months.

The timeframe referred to in this report will cover April 2022 to September 2023 to allow for a shift in reporting period from next year. Moving forward, the Trust board reports will cover 12-month periods, running from September to September.

1.1 Purpose of Paper

This paper is intended to update the Board on progress with the Trust's compliance level with the NHS England's (NHSE's) EPRR Core Standards and other statutory requirements placed upon the Trust by the CCA (2004) and the NHSE EPRR Framework. It will also provide

the Board with an update on the progress made with the EPRR Work Programme and other activities undertaken by the department in the preceding 15 months. As such, it will summarise:

- The governance arrangements supporting EPRR.
- Details of the meetings held to support EPRR.
- Development and reviews of the Trust's emergency plans and business continuity plans.
- Training & exercising undertaken to embed and test plans.
- Any business continuity, critical incidents and major incidents experienced by the organisation.
- Lessons identified and learning undertaken from such incidents and exercises; and
- The annual national assurance process for EPRR.

2 GOVERNANCE

2.1 Executive Director & Accountable Emergency Officer (AEO)

Andy Welch, the Trust's Medical Director is the designated Accountable Emergency Officer (AEO) for EPRR and has delegated responsibility for ensuring that the Trust is in a position to provide assurance that it has in place the necessary EPRR Framework. The Accountable Emergency Officer for EPRR is also a member of the Trust Board and chairs the EPRR Strategy Group.

2.2 Non-Executive Director

A non-executive director has been appointed by the Board to endorse assurance to the Board that the organisation is meeting its obligations with respect to EPRR and the Civil Contingencies Act. This supporting role also seeks assurance that the organisation has allocated appropriate resources to meet these requirements, including the support of properly trained and competent emergency planning officers and business continuity managers as appropriate. The appointed non-executive director for EPRR is Mr Bill MacLeod.

2.3 Resources

The Trust's EPRR function is delivered by the EPRR Team, made up of the Trust Head of EPRR and the EPRR Coordinator. Recent long-term sickness affecting both the EPRR Team, and the wider Organisational Resilience Team has posed significant challenges in service delivery for both EPRR and Patient Flow. This is discussed in greater depth in Section 7.3.

2.4 Emergency Preparedness, Resilience and Response (EPRR) Strategy Group

Designated leads, responsible for the EPRR work programme of their respective committee, provide reports to the EPRR Strategy Group – see diagram below.

Diagram 1 – Newcastle Hospitals EPRR Committee Structure

The EPRR Strategy Group meets quarterly to direct and oversee both Emergency Planning and Business Continuity Planning on behalf of the Trust Board.

Within the Trust's Fit for the Future restructure process, the EPRR Team will now sit within Clinical & Research Services (Board 8). This does not change line management, which will remain under the Associate Director of Operations, nor will it change professional accountability, which will remain with the Medical Director as AEO.

2.5 Risk

Risk assessment of threats and hazards which affect or may affect the ability of the organisation to deliver its critical functions is undertaken annually and compiled on the EPRR Risk Register. This is monitored quarterly by the EPRR Strategy Group.

The EPRR Risk Register takes account of Local Resilience Forum community risk registers and includes reasonable worst case scenarios specific to the Trust in the following areas:

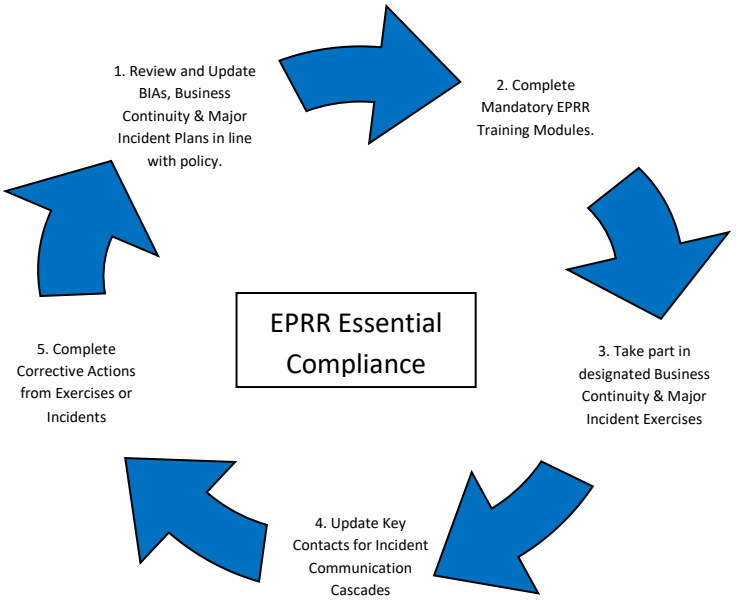
- Severe weather
- Staff absence including industrial action
- The working environment, buildings and equipment (including denial of access)
- Fuel shortages
- Surges and escalation of activity
- IT and communications downtime
- Utility failure
- Response to a major incident / mass casualty / Chemical, Biological, Radiological and Nuclear (CBRN) event
- Supply chain failure
- Associated risks in the surrounding area (Control of Major Accident Hazards (COMAH) sites)
- Internal risks (flooding etc.)

Actions to mitigate the assessed risks where required are agreed and form part of the EPRR Work Programme.

The EPRR Risk Register was updated in April 2023 to reflect the change in likelihood of a significant staffing shortage caused by industrial action. The mitigation measures were also updated to reflect the processes that were implemented to manage this.

2.6 Policy Updates

In August 2023, the Trust's EPRR Policy underwent significant changes to improve the level of assurance available corporately that services are prepared to deal with disruptive incidents. The introduction of the EPRR Essential Compliance Cycle represents the most significant change to the way the Trust manages and tracks progress against business continuity, major incident planning, training and exercising. The concept of a cycle is at the heart of both business continuity and emergency management, so it is natural that this process should be effectively embedded into an organisation's own resilience function.
At Corporate level and within each Clinical Board, the EPRR Essential Compliance Cycle (ECC) outlines the Key Performance Indicators (KPIs) to ensure the Trust remains compliant with the EPRR policy. The Cycle consists of five core tasks that Clinical Board Directors of Operations, Associates & Departmental Managers, supported by BCROs and MIRO's, must complete on an annual basis. These are outlined in the diagram below:



Clinical Boards and their sub-specialties, as well as Corporate & Support Services will be monitored against their compliance with each of these key performance areas to provide assurance that the EPRR programme is being embedded sufficiently within the organisation. Rather than solely tracking the number of plans that are up to date, moving forwards, EPRR compliance will be reported to the relevant committees in this new format that takes account of each stage of the cycle. This will happen quarterly to the EPRR Strategy Group and Compliance & Assurance Group as well as annually to the Trust Board, starting in 2024.
The Trust Business Continuity Management Policy was updated in August 2023 to apply improvements to the planning process that had been identified during the last round of exercises in winter 2022/23. The policy now outlines a need to identify minimum business continuity objectives and work area recovery locations.

The policy has also changed the review timeframe of service plans to reflect the level of criticality each plan contains – those plans that are for the most critical areas need to be updated annually as is already the case, but those area with less critical services now need to be updated every two or every three years.

2.7 Meetings & Groups

Through the year April 2022 to September 2023, all sub-groups for EPRR met as scheduled. The exception to this was a cancellation of one Major Incident Planning Group meeting in March 2023, due to the meeting coinciding with a period of junior doctors' industrial action (IA), meaning many attendees were working clinical shifts.

	EPRR Strategy Group	Business Continuity Operational Group	Major Incident Planning Group
2022/23 – Q1	05/04/2022	17/05/2022	28/07/2022
2022/23 – Q2	05/07/2022	16/08/2022	22/09/2022
2022/23 – Q3	04/10/2022	15/11/2022	14/12/2022
2022/23 – Q4	10/01/2023	21/02/2023	Stood down due to IA
2023/24 – Q1	25/04/2023	23/05/2023	18/07/2023
2023/24 – Q2	15/08/2023	26/09/2023	28/09/2023

3 PLAN UPDATES

As means of mitigation to items identified on the EPRR Risk Register, the Trust has developed both generic, all-hazard plans that cover a wide variety of potential disruptions, and hazard-specific plans for risks such as severe weather and downtime.

Documents	Objective of the Document	Status
All-Hazard Plans & Policies		
EPRR Policy	Sets out an all-hazard EPRR framework and strategic direction for the Trust.	Version 4 – updated in September 2023.
Business Continuity Management Policy	Outlines how the Trust plans for business continuity incidents.	Version 7 – updated in September 2023.
Incident Response Plan	Outlines how the Trust responds to business continuity or critical incidents. Replaces Section Two of Business Continuity Management (BCM) Policy.	Version 1 – completed in April 2023.
Major Incident Plan	Outlines how the Trust co-ordinates its response to a Major Incident (including mass casualty events).	Version 8 – up to date as of April 2023.
Hazard Specific Plans & Policies		

Lockdown Policy	Covers how a Trust owned and leased building / sites would be locked down and controlled.	Version 3 – updated in September 2023.
Full-site Evacuation Plan	Outlines the process for the evacuation and onward transfer of patients from an entire hospital site.	Version 1.1 – no changes required after national guidance issued.
All Hazard Severe Weather Plan	Outlines procedures for the response to multiple severe weather hazards.	Version 1 – up to date as of July 2023.
eRecord Downtime Incident Response Plan	Outlines the process for planning for and responding to the loss of the electronic patient record system.	Version 2 – up to date as of July 2023.
Telephony Downtime Plan	Outlines the procedures for the management of a loss of any aspect of the Trust telephony system.	Version 2 – up to date as of November 2022.
Trust Pandemic Plan	Outlines the procedures required in planning for and responding to a pandemic.	Version 3 – this has now been superseded by the Pandemic Flu Plan – signed off in October 2023.
Emergency Department (ED) CBRN Plan	Outlines the procedures for the management of patients contaminated with a chemical, biological, radiological or nuclear agent.	Version 7 - signed off in September 2023.
High Consequence Infectious Disease (HCID) Policy & Action Cards	Outlines the procedures for the management of patients admitted to the Trust with a HCID.	Version 4.0 - Up to date as of April 2023.
Crisis Management & Incident Communications Plan	Outlines how the Trust will communicate internally and externally in the event of an incident or emergency.	Version 1 – signed off in July 2023.

4. TRAINING & EXERCISING

As a Category 1 responder, the Trust must carry out training and exercising of our emergency plans and contribute towards collaborative exercising of local partner agencies' emergency plans. Exercises provide an opportunity for wards, departments, and clinical leaders at operational, tactical and strategic level to test readiness to respond to incidents.

4.1 EPRR Exercises

The Trust is required under the NHS England EPRR Framework to undertake the following exercises:

TYPE OF EXERCISE	COMPLIANCE
An annual command post exercise	**FULL** ICC Training

	(Held on 15/11/2023)
An annual desktop exercise (317EPRR36/37)	**FULL** Cyber Security Exercise (Held on 11/05/2023)
Hold a six-monthly communication exercise (317EPRR19)	**FULL** Major Incident Comms Exercise (Held on 21/09/2023)
Hold a three yearly live or simulated exercise (317EPRR11)	**FULL** Exercise Northern Bridge (Held on 14/05/2023)

In addition to the requirements of the NHS England EPRR Framework, the Trust EPRR Policy outlines internal exercising requirements. Under the NHS England EPRR Framework (2022), if an organisation activates its plan for response to a live incident, this replaces the need to run an exercise, providing lessons are identified and logged.

EXERCISE CATEGORY	COMPLIANCE
Directorate Level Business Continuity Exercise (317EPRR09)	**PARTIAL** EPRR Strategy Group took decision to defer requirement in lieu of managing Industrial Action.
Directorate Level Major Incident Exercise (317EPRR10)	**FULL** Exercise Northern Bridge (Held on 14/05/2023)
Corporate Business Continuity Exercise (317EPRR36)	**FULL** Exercise Pink Panther - Cyber (Held on 11/05/2023)
Corporate Major Incident Exercise (317EPRR37)	**FULL** ICC Training (Held on 08/12/2021)

4.2 Exercise Northern Bridge - Live Major Incident Exercise (May 2023)

In May 2023 we ran the largest simulation exercise the Trust has seen as part of a test of our Major Incident Plan. Over 100 staff from across the Trust took part, as well as a number of volunteers from Newcastle University Medical School acting as simulated casualties. The fictitious scenario saw our clinical teams treat 25 casualties from a major rail disaster over two challenging hours. Feedback from the exercise was extremely positive from all involved. A total of 18 recommendations were outlined and approved by the EPRR Strategy Group, a selection of these is outlined below and full version of the post-exercise report is available upon request:

- Review the Trust EPRR Training Needs Analysis to ensure that there is a wider knowledge of incident management and civil contingencies for key staff groups.
- Align the major incident plans across Peri-op, critical care, general and orthopaedic surgery.
- Explore the possibility of moving the overflow area for P3 casualties from the Dental Hospital to Fracture Clinic by working with the relevant clinical teams.

- Expand the availability of the MAJAX Patient List within eRecord so that this can be viewed within the Incident Command Centre (ICC).

4.5 EPRR Mandatory Training

The Trust EPRR Policy and Training Needs Analysis mandates four specific sessions that staff must undertake depending on their roll.

TRAINING	COMPLIANCE
317EPRR03 – Annual Incident Simulation Exercise (On-call Team)	95%
317EPRR04 – Corporate On-call Training	100%
317EPRR06 – Business Impact Assessment	91.2%
317EPRR14 – How to work with your Loggist	93.6%
317EPRR16 – CBRN Awareness	90.9%
317EPRR30 – Principles of Health Command – Strategic	59%
317EPRR31 – Principles of Health Command – Tactical	75%

A project is underway with the team from Technology Enhanced Learning to improve the EPRR e-Learning packages as well as adding further courses to the Learning Lab so that the department can improve the tracking and reporting of attendance at training courses, thereby giving the Board greater assurance that the Trust is prepared to manage a range of incidents.

5 INCIDENTS & CONTINUAL IMPROVEMENT

5.1 Queen Victoria Road Gas Leak (September 2022)

On the morning of 8 September 2022 workers hit a gas main on Queen Victoria Road, causing significant damage to the mains gas pipe. This was attended by the Police and Fire service who put a 100-meter cordon in place. Pharmacy production unit, Estates and Catering were subsequently evacuated, there was also no access to the multi storey carpark for staff or patients as this was also within the 100-meter cordon.

A number of lessons were identified, and an action plan was developed. The action plans was reported to the EPRR Strategy Group to monitor progress on implementing the recommendations. These related to:

- Communication with the incident scene and multi-agency partners;
- Improving business continuity plans to identify alternative workplace locations; and
- Designation of staff and public welfare points for use during an incident.

5.2 eRecord Downtime (September 2022)

On the morning of the 13 September there was an issue of overheating in the server room causing the server to go off. The systems on this server should have switched over to using a server at another site but this failed and did not switch across. The main systems affected by this were PACS, RIS, CapMan, Netcall and eRecord. During the course of the day eRecord

and Netcall services were restored, with PACS, RIS and CapMan still having issues. By early evening PACS and RIS were restored, leaving CapMan still experiencing problems. From 8pm onward further issues with eRecord resulted in a full downtime process being implemented. Issues with eRecord continued into the following day and were finally restored around 5.30pm, with CapMan being fully restored the following morning of the 15 September. An operational debrief identified a number of recommendations that have been implemented by the EPRR & Information Management & technology (IM&T) Teams:

- Improving the ways of communication to ensure the message reach clinical teams wards quicker.
- Improving training for staff in use of downtime procedures and providing clearer process/action cards.
- Improving the monitoring of systems so that incidents can be discovered in their early stages.

5.3 Industrial Action (December 2022 to October 2023)

Following multiple rounds of industrial action from December 2022 to May 2023 a review took place ahead of anticipated consultant action in the Summer of 2023. Overall, the Trust's response to Industrial Action was seen as broadly positive and effective. The main positives related to the effectiveness of the planning and preparation, particularly the engagement with senior nursing staff and operational teams across the Trust, allowing clinical boards to effectively make their own plans for their own areas. The following recommendations were put forward and approved by the EPRR Strategy Group:

- Develop a framework for industrial action that clearly sets out decision points relating to the elective programme and when communications will be issued.
- Develop an outline agenda for operational planning calls and establish an Action Log where asks of operational teams are captured, tracked and revisited.
- Encourage a level of subsidiarity by devolving some decisions to clinical boards to manage their own planning for industrial action.
- The Senior Nursing Team should consider running sessions that directly engage with junior nursing staff. These sessions should cover what work is being done corporately to prepare for the industrial action as well as expectations of staff should safety critical mitigations be granted at a late stage.
- Establish a clear position with operational teams early in the planning process that manages expectations regarding the likely fluid nature of the planning process as guidance changes at short notice, or a regional or national position changes with the Royal of College Nursing (RCN), NHS England or the North East & North Cumbria (NE&NC) Integrated Care Board (ICB).
- With a view to achieving more robust and accurate regional messages, the Trust should seek to engage members of the NE&NC ICB EPRR Team to ensure that all Trust Communications Teams are represented on planning calls, and that communications has a regular slot on the agenda at these meetings.

5.4 High Consequence Infectious Diseases

Through 2022 and early 2023, the Trust's HCID unit was put on alert for two potential HCID incidents - these included Lassa Fever and Middle East Respiratory Syndrome (MERS). No confirmed cases were admitted to the Trust, but the Infectious Diseases Team took the opportunity to train new staff and familiarise others with procedures.

A scheduled closure of the Ward 19 Trexler Unit from June to September 2023 occurred to allow for essential maintenance work is carried out. Following the successful recommissioning of the unit, the UK's primary unit at the Royal Free in London was shut down for maintenance, meaning that the RVI was the primary receiving unit for Contact HCID patients from 09/10/23 to 06/11/23.

6 EPRR KEY PRIORITIES FOR 2023 – 2024

- Adress gaps in compliance against EPRR Core Standards.
- Undertake a demand v capacity assessment for EPRR to evidence resource requirements.
- Embed Corporate On-call Framework and roll-out regional version of Health Commander Portfolios for On-call Team.
- Move all EPRR Training & Exercise Modules on LLL to improve tracking and reporting of compliance.
- Redesign existing and develop new EPRR Training modules with the Technology Enhanced Learning Team.
- Work with both Trust and ED Clinical Leads for MI Planning to improve training compliance with CBRN modules to ensure sufficient staff trained to cover every shift.
- Deliver x1 HMIMMS Course for Clinical Staff.

7 NATIONAL ASSURANCE PROCESS

7.1 EPRR Assurance 2023/24

The annual national assurance process for EPRR was issued in May 2023, with a deadline of 29 September. Following an update to the Core Standards in 2022 which saw the creation of new standards and amendment to the evidence criteria for a number of other standards, the Trust was able to score 'Partially Compliant'. An action plan was put in place to address gaps which has improved the Trust's level of preparedness over the last 12 months.

The process for 2023 has undergone further changes, with new guidance received from the NHS England Area Team regarding the evidence criteria required to achieve compliance with individual standards. Furthermore, this year's process also requires the submission of evidence for review, rather than solely being a self-assessment process. In September 2023, the AEO for the NE&NC ICB wrote to Trust AEOs and CEOs categorising the process as a re-basing of the standards and preparing Boards for a significant fall in compliance across the region – this letter is available in Appendix A.

Following consultation with the Trust's AEO, the Head of EPRR has undertaken a thorough and reflective self-assessment of the Trust's position in relation to compliance against this

year's EPRR Core Standards. This self-assessment was reviewed by NHSE, with comments provided and the Trust required to provide further evidence to justify the self-assessment position. Following the provision of this supplementary evidence final comments were received from NHSE and the Trust asked to come to a final compliance position. The process and these comments are outlined in full in a separate document, available for Board members on request.

Overall EPRR Assurance Rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are required to achieve.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve.

7.2 Compliance Position

The tables below summarise the current Trust compliance position against all relevant domains within the 2023/24 Core Standards.

Following the completion of the self-assessment process, the Trust is **Partially Compliant.**

Percentage Compliance	77%
Overall Assessment	Partially Compliant

Domain	Total Applicable Standards	Fully Compliant	Partially Compliant	Not Compliant
Governance	6	5	1	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	11	7	4	0
Command and control	2	1	1	0
Training and exercising	4	2	2	0
Response	7	7	0	0
Warning and informing	4	4	0	0
Cooperation	4	3	1	0
Business continuity	10	9	1	0
CBRN	12	8	4	0

Total	**62**	**48**	**14**	**0**

7.3 Priority Areas for Action

Following comments from NHSE, the Head of EPRR has outlined the following priority areas as needing action. Comments also highlighted other areas to improve, but these already have action plans in place to address compliance.

i) There is a National requirement for the Board/Governing body to be satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties. No evidence has been provided that the resources available to the Trust are sufficient as outlined via a capacity versus demand assessment.

ii) The Trust needs to review the list of staff who are trained and safe to work in PRPS suits as the recertification period for PRPS is 1 year. The number of staff trained within the Emergency Department needs to be increased to ensure there are sufficient numbers of staff on every shift to maintain the operational decontamination requirement.

iii) Hazmat/CBRN risks, inclusive of the process by which these are managed through internal governance, should be reviewed and updated on the EPRR risk register.

iv) There is a national requirement for organisations to undertake training for ALL staff who are most likely to come into contact with potentially contaminated patients and those requiring decontamination. A risk assessment and increased training needs to be provided for areas that could come into contact with contaminated patients.

v) The organisational Mass Countermeasures/Prophylaxis Plan is out of date and needs to be reviewed following the delivery of the regional COVID vaccination programme.

vi) There is a need to update the Mass Casualty Annex in Major Incident Plan to specifically outline casualty dispersal figures and measures that need to be taken with the Trust to achieve the requirements of the Regional Mass Casualty Framework.

vii) National requirement is for the AEO, or a director level representative with delegated authority to attend the LHRP. This includes a requirement for AEO or Director level representatives to attend 75% of LHRPs, with the AEO needing to attend at least 1 as a recommendation from the Manchester Arena Inquiry. Evidence provided by the Trust and ICB indicate that all LHRP meetings have been attended by the EPRR team.

8. RECOMMENDATIONS

The Board are invited to:

i) Note progress made over the last year on the EPRR Work Programme in planning, training and exercising as well as the successful response to incidents as detailed within this paper;

ii) Be cognisant of significant change to this year's EPRR Core Standards assurance process and the accept the assessment of 'Partially Compliant,' with an action plan to achieve Full Compliance; and

iii) Support the Head of EPRR in addressing the priority areas requiring action as outlined in Section 7.3 of this report.

A R Welch FRCS
Medical Director/ Deputy Chief Executive Officer
20 November 2023

Annex A – Letter from NE&NC ICB AEO outlining changes to the EPRR core standards assurance process

Annex B – EPRR Core Standards Self-Assessment Spreadsheet

NHS
North East and North Cumbria

To: NENC ICB Trust Chief Executives and Accountable Emergency Officers
Cc: Emergency Planning Managers

Via email

North East and North Cumbria Integrated Care Board
Pemberton House
Colima Avenue
Sunderland Enterprise Park
Sunderland SR5 3XB

29 September 2023

Dear Colleagues

CHANGES TO THE EPRR CORE STANDARDS ASSURANCE PROCESS

NHS England Core Standards for Emergency Preparedness Resilience and Response (EPRR) sets out the minimum standards which NHS organisations and providers of NHS funded care must meet. Annually, these providers and their Integrated Care Boards (ICBs) complete a self-assessment as part of the process to assess their degree of compliance with these standards. This assurance process is led nationally and regionally by NHS England and locally by ICBs.

You will be aware that the annual assurance process is underway with the initial self-assessment of compliance levels having been submitted by 29 September.

I wanted to make sure you are sighted on the significant changes that the North East and Yorkshire NHSE team made to the assurance process this year, as they may have an impact on your Trust's reported level of compliance.

Previously Trusts were required to provide a RAG-rating for each applicable standard and comments on the evidence that supported this assessment. This year the process has been revised, requiring the submission of actual evidence via a national portal. The evidence will then be reviewed by a regional panel and may be subject to challenges and requests for supplementary evidence.

This is a more rigorous process which should support more reliable assurance and point up areas for further work to strengthen arrangements. We are cognisant that this level of rigor is particularly important in light of the recent recommendations from the public enquiries into Manchester Arena and the Grenfell Tower fire.

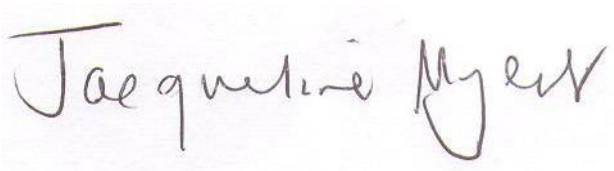
In the short term, however, reported compliance levels are likely to fall. When this process was piloted in the Midlands Region in 2022, 66% of organisations reported a reduction and only 2% an improvement on their previous assessments.

It is important then that we regard this year's assurance process as, in effect, a re-basing of organisations' self-assessments. You may wish to draw these changes to the attention of your Board so they have context for any material changes to your assurance rating. I will be similarly briefing the ICB Board to this effect.

Our EPRR Team will continue to work collaboratively with you and your EPRR leads to ensure that as an ICS we can effectively respond to major, critical and business continuity incidents whilst maintaining services to patients over the coming months. If you wish to discuss any elements of this letter, please do get in touch.

Finally the ICB EPRR and Executive Team recognise, and are extremely grateful for, the professional and diligent work that your EPRR leads and teams are undertaking at a time when their capacity is severely stretched as a result of other demands, in particular the ongoing industrial action.

Your Sincerely



Jacqueline Myers
Executive Chief of Strategy and Operations

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	30 November 2023						
Title	Executive Chief Nurse (ECN) Report						
Report of	Maurya Cushlow, Executive Chief Nurse						
Prepared by	Ian Joy, Deputy Chief Nurse Diane Cree, Personal Assistant						
Status of Report	Public		Private		Internal		
	☒		☐		☐		
Purpose of Report	For Decision		For Assurance		For Information		
	☐		☐		☒		
Summary	This paper has been prepared to inform the Board of Directors of key issues, challenges, and information regarding the Executive Chief Nurse areas of responsibility. The content of this report outlines: • Spotlight on our Nursing, Midwifery and Allied Health Professionals Strategy – One year on • Patient Experience Quarter 2 (Q2) Summary • Safeguarding and Mental Capacity Act (Q2) Summary • Learning Disability Q2 Summary						
Recommendation	The Board of Directors is asked to note and discuss the content of this report.						
Links to Strategic Objectives	• Putting patients at the heart of everything we do. Providing care of the highest standard focusing on safety and quality. • We will be an effective partner, developing and delivering integrated care and playing our part in local, national, and international programmes. • Being outstanding, now and in the future.						
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☒	☒	☒	☐	☒	☐	☐
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 the Trust Board.						

EXECUTIVE CHIEF NURSE REPORT

EXECUTIVE SUMMARY

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

Section 1: Spotlight on the Nursing, Midwifery and Allied Health (NMAHP) Professional Strategy

Section one of the report contains this month's 'Spotlight' section which provides a review of progress with the Nursing, Midwifery and Allied Health Professional Strategy, one year after its launch.

In July 2022 the Trust launched its new NMAHP Strategy. As previously highlighted to Board, the strategy is split into six key priorities. These priorities outline what we are already achieving in the relevant domain with a clear "We Are" statement and contain between three to four high level "We Will" statements outlining our aspirations for the future. Over the first six months there were monthly deep dive sessions to help culture the key priorities across the workforce. This has included in-person and virtual events as well as sharing our practices via the new NMAHP website and social media platforms. One year on we reflect on the work done to date.

Despite all the challenges faced by our staff over the last year, our teams are starting to embed the principles of the strategy across the Trust. There is still much work to do to ensure that this strategy feels relevant and meaningful for staff in all wards and departments, and this must be our focus for the year head.

In early November, we took the opportunity to have a weeklong focus and celebration of our strategy to share the patient centred initiatives staff have led on, challenging traditional approaches and breaking down barriers to improve care and outcomes. This included sharing over 100 poster presentations of NMAHP led Quality Improvement (QI) projects. We also took the opportunity to have several career clinics to help guide staff to resources and programmes to help them reach their personal and professional aspirations.

Whilst there have been many achievements over the last year, a number are highlighted within the report, aligned to the six strategy pillars. A few examples are noted below:

- To ensure all NMAHPs can liberate their potential is important and all staff can access funding support in the way of continuous professional development (CPD). At the end of October, we had received over 3,500 applications and invested over £3.5m to ensure staff had access to a wide range of funded CPD opportunities. (*(Developing a workforce strategy, plan and metrics for improvement)*
- We have supported 600 NMAHPs to take part in our collaborative Leading an Empowered Organisation (LEO) programme as well as many internal and external offers such as Coaching and Mentorship, the Institute of Leadership and

Management (ILM) and the NHS Leadership Academy *(Developing leadership capacity, capability and resilience).*

- A new ward managers' handbook – a 'toolkit' providing signposts for newly appointed ward leaders when faced with commonly encountered issues – was launched *(Developing leadership capacity, capability and resilience).*
- Building on our reputation as a national leader in research is a key priority for us and in August 2022 we launched our NMAHPs Researcher Development Institute (RDI) thanks to a major £3.2m grant from our colleagues at Newcastle Hospitals Charity. We have since welcomed 13 NMAHP RDI Fellows and supported peers at regional and national level *(Increasing research opportunities and impact).*

We have made great progress in this last year, but we know through our discussions with staff and the feedback that we receive there is still so much more we can do together to grow and develop across and within our professional groups and continue to bring this strategy to life. Our focus for the year ahead, which was commenced during the celebration week, is to agree and share our high impact actions for the year ahead and ensure they are both meaningful to staff and help us deliver on the ambitions of our strategy.

Section 2: Quarter 2 (Q2) Patient Experience Update

Section two provides a Q2 summary of the work of the Patient Experience team.

The Trust has opened 138 formal complaints in Q2, which is an increase of 16% from the previous quarter. The Trust has received, on average, 46 formal complaints per month, which is an increase of 5% for the same quarter in the previous financial year but is consistent with the overall average for 2022/23.

In Q2, Medicine & Emergency Care received the most formal complaints, with 37 (27%), which is an increase of 4% from the previous quarter.

The report includes an outline of several national patient experience surveys, as well as a detailed overview of the following:

- The Care Quality Commission (CQC) 2022 Urgent and Emergency Care survey results were published in August 2023. Overall, the Trust has performed well, with 75% of patients rating their experience as 7/10 or higher. The Trust scored 'Worse' than expected in one question when compared to other trusts. Robust action plans have been developed and progress will be reported to the patient experience and monitoring group.
- The results of the annual adult inpatient survey were published by the CQC on 12 September 2023. Nationally it has been reported that the majority of patients felt they were treated with dignity and respect and reported positive interactions with doctors and nurses. The Trust obtained responses from 551 people giving an overall response rate of 45% compared to 40% national average. Results show that 40 out of 45 questions scored about the same as other Trusts and 8 scored 'better' or 'somewhat better' than expected when compared to other trusts. 4 areas had shown deterioration when compared to the 2021 survey.

- The National Cancer Patient Experience Survey is conducted by Picker Institute Europe on behalf of NHS England (NHSE) each year. The results were published on 20 July 2023. Of the 61 questions in the survey, the Trust was above the expected upper range compared to other Trusts that took part for 19 questions, and no questions were below the expected lower range. All 61 questions were comparable to 2021 although two questions had a statistically significant improvement compared to 2021. No questions had a statistically significant decrease compared to 2022.

The report also contains an overview of the Equality Delivery System (EDS) which is a mandatory NHS improvement tool from NHSE to help trusts to improve their performance for individuals and groups protected by the Equality Act 2010. The 2023 Annual Report (found in Appendix One) is required for the Trust to grade their performance against set goals by NHSE and to set new objectives. The Trust is required to publish the annual report on the Trust website and the report also fulfils the Trust's legal Public Sector Equality Duties set out in the Equality Act 2010. This annual report looks at the patient focused outcomes of the EDS.

Domains 1A, 1C, 1D ratings remain the same as the previous years. The Equality, Diversity, Human Rights (EDHR) group were not confident to upgrade 1A due to delays in implementing the accessible information standards and ongoing work in relation to enhancing care for those with learning disability and/or autism. The Patient Experience and Engagement Group discussed the domain 1B and suggested this should be graded instead as 'Developing' which reflects the recent CQC recommendations in relation to the 'Care for me, with me' workstreams.

Section 3: Safeguarding and Mental Capacity Act (MCA) Q2 Update

Section three of the report provides a Q2 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 Q2 evidences the following key high-level points:

- In Adult Safeguarding, when compared to the previous quarter, activity was slightly lower. 980 referrals/cause for concern were received against a total of 1,052 in Q1, with self-neglect continuing to present as the most significant concern.
- The Safeguarding Children's team have seen a marginal decrease in overall activity compared to Q1. There has been 952 cause for concerns submitted in Q2 compared to 1,066 in Q1, a 11% decrease. Neglect, physical abuse, domestic abuse, and self-harm/overdose/substance misuse for both adults and children all feature high in categories of referral, all of which are key priority areas of Safeguarding Practice for Newcastle Children's Safeguarding Partnership (NSCP).
- In Q2 there were 107 reported MCA enquiries, with 10 regarded as complex. This is a significant increase compared to Q1 which demonstrated 45 enquiries, 15 of which were complex.
- In relation to urgent Deprivation of Liberty Standards (DoLS) applications, for each month in Q2, numbers have remained consistently at 180 applications. Q1 & 2 totals combined currently stand at 921, which is significantly higher than any previous full

financial year. This demonstrates the impact training and education over the last year as part of the 'Care for me, with me' work.

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

- 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 82% in adults and 84% in Children, only a 1% increase since the last report. 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 22 November sits at 91%. Work is underway to develop and launch a level 2 package for MCA and DoLS early in the new year. To maximise all education opportunities, bitesize sessions remain in place and an introduction to the MCA has been introduced into corporate induction.

The report provides an overview of a number of audit reports presented to the Safeguarding Committee for discussion. Of note, the MCA Steering group has approved an ongoing audit plan of 60 electronic patient files per quarter. This has changed from 60 files per year and aims to provide greater assurance over each quarter. Q1 showed a significant increase in completed assessments of capacity for patients subject to urgent DoLS. Although the Q2 audit was not complete by the time the Committee met, preliminary findings are that this trend continues with notable improvement.

Section 4: Learning Disabilities Q2 report.

This section of the report provides a Q2 summary update regarding the work of the Learning Disability Liaison Team.

In Q2 there were 898 referrals, compared to 783 in Q1. In Q2 2022 there were 683 referrals demonstrating the sustained increase in overall activity. There have been 335 inpatients and 334 Accident and Emergency (A/E) attendances in Q2 which is comparable to Q1.

At the time of writing, Trust compliance with the Diamond Standards Mandatory eLearning training for Learning Disabilities and Autism is 88.6%.

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 consultation closed on 19th September 2023. The Trust has responded to the consultation. It is envisaged that the final paper will be released towards the end of the year and will define what is legally mandated in terms of learning disability and autism training. Once this is released and understood, a gap analysis will be undertaken and risks to compliance identified.

The Trust continues to be part of the regional pilot for Learning Disability and Autism training led by the Learning Disability Northeast and North Cumbria Network. The Trust is piloting the Oliver McGowan Training on Learning Disability and Autism. The Trust has been allocated 200 training places available for Tier 1 and 90 spaces for Tier 2. A Trust Task and Finish Group is in place to oversee this work.

The report includes an update on the continued actions in response the CQC report which highlighted concerns around record keeping of reasonable adjustments for people with a Learning Disability. The actions from the 'Care for me With Me' workstream are now incorporated within the action plan for the Learning Disability Steering Group.

RECOMMENDATION

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

Report of Maurya Cushlow
Executive Chief Nurse
27 November 2023

EXECUTIVE CHIEF NURSE REPORT

SPOTLIGHT - NURSING, MIDWIFERY AND ALLIED HEALTH PROFESSIONAL (NMAHP) STRATEGY – ONE YEAR ON

In July 2022 the Trust launched its new NMAHP Strategy. As previously highlighted to the Board of Directors, the strategy is split into six key priorities. These priorities outline what we are already achieving in the relevant domain with a clear "We Are" statement and contain between three to four high level "We Will" statements outlining our aspirations for the future. Over the first six months there were monthly deep dive sessions to help culture the key priorities. This has included in person and virtual events as well as sharing our practices via the new NMAHP website and social media platforms. One year on we reflect on the work done to date.

1.1 Current Progress

Despite all the challenges faced by our staff over the last year, our teams are starting to embed the principles of the strategy across the Trust. There is still so much work to do to ensure that this strategy feels relevant and meaningful for staff in all wards and departments, and this must be our focus for the year head.

In early November, we took the opportunity to have a weeklong focus and celebration of our strategy to share the patient centred initiatives staff have led on, challenging traditional approaches, and breaking down barriers to improve care and outcomes. This included sharing over 100 poster presentations of NMAHP led QI projects. We also took the opportunity to have a number of career clinics to help guide staff to resources and programmes to help them reach their personal and professional aspirations.

Whilst there have been many achievements over the last year, a number are highlighted below linked to each strategy domain:

- This year we relaunched our Dementia Care Plan, Palliative Care Strategy and Food and Drink Strategy and have been working hard to embed the priorities of these across the Trust. Thanks to staff across our wards and departments, we have made great strides with malnutrition screening and this month held a Nutrition and Hydration Conference attended by over 100 delegates *(Improve quality and reduce patient harms).*
- Our Newcastle Specialist Continence Care team have several projects underway to help improve the quality of life for people affected by continence issues and were once again recognised nationally, winning the British Journal of Nursing 'Continence Nurse of the Year' award two years in a row as well as the Silver Award this year *(Improve quality and reduce patient harms).*
- We have watched Health Care Support Worker colleagues progress into Nursing Associate roles with some of them, alongside a number of our Assistant Practitioners, take up the opportunity of an 18-month Registered Nurse Degree Apprenticeship leading to qualification as a registered nurse *(Developing a workforce strategy, plan and metrics for improvement).*

- Ensuring NMAHPs can liberate their potential is important and all staff can access funding support in the way of CPD. At the end of October, we had received over 3,500 applications and invested over £3.5m to ensure staff had access to a wide range of funded CPD opportunities *(Developing a workforce strategy, plan and metrics for improvement).*
- We supported 600 NMAHPs to take part in our collaborative LEO programme as well as many internal and external offers such as Coaching and Mentorship, the ILM and the NHS Leadership Academy *(Developing leadership capacity, capability and resilience).*
- A new ward managers' handbook – a 'toolkit' providing signposts for newly appointed ward leaders when faced with commonly encountered issues – was launched *(Developing leadership capacity, capability and resilience).*
- Specialist pelvic health physiotherapists won this year's Q Factor Awards for their commitment to improving the patient experience for overactive bladders and this year's awards are now open for applications with a deadline of 31 January 2023 (*Engagement for Improvement*).
- Building on our reputation as a national leader in research is a key priority for us and in August 2022 we launched our NMAHPs RDI thanks to a major £3.2m grant from our colleagues at Newcastle Hospitals Charity. We have since welcomed 13 NMAHP RDI Fellows and supported peers at regional and national level *(Increasing research opportunities and impact).*
- Newcastle's 4Ps Researcher Development Programme also goes from strength to strength and is now available to NMAHPs from other health and social care organisations (*Increasing research opportunities and impact).*
- The Trust's digital health team has continued to grow drawing on expertise from both community and hospital-based NMAHPs with a special interest in the digitisation of health documentation, dashboards and other mechanisms to support colleagues (*Leading the digital healthcare agenda).*

1.2 Next Steps

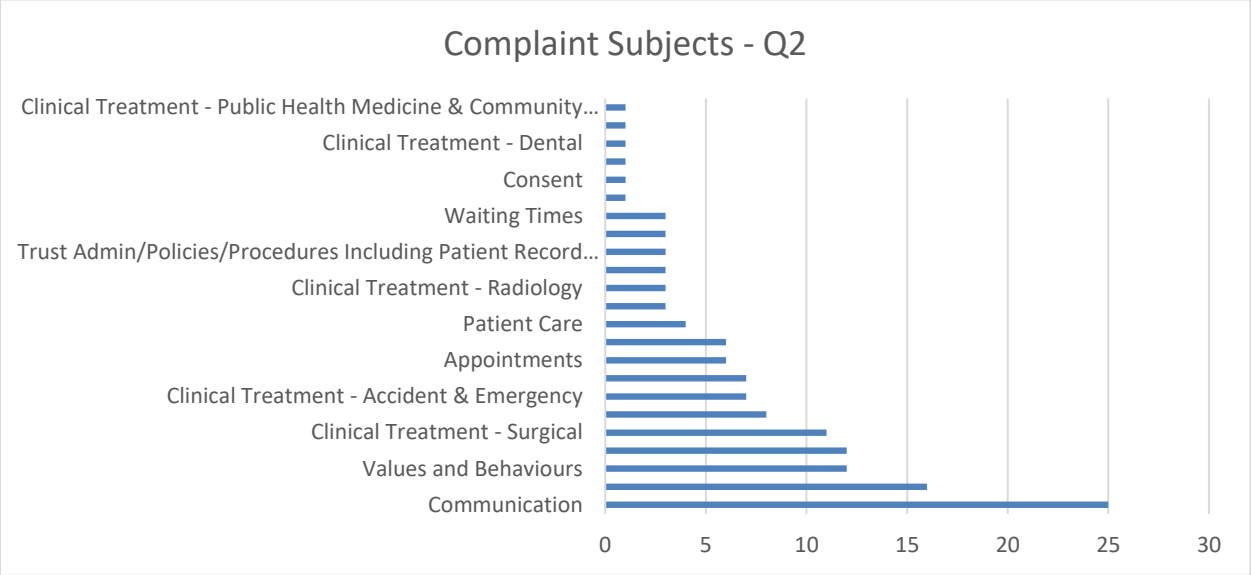
We have made great progress in this last year but we know through our discussions with staff and the feedback that we receive there is still so much more we can do together to grow and develop across and within our professional groups and continue to bring this strategy to life. Our focus for the year ahead, which was commenced during the celebration week, is to agree and share our high impact actions for the year ahead and ensure they are both meaningful to staff and help us deliver our commitment to deliver on our ambitions.

2. PATIENT EXPERIENCE QUARTER 2 (Q2) REPORT

2.1 Complaints Activity

The Trust has opened 138 formal complaints in Q2, which is an increase of 16% from the previous quarter. The Trust has received, on average, 46 formal complaints per month, which is an increase of 5% for the same quarter in the previous financial year but is consistent with the overall average for 2022/23.

In Q2, Medicine & Emergency Care received the most formal complaints, with 37 (27%), which is an increase of 4% from the previous quarter.

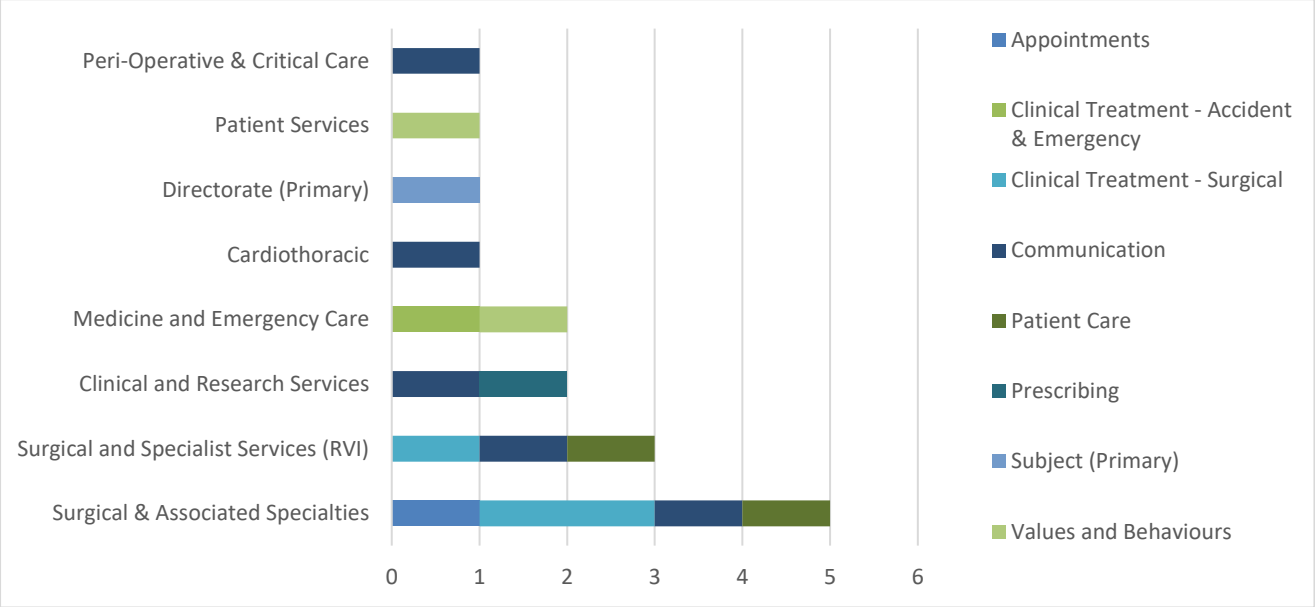


25 complaints (18%) opened in this quarter had a primary concern of 'communication'. Within this category, 44% related to 'communication failure with patient' and 28% related to 'communication failure with relatives or carers'. The remaining complaints are split between 'conflicting information', 'incorrect or no information given', 'delay in giving information or results', 'access to interpreting service' 'breaking bad news' and 'breakdown in communication between departments'.

2.2 KO41 Mandatory Return

This quarter, 127 formal complaints were closed, which is a decrease of 24% from the previous quarter. Of these, 15 complaints were upheld, 26 were partially upheld, 78 were not upheld and 8 were withdrawn.

The table below shows the breakdown of the 15 upheld complaints between clinical boards and categories. Surgical and Associated Specialties have the most upheld complaints with 5, accounting for 33% of all upheld complaints for this period. The most frequent category is communication with 27% across five directorates: Surgical and Specialist Services (RVI), Surgical and Specialist Services (FH), Cardiothoracic, Clinical & Research Services and Peri-Operative & Critical Care.



2.3 PALS

908 issues have been raised with PALS over this period. This compares to 938 in the previous quarter a 3% decrease and 833 in the same quarter 2021-22, a 12% increase. 33 enquiries were from carers. There has been an increase in the number of issues for Renal & Urology this quarter with 56 compared to 39 in the previous quarter and 33 in the same period last year. There has been a slight increase in the requests for access to medical records.

2.4 CQC 2022 Urgent and Emergency Care

The CQC 2022 Urgent and Emergency Care survey results were published in August 2023. Overall, the Trust has performed well, with 75% of patients rating their experience as 7/10 or higher. The Trust scored 'Worse' than expected in one question when compared to other trusts: While you were in A&E, did you feel threatened by other patients or visitors?

The management team have reviewed the findings of the Picker Institute and the CQC report and have identified the following questions for areas of improvement:

- Q - Did not feel threatened by other patients or visitors
- Q - Waiting under an hour to speak to a doctor or nurse
- Q - Told purpose of medications
- Q - Waited under four hours to be examined by a doctor/nurse
- Q - Cleanliness in the ED

Robust action plans have been developed and progress will be reported to the patient experience and monitoring group (PEMG).

2.5 National Inpatient Survey – CQC results

The results of the annual adult inpatient survey were published by the CQC on 12 September 2023. Nationally it has been reported that the majority of patients felt they were treated with dignity and respect and reported positive interactions with doctors and nurses.

The Trust obtained responses from 551 people giving a response rate of 45% compared to 40% national average. Results show that 40 out of 45 questions scored about the same as other Trusts and 8 scored 'better' or 'somewhat better' than expected when compared to other trusts.

When comparing the survey results with 2021 results, four areas had shown a significant deterioration:

- Were you able to get hospital food outside of set mealtimes?
- How did you feel about the length of time you were on the waiting list before your admission to hospital?
- How long do you feel you had to wait to get to a bed on a ward after you arrived at the hospital?
- Were you able to get a member of staff to help you when you needed attention?

Specific results relating to the various aspects of the patient journey such as food, nursing care and facilities are being presented to the relevant working groups, to ensure improvements are being embedded to help improve the overall patient experience.

2.6 National Cancer Patient Experience Survey

The National Cancer Patient Experience Survey is conducted by Picker Institute Europe on behalf of NHSE each year. The results were published on 20 July 2023. In summary:

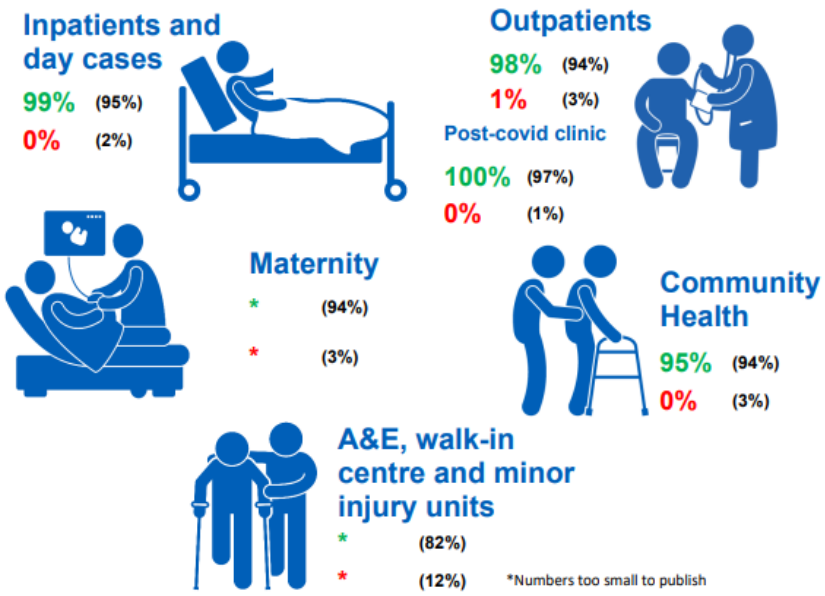
- Of the 61 questions in the survey, the Trust was above the expected upper range compared to other Trusts that took part for 19 questions, and no questions were below the expected lower range.
- All 61 questions were comparable to 2021 although two questions had a statistically significant improvement compared to 2021: 'Have you had a review of your cancer care by a member of staff at your GP practice' and' Were your family and/or carers able to be involved as much as you wanted them to be in decisions about your treatment options?'
- No questions had a statistically significant decrease compared to 2022.

Cancer teams are looking at the data in detail and are sharing the results with specialist teams, including comments pertinent to individual teams when they are made available.

Dashboards for each of the three surveys are included at the end of this report with more detailed information.

2.7 NHS Friends and Family Test (FFT)

The national NHSE technical issues that delayed publication from March 2023 onwards is now resolved. The infographic below displays the overall positive and negative ratings for the services in July 2023 (published September 2023). In July 2023 there were 2,268 responses to the Friends and Family Test from the Trust (published September 2023) compared to 2,209 in the previous month.



NHS Website

The Trust has received 31 items of feedback on the reviews and rating section of the NHS website, with most comments being in relation to Medicine (n6) and Surgery (n6). The Trust received the maximum score rating of five stars from 58% (n18) of comments received.

Surgery (5 Star) – *"I was on Ward 45 for hernia surgery. All the team were fantastic, the nurses, the cleaning staff, the surgical team and consultant were brilliant. I just want to say a massive thank you, you all were friendly and could not do enough for me. I wish I could name each and everyone but for everyone I had contact with thank you for putting me at ease, your friendliness, your professionalism and the laughter. The surgical team were amazing and the team in recovery were fantastic too. Thank you all you are all worth your weight in gold".*

2.8 Advising on the Patient Experience (APEX)

This quarter, APEX have commented on a research project looking at the implementation of a primary care clinical decision support application to increase testing for HIV and viral hepatitis. This work has developed an algorithm for use in GP practices to establish patients more likely at risk based on a variety of characteristics. APEX members were keen to hear further outcomes as the work progresses.

Members have also commented on a poster presenting the results of a real-world analysis of surgical interventions to treat benign prostate enlargement with the aim of making the poster more patient-friendly.

2.9 Maternity Voice Partnership

The Maternity and Neonatal Voices Partnership (MNVP) focus this quarter has centred around extending and embedding co-production. MNVP were invited to participate in the work undertaken by 'WeAreStand' who are supporting the Trust in the review of patient experience and engagement to inform the development of a strategy.

MNVP are also part of the Maternity Equity and Equality Group collaborating on workstreams within the LMNS aligned action plan that seek to ensure maternity services are accessible and inclusive and provide personalised care and support plans. Regular attendance at the Obstetric Governance Group, CQC Maternity Survey Task and Finish Group, Perinatal Mental Health Group and Maternity Strategy planning meetings have further cemented the MNVP as a key contributor within maternity services. The MNVP have also successfully championed the re-introduction of antenatal education classes with content being informed by service user feedback.

The Connie E-Midwife service has seen an upturn in activity during this quarter and a steady increase in following, now 2.3k. As well as continuing her regular weekly Question and Answer (Q&A) and monthly birth statistics features, Connie has provided service user information and reassurance around care in labour, describing the environmental adaptations that can be accommodated in our birthing rooms to optimise both the physiology and experience of birthing people.

As well as information sharing, Connie serves as an important conduit of communication between our services and service users. Regular updates and notifications regarding changes to service provision have been well followed and well received and there have been many heartening accounts from service users reporting their positive experiences and the excellent care they received.

2.10 Interpretation and Translation Update

Language Empire commenced their new contract on 1 May 2023 to provide interpreting and translation services. Prior to the commencement of the contract, Language Empire were on site for many weeks to deliver training to wards, clinics, community sites and administrative staff.

The contract has started well, with Language Empire meeting Key Performance Indicators (KPIs) of 95% fulfilment in the first few months. Staff have provided good feedback on using the online booking portal, the customer service provided by Language Empire and the ability to book for certain dialects. Staff also praised the timely and early communication from Language Empire when they may be struggling to find an interpreter and offering alternatives, such as scheduling a telephone or video interpreter.

The monthly data reports showing interpreting activity across the organisation, reassuringly confirms that all services have remained consistent in accessing interpreters, providing

confidence in how the new contract was implemented. Women's services remain the highest user of interpreting services.

Language Empire are also working closely with local community organisations to ensure their improvements are meeting local patient needs. For example, procedures have been established between Language Empire and Deaflink's Health Navigator Service when Deaflink are supporting Deaf patients for their appointments.

Some challenges remain, such as sourcing interpreters for rarer languages and out of hours in emergencies. Language Empire are focusing their training and recruitment campaigns for certain languages. The patient experience team are also working with the business development team to explore digital solutions for interpreting in emergencies, with maternity services volunteering to pilot a solution.

2.11 Support for Inpatients with Dementia

Recent ward surveys conducted by the patient experience team have shown that older people report a higher rate of boredom and lack of stimulation on wards. This all has a direct impact on quality, experience and length of stay.

The patient experience team and dementia team explored options of how to address this and have identified an innovative solution to support dementia inpatients. This is called Reminiscence Interactive Therapy Activities (RITA), which is a touch screen solution offering digital reminiscence therapy. This encompasses entertainment through music, watching old news reports, listening to historical speeches, playing games and watching films. RITA has been implemented at other NHS Trusts, hospices and care homes with very good outcomes and improvements.

A charitable application for three RITA devices and associated maintenance and support has been successful. There is also work ongoing with volunteering services on having volunteers working alongside the dementia team to befriend dementia patients and utilise the RITA systems.

Once implemented, the effectiveness of RITA will be reviewed utilising staff feedback, carer feedback and incidents regarding falls and agitation.

2.12 Equality Delivery System 2022 (Patients) 2023 Annual Report

The EDS is a mandatory NHS improvement tool from NHSE to help trusts to improve their performance for individuals and groups protected by the Equality Act 2010.

The 2023 Annual report (found in Appendix One) is required for the Trust to grade their performance against set goals by NHSE and to set new objectives. The Trust is required to publish the annual report on the Trust website and the report also fulfils the Trust's legal Public Sector Equality Duties set out in the Equality Act 2010. This annual report looks at the patient focused outcomes of the EDS.

The grading used within the annual report has involved:

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

Ratings of the four domains have been agreed as:

- 1A Developing: Patients have required levels of access to the service.
- 1B Developing Individual patients health needs are met.
- 1C Achieving: When patients use the service, they are free from harm.
- 1D Achieving: Patients report positive experience of the service.

Domains 1A, 1C, 1D ratings remain the same as the previous years. The EDHR group were not confident to upgrade 1A due to delays in implementing the accessible information standards and ongoing work in relation to enhancing care for those with learning disability and/or autism. It was also felt there was not enough data in relation to the KPI's associated with the implementation of the new interpretation contract with Language Empire, which would provide assurance of a good quality service at this point.

The Patient Experience and Engagement Group discussed the domain 1B and suggested this should be graded instead as developing, due to the recent CQC recommendations in relation to the 'Care for me, with me' workstreams.

3. SAFEGUARDING AND MENTAL CAPACITY ACT Q2 REPORT

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

3.1 Activity

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

- In Adult Safeguarding when compared to the previous quarter, activity was slightly lower. 980 referrals/cause for concern were received against a total of 1,052 in Q1, with self-neglect continuing to present as the most significant concern.
- The Safeguarding Children's team have seen a marginal decrease in overall activity compared to Q1. There has been 952 cause for concerns submitted in Q2 compared to 1,066 in Q1, a 11% decrease. Neglect, physical abuse, domestic abuse, and self-harm/overdose/substance misuse for both adults and children all feature high in categories of referral, all of which are key priority areas of Safeguarding Practice for NSCP.
- In Q2 there were 107 reported MCA enquiries, with 10 regarded as complex. This is a significant increase compared to Q1 which demonstrated 45 enquiries, 15 of which were complex.
- In relation to urgent DoLS applications, for each month in Q2, numbers have remained consistently at 180 applications. Q1 & 2 totals combined currently stand at

921, which is significantly higher than any previous full financial year. This demonstrates the impact training and education over the last year as part of the 'Care for me, with me' work.

3.2 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 82% in adults and 84% in children, only a 1% increase since the last report. 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 22 November sits at 91%. Work is underway to develop and launch a level 2 package for MCA and DoLS. This is due to be launched early in the new year. To maximise all education opportunities, bitesize sessions remain in place and an introduction to the MCA has been introduced into corporate induction.

3.3 Audit and Assurance

A number of audit reports were presented to the Safeguarding Committee in Q2 for review and discussion. This included the following:

- The children's safeguarding team are currently involved in a Multi-agency Thematic audit with Newcastle Safeguarding Children's Partnership to review the Risk Factors relating to Serious Youth Violence. The initial findings for the Trust are very positive and the final audit report will be presented at the Q3 Safeguarding Committee.
- The MCA Steering group has approved an ongoing audit plan of 60 electronic patient files per quarter. This has changed from 60 files per year and aims to provide greater assurance over each quarter. Q1 showed significant increase in completed assessments of capacity for patients subject to urgent DoLS. Although the Q2 audit was not complete by the time the committee met, preliminary findings are that this trend continues with notable improvement.

4. LEARNING DISABILITIES Q2 REPORT

4.1 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 Q2:

- In Q2 there were 898 referrals, compared to 783 in Q1. In Q2 2022 there were 683 referrals demonstrating the sustained increase in overall activity.

- There have been 335 inpatients and 334 A/E attendances in Q2 which is comparable to Q1.
- In Q2, the Safeguarding Committee were provided with details of all complex cases that are either having their admission planned or are currently an inpatient. This data will be shared monthly with the Executive Chief Nurse, Medical Director and Director of Quality and Effectiveness. One of the benefits of sharing this information is to highlight and discuss proposed implementation of complex reasonable adjustments that may carry risk.

4.2 Education and training

At the time of writing, Trust compliance with the Diamond Standards Mandatory eLearning training for Learning Disabilities and Autism is 88.6%. The training continues to be promoted by the Learning Disability Liaison Team and additional training has been implemented across the organisation led by the Clinical Educator within the team.

The Trust continues to be part of the regional pilot for learning disability training led by the Learning Disability Northeast and North Cumbria Network. The Trust is piloting the Oliver McGowan Training on Learning Disability and Autism. The Trust has been allocated 200 training places available for Tier 1 and 90 spaces for Tier 2. A Trust Task and Finish Group is in place to oversee this work and feeds into the regional group.

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 consultation closed on 19 September 2023. The Trust has responded to the consultation. It is envisaged that the final paper will be released towards the end of the year and will define what is legally mandated in terms of learning disability and autism training. Once this is released and understood, a gap analysis will be undertaken and risks to compliance identified.

4.3 CQC focussed Inspection Update

The actions from the Care for me With Me workstream are now incorporated within the action planning for the Learning Disability Steering Group. These include;

- Development of a Trust Strategy – This work has commenced and is supported by the Patient Experience Team who have submitted a request to Newcastle Charities to support the strategy development and to facilitate co-production with people with lived experience.
- Ongoing review and audit of e-record documentation which is overseen by the Steering Group.
- Review and revamp of the role of Champions for learning disability and autism. Sessions were completed throughout October to discuss with staff the expectation and role descriptor. Following this a briefing will be submitted to the Steering Group who will agree the role descriptor and support the role in practice.

Report of Maurya Cushlow
Executive Chief Nurse
27 November 2023

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Trust Board

Date of meeting	30 November 2023						
Title	Trust Board						
Report of	Maurya Cushlow, Executive Chief Nurse						
Prepared by	Tracy Scott, Head of Patient Experience Fardeen Choudhury, Equality, Diversity & Inclusion Manager						
Status of Report	Public		Private		Internal		
	☒		☐		☐		
Purpose of Report	For Decision		For Assurance		For Information		
	☐		☒		☒		
Summary	The Equality Delivery System (EDS) is a mandatory NHS improvement tool from NHS England to help NHS organisations improve their performance for individuals and groups protected by the Equality Act 2010. This report fulfils the annual EDS requirement to produce a report that grades the Trust's performance against set goals by NHS England, review Trust objectives and establish new objectives. The report is then required to be published online on the trust website. This report also fulfils the trust's legal Public Sector Equality Duties set out in the Equality Act 2010						
Recommendation	Trust Board is asked to read and acknowledge the content of this paper.						
Links to Strategic Objectives	We deliver the best possible health outcomes for our patients. Learning and continuous improvements is embedded across the organisation. We focus on prevention and population health. Our partnerships provide added value in all that we do.						
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☒	☒	☐	☐	☒	☒	☐
Link to Board Assurance Framework [BAF]	No risks identified.						
Reports previously considered by	Annual report						

The Newcastle upon Tyne Hospitals NHS Foundation Trust

EQUALITY DELIVERY SYSTEM 2022 – PATIENTS 2023 ANNUAL REPORT

EXECUTIVE SUMMARY

The Equality Delivery System (EDS) is a mandatory NHS improvement tool from NHS England to help trusts to improve their performance for individuals and groups protected by the Equality Act 2010.

The 2023 Annual report is required for the Trust to grade their performance against set goals by NHS England and to set new objectives. The Trust is required to publish the annual report on the Trust website and the report also fulfils the Trust's legal Public Sector Equality Duties set out in the Equality Act 2010. This annual report looks at the patient focused outcomes of the EDS.

The grading used within the annual report has involved:

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

Ratings of the four domains have been agreed as:

- 1A Developing: Patients have required levels of access to the service
- 1B Developing: Individual patients health needs are met
- 1C Achieving: When patients use the service, they are free from harm
- 1D Achieving: Patients report positive experience of the service

RECOMMENDATION

Trust Board is asked to note and discuss the content of this report. No risks have been identified.

EQUALITY DELIVERY SYSTEM 2022 – PATIENTS 2023 ANNUAL REPORT

1.0 INTRODUCTION TO THE EQUALITY DELIVERY SYSTEM 2022

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

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

The EDS2022 has 11 outcomes grouped into three goals. The three overarching goals are:

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

The patient focused EDS2022 objectives have been developed through a process of:

- Profiling demographic information on the population of Newcastle from Census data
- Collating qualitative and quantitative data in relation to equality issues
- Involvement with the third sector, voluntary organisations, patient representatives, Trust staff and neighbouring NHS organisations.
- Considering what the Trust currently does to meet needs

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

2.0 PUBLIC SECTOR EQUALITY DUTY

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

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

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

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

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

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

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

3.0 EDS2022 GRADING

3.1 Monitoring and Reviewing the EDS2022

The Executive Chief Nurse has Executive responsibility for Equality, Diversity, and Inclusion for Patients. The implementation, monitoring and reviewing of the EDS2022 (patient focused) is overseen by the Equality, Diversity and Human Rights Groups (EDHR) which is chaired by the Associate Director of Nursing. This group meets quarterly and monitors progress of the EDS2022 work plan.

The EDHR group membership includes representatives from: Elders Council, West End Youth Enquiry Service, Be-North, Chaplaincy, MESMAC/SHINE, Newcastle Disability Forum, The National Association of Laryngectomies Club, Deaflink, Newcastle Vision Support, Launchpad, Newcastle Carers Centre, HAREF, Healthwatch, PALS, Outpatients and Staff Networks.

3.2 EDS2022 Grading

Grading of objectives has involved:

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

There are four grades:

- Excelling

- Achieving
- Developing
- Undeveloped

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

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

	1C: When patients (service users) use the service, they are free from harm	- Refreshed Dementia strategy that focuses on training, and working with families and carers	**2 – Achieving**	- Dementia team
		- Validation exercise during COVID to prioritise patients and manage waiting lists - Schwartz Rounds to support trust wide learning - Equality analysis on policies and service developments - Communication assessment on electronic admission form		- Trust wide
		- Specialist roles, such as learning disability sexual health nurse		- Sexual health/LD
		- Dedicated safeguarding policies for adults, children, and maternity		- Safeguarding/ Children's/ Maternity
		- SI panel to review incidents and events and share learnings		- Clinical governance
	1D: Patients (service users) report positive experiences of the service	- Equality monitoring of complaints and offering flexibility in the complaints process - Working with local community organisations to gather insight and feedback into services and develop improvement work - Equality monitoring on surveys	**2 – Achieving**	- Patient Experience
		- Patient Experience Monitoring Group to review patient feedback to services and establish action plans and share learnings		- Trust wide
		- Local services have dedicated patient engagement forums e.g., Maternity Voices Partnership/YPAG		- Women's, Children's
		- New day case pathway gathering feedback from patients who have gone through the pathway		- Day case surgery
Domain 1: Commissioned or provided services overall rating			6	

4.0 PATIENT FOCUSED EQUALITY OBJECTIVES

4.1 Progress on Current Objectives

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

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

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

The Newcastle upon Tyne Hospitals NHS Foundation Trust

4.2 2022 – 2024 Equality Objectives

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

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

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

Annex 1 – Grading Criteria

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

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

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

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

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

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

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

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

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Equality & Diversity Access Data

Equality & Diversity Statistics for Patients Treated

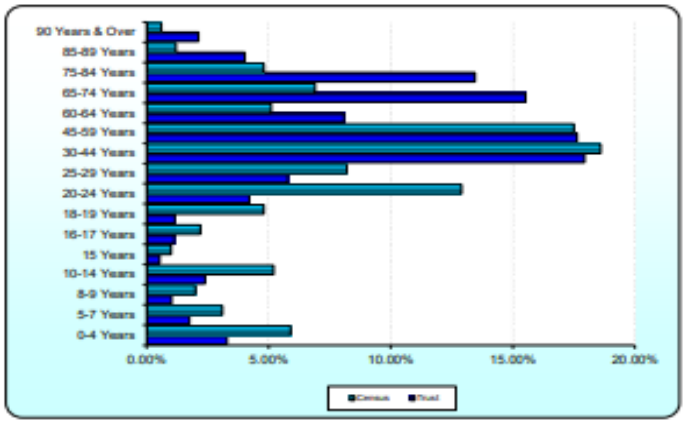
The Newcastle upon Tyne Hospitals NHS Foundation Trust

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

1. Age.

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

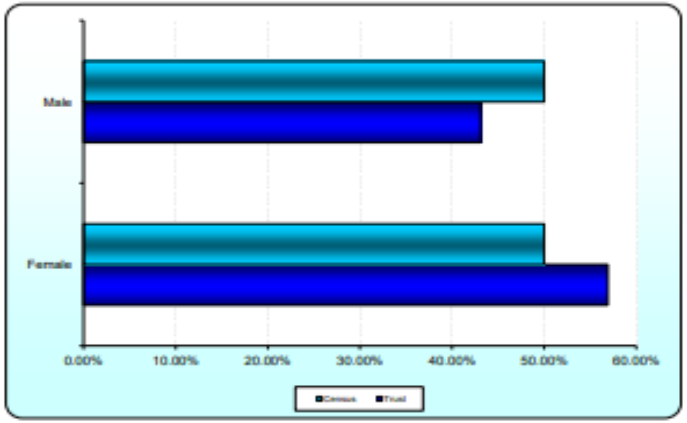
Age Band	Trust	Census
0-4 Years	3.29%	5.90%
5-7 Years	1.75%	3.10%
8-9 Years	1.02%	2.00%
10-14 Years	2.39%	5.20%
15 Years	0.53%	1.00%
16-17 Years	1.13%	2.20%
18-19 Years	1.15%	4.80%
20-24 Years	4.20%	12.90%
25-29 Years	5.78%	8.20%
30-44 Years	17.94%	18.60%
45-59 Years	17.63%	17.50%
60-64 Years	8.08%	5.10%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



2. Gender

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

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



3. Ethnic Origin

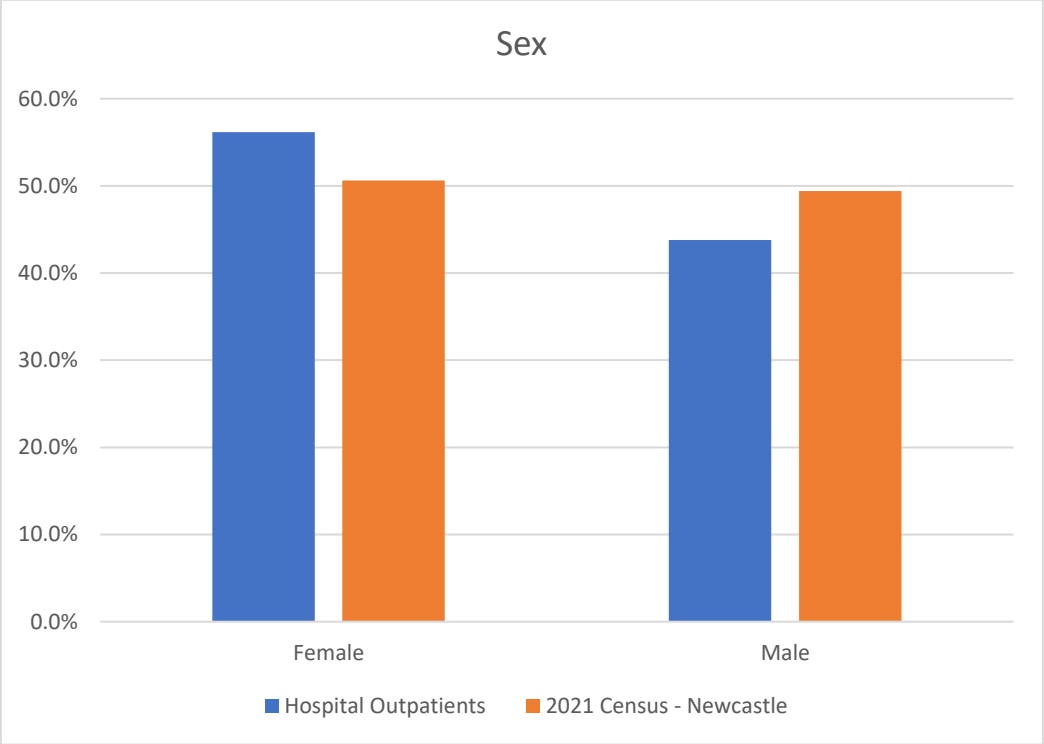
Compares the ethnic origin of patients seen by the Trust during the period to the ethnic origin of Newcastle residents as collected in the 2011 census.

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Access Data

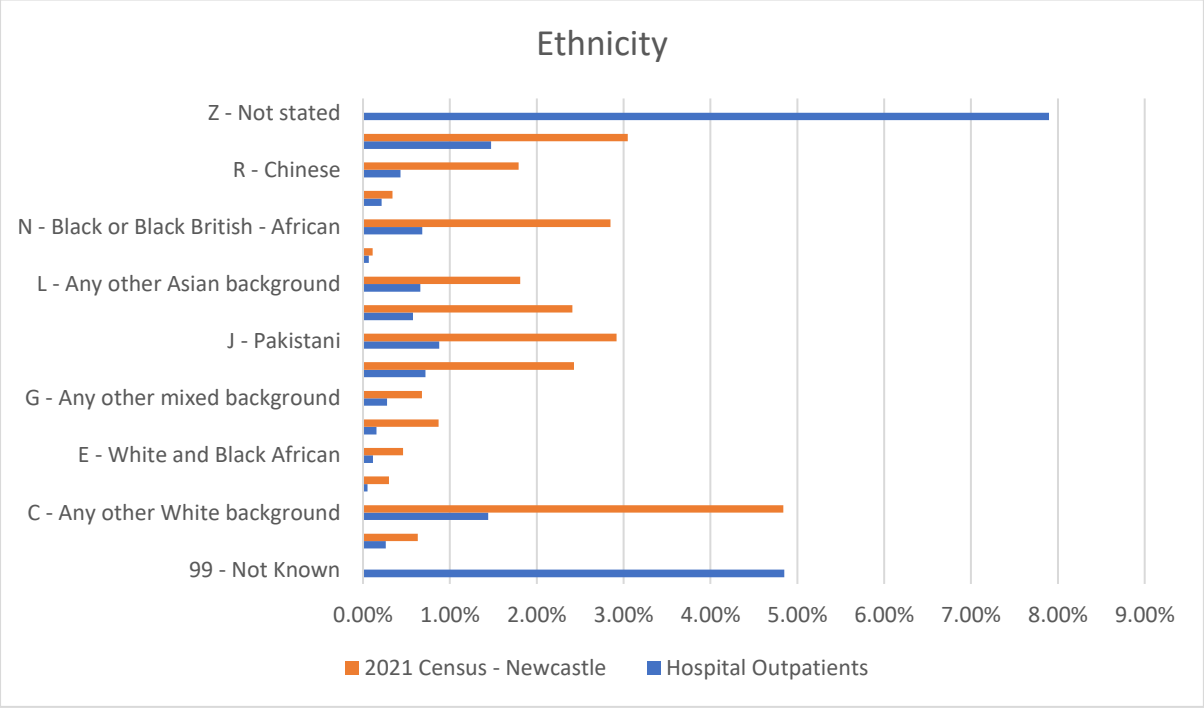
1. Sex

Sex	Hospital Outpatients	2021 Census - Newcastle
Female	56.2%	50.6%
Male	43.8%	49.4%



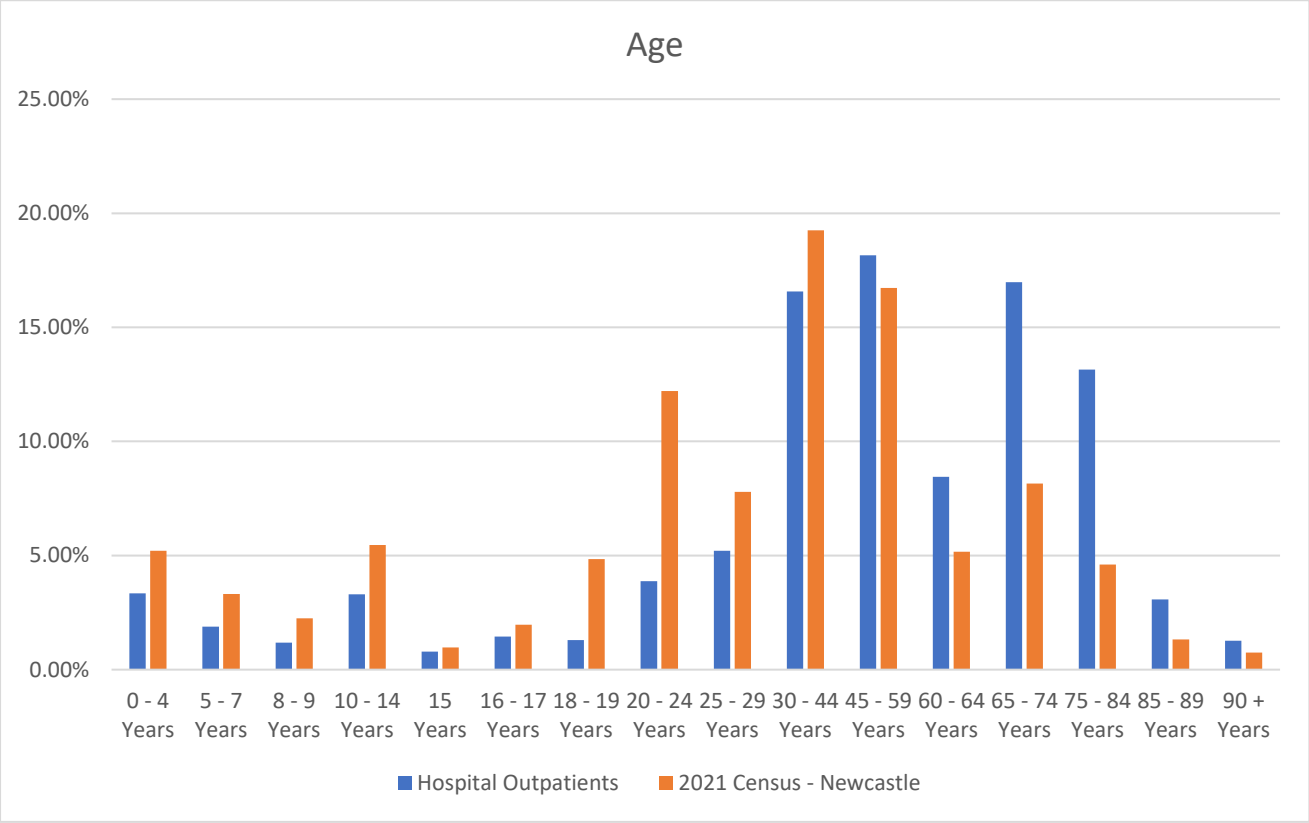
2. Ethnicity

Ethnicity	Hospital Outpatients	2021 Census - Newcastle
99 - Not Known	4.85%	0.00%
A - White - British	79.25%	74.50%
B - White - Irish	0.26%	0.63%
C - Any other White background	1.44%	4.84%
D - White and Black Caribbean	0.05%	0.30%
E - White and Black African	0.12%	0.46%
F - White and Asian	0.15%	0.87%
G - Any other mixed background	0.28%	0.68%
H - Indian	0.72%	2.43%
J - Pakistani	0.88%	2.92%
K - Bangladeshi	0.58%	2.41%
L - Any other Asian background	0.66%	1.81%
M - Black or Black British - Caribbean	0.07%	0.11%
N - Black or Black British - African	0.68%	2.85%
P - Black or Black British - Any other Black background	0.21%	0.34%
R - Chinese	0.43%	1.79%
S - Any other ethnic group	1.47%	3.05%
Z - Not stated	7.90%	0.00%



3. Age

Age	Hospital Outpatients	2021 Census - Newcastle
0 - 4 Years	3.35%	5.21%
5 - 7 Years	1.89%	3.31%
8 - 9 Years	1.19%	2.25%
10 - 14 Years	3.29%	5.47%
15 Years	0.80%	0.97%
16 - 17 Years	1.45%	1.97%
18 - 19 Years	1.30%	4.84%
20 - 24 Years	3.88%	12.21%
25 - 29 Years	5.20%	7.79%
30 - 44 Years	16.58%	19.25%
45 - 59 Years	18.16%	16.72%
60 - 64 Years	8.45%	5.16%
65 - 74 Years	16.98%	8.15%
75 - 84 Years	13.14%	4.61%
85 - 89 Years	3.08%	1.32%
90 + Years	1.26%	0.75%



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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**
Updated 15.11.23	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 on weekdays by Ward Managers with weekly oversight by the Matrons. An assurance framework has been implemented to include weekly oversight by the Director of Midwifery (DoM).	Head of Midwifery Matrons	B7 DS Leads B7 NBC Leads B7 Ward Leads	**Compliant**	Clinical Standards checklist for each area, weekly leader's assurance checklist. Information gathered and recorded at DoM weekly meeting. Central storage of records in place.
Updated 15.11.23	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. There is an ongoing plan in place to meet the Trust target of 95% by March 2024, which is within the expected timeframe. Appraisal rates in October 2023: 84%.	Directorate Management Team	Matrons B7 Team Leads Appraisers/ Appraisees	**Compliant**	Implementing and embedding a new 'appraisal tree' for Senior Leadership Team review and sharing within the workforce. Monthly focus on appraisals by the Senior Leadership Team at DMT to maintain compliance, this approach is then cascaded by the Matrons

							throughout their teams.
Updated 15.11.23	The trust must ensure the proper and safe management of medicines, ensuring out of date medicines are removed and medicines are stored securely. Regulation 12 (1) (2) (g)	Must	Improvement work has been undertaken to strengthen the management and storage of medicines, together with the implementation of a monthly assurance framework for the disposal of out of date medicines.	Head of Midwifery Matrons	B7 DS Leads B7 NBC Lead B7 Ward Leads B7 Team Leads Community	**Compliant** with mechanism for ongoing monitoring and reporting to ensure embedded practice.	Monthly medication and IV Fluid checklist, Home Birth bags monthly checklist.
Updated 15.11.23	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 Newcastle and the additional financial resource required.	Directorate Management Team	Head of Obstetrics, Senior Midwife Workforce, Matrons, B7 Team Leads, Lead Midwives Safeguarding, Quality & Effectiveness Midwife, Senior Midwife Practice Development Lead Midwife	**Partially Compliant:** Trust level Mandatory Training 88% against a target of 95% Children's Safeguarding Level 3: 90% against a target of 95% Core Competency Training (Public Health in Practice day): 79% against a revised target of	

						80%. Core Competency Training (Clinical Skills): 79% against a revised target of 80%	
Updated 15.11.23	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 Ward Manager presence within each area in relation to expected standards with weekly Matron oversight. 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 Head of Midwifery	Matrons Band 7 Leads, Trust IPC Team Hotel Services Leads	**Compliant,** to continue to monitor.	Daily and weekly checklists. CAT tool.
Updated 15.11.23	The Trust should ensure sufficient midwifery staff are deployed to keep women, birthing people and babies safe. (Regulation 18)	Should	Currently 0.37% above recommended Birthrate Plus establishment. A further 9.04 WTE newly appointed midwives waiting to commence employment which projects to WTE of 258.8 - 3.3% over the funded establishment. Recruitment will continue thereafter to further increase up to approved 20wte over establishment. Assurance process in place ensuring daily monitoring and oversight of	Director of Midwifery Head of Midwifery	Head of Midwifery, Senior Midwife for Workforce, Head 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.

			staffing versus acuity at ward level - overseen by a Matron daily and by Head of Midwifery twice weekly for additional assurance with regard to workforce planning and mitigation of risk.				
Updated 15.11.23	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 explored to refurbishment bereavement facilities to improve the provision of privacy and dignity for families. This work is planned for completion in 2024. General work across the estate will continue to be a priority. Despite the challenges presented by the estate, staff continuously prioritise the privacy and dignity of service users at all times in the provision of care.	Directorate Management Team	Directorate Management Team Director of Estates	**Partially Compliant -** Architect drawings have been completed of the newly proposed extended bereavement suite. The estates department are in the process of costing this improvement. The timeframe for completion is expected to be 2024.	
Updated 15.11.23	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 implemented Modified Early Warning Score (MEWS) system e-obs in July 2023. This will enable a continuous process of review in relation to completion of MEWS, and greater quality assurance through audit.	Directorate Governance Team and Quality & Clinical Effectiveness Midwife	Risk Management Midwives, Team Leads, Shift Coordinators	**Partially Compliant,** Current compliance 31% against Trust target of 90%.	On DoM monthly professional meeting agenda.

Updated 15.11.23	The Trust should continue to monitor the security of the unit continues to be reviewed in line with national guidance.	Should	All security work completed; annual Baby abduction simulation undertaken in collaboration with Security Services.	Directorate Management Team	Head of Security, PN Matron	**Compliant**	
Updated 15.11.23	The Trust should continue work to introduce a robust formal triage and escalation process within the maternity assessment unit.	Should	Work underway toward the implementation of a bespoke electronic Maternity Triage system (BSOTS). Anticipated 'go-live' date December 2023. Interim measures include paper based system to support triage and escalation, together with schedule of audit to inform the quality of assessment.	Clinical Director Director of Midwifery	Head of Obstetrics Matron for MAU, B7 Team Lead MAU	**Partially Compliant,** pending implementation of BSOTS scheduled for November 2023. Interim paper based system in place with audit schedule.	

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	Fetal wellbeing training and competency assessment	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:	1.1	To fund maternity and neonatal services appropriately requires a multi-year settlement to ensure the workforce is enabled to deliver consistently safe maternity and neonatal care across England.	n/a

Financing a safe maternity workforce The recommendations from the Health and Social Care Committee Report: The safety of maternity services in England must be implemented.			Awaiting information on further funding
	1.2	Minimum staffing levels should be those agreed nationally, or where there are no agreed national levels, staffing levels should be locally agreed with the LMNS. This must encompass the increased acuity and complexity of women, vulnerable families, and additional mandatory training to ensure trusts are able to safely meet organisational CNST and CQC requirements.	Compliant
	1.3	Minimum staffing levels must include a locally calculated uplift, representative of the three previous years' data, for all absences including sickness, mandatory training, annual leave, and maternity leave.	Partially 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 every	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

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.	Partial Compliance (due to changes in CCFv2)
	2.7	All trusts must ensure there are visible, supernumerary clinical skills facilitators to support midwives in clinical practice across all settings.	Partial compliance
	2.8	Newly appointed Band 7/8 midwives must be allocated a named and experienced mentor to support their transition into leadership and management roles.	Compliant
	2.9	All trusts must develop strategies to maintain bi-directional robust pathways between midwifery staff in the community setting and those based in the hospital setting, to ensure high quality care and communication.	Compliant
	2.10	All trusts should follow the latest RCOG guidance on managements of locums. The RCOG encourages the use of internal locums and has developed practical guidance with NHS England on the management of locums. This includes support for locums and ensuring they comply with recommended processes such as pre-employment checks and appropriate induction.	Compliant

3. Escalation and Accountability: There must be clear processes for ensuring that obstetric units are staffed by appropriately trained staff at all times. If not resident there must be clear guidelines for when a consultant obstetrician should attend.	3.1	All trusts must develop and maintain a conflict of clinical opinion policy to support staff members in being able to escalate their clinical concerns regarding a woman's care in case of disagreement between professionals.	Compliant
	3.2	When a middle grade or trainee obstetrician (non-consultant) is managing the maternity service without direct consultant presence trusts must have an assurance mechanism to ensure the middle grade or trainee is competent for this role.	Compliant
	3.3	Trusts should aim to increase resident consultant obstetrician presence where this is achievable.	Compliant
	3.4	There must be clear local guidelines for when consultant obstetricians' attendance is mandatory within the unit.	Compliant
	3.5	There must be clear local guidelines detailing when the consultant obstetrician and the midwifery manager on-call should be informed of activity within the unit.	Compliant
4. Clinical Governance: Leadership: Trust boards must have oversight of the quality and performance of their maternity services. In all maternity services the Director of Midwifery and Clinical Director for obstetrics must be jointly operationally responsible and accountable for the maternity governance systems.	4.1	Members of the Trust Board must work together with maternity departments to develop regular progress and exception reports, assurance reviews and regularly review the progress of any maternity improvement and transformation plans.	Compliant
	4.2	All maternity service senior leadership teams must use appreciative inquiry to complete the National Maternity Self-Assessment Tool if not previously done. A comprehensive report of their self-assessment including governance structures and any remedial plans must be shared with their trust board.	Partial compliance
	4.3	Every trust must ensure they have a patient safety specialist, specifically dedicated to maternity services.	Compliant
	4.4	All clinicians with responsibility for maternity governance must be given sufficient time in their job plans to be able to engage effectively with their management responsibilities.	Partial compliance
	4.5	All trusts must ensure that those individuals leading maternity governance teams are trained in human factors, causal analysis, and family engagement.	Partial compliance

	4.6	All maternity services must ensure there are midwifery and obstetric co-leads for developing guidelines. The midwife co-lead must be of a senior level, such as a consultant midwife, who can drive the guideline agenda and have links with audit and research.	Compliant
	4.7	All maternity services must ensure they have midwifery and obstetric co-leads for audits.	Compliant
5. Clinical Governance – Incident investigation and complaints Incident investigations must be meaningful for families and staff and lessons must be learned and implemented in practice in a timely manner.	5.1	All maternity governance teams must ensure the language used in investigation reports is easy to understand for families, for example ensuring any medical terms are explained in lay terms.	Compliant
	5.2	Lessons from clinical incidents must inform delivery of the local multidisciplinary training plan.	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
	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	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

PM examinations must be conducted by a pathologist who is an expert in maternal physiology and pregnancy related pathologies. In the case of a maternal death a joint review panel/investigation of all services involved in the care must include representation from all applicable hospitals/clinical settings.	6.2	This joint review panel/investigation must have an independent chair, must be aligned with local and regional staff, and seek external clinical expert opinion where required.	n/a
	6.3	Learning from this review must be introduced into clinical practice within 6 months of the completion of the panel. The learning must also be shared across the LMS.	To action once implemented by external stakeholder
7. Multidisciplinary Training Staff who work together must train together Staff should attend regular mandatory training. Rotas & Job planning need to ensure all staff can attend. Clinicians must not work on labour ward without appropriate regular CTG training and emergency skills training	7.1	All members of the multidisciplinary team working within maternity should attend regular joint training, governance, and audit events. Staff should have allocated time in job plans to ensure attendance, which must be monitored.	Partial compliance
	7.2	Multidisciplinary training must integrate the local handover tools (such as SBAR) into the teaching programme at all trusts.	Compliant
	7.3	All trusts must mandate annual human factor training for all staff working in a maternity setting; this should include the principles of psychological safety and upholding civility in the workplace, ensuring staff are enabled to escalate clinical concerns. The content of human factor training must be agreed with the LMS.	Compliant
	7.4	There must be regular multidisciplinary skills drills and on-site training for the management of common obstetric emergencies including haemorrhage, hypertension and cardiac arrest and the deteriorating patient.	Compliant
	7.5	There must be mechanisms in place to support the emotional and psychological needs of staff, at both an individual and team level, recognising that well supported staff teams are better able to consistently deliver kind and compassionate care.	Compliant

	7.6	Systems must be in place in all trusts to ensure that all staff are trained and up to date in CTG and emergency skills.	Compliant
	7.7	Clinicians must not work on labour wards or provide intrapartum care in any location without appropriate regular CTG training and emergency skills training. This must be mandatory.	Compliant
8. Complex Antenatal Care: Local Maternity Systems, Maternal Medicine Networks and trusts must ensure that women have access to preconception care. Trusts must provide services for women with multiple pregnancy in line with national guidance Trusts must follow national guidance for managing women with diabetes and hypertension in pregnancy	8.1	Women with pre-existing medical disorders, including cardiac disease, epilepsy, diabetes, and chronic hypertension, must have access to preconception care with a specialist familiar in managing that disorder and who understands the impact that pregnancy may have.	Compliant
	8.2	Trusts must have in place specialist antenatal clinics dedicated to accommodate women with multifetal pregnancies. They must have a dedicated consultant and have dedicated specialist midwifery staffing. These recommendations are supported by the NICE Guideline Twin and Triplet Pregnancies 2019.	Compliant
	8.3	NICE Diabetes and Pregnancy Guidance 2020 should be followed when managing all pregnant women with pre-existing diabetes and gestational diabetes.	Compliant
	8.4	When considering and planning delivery for women with diabetes, clinicians should present women with evidence-based advice as well as relevant national recommendations. Documentation of these joint discussions must be made in the woman's maternity records.	Compliant (to audit)
	8.5	Trusts must develop antenatal services for the care of women with chronic hypertension. Women who are identified with chronic hypertension must be seen in a specialist consultant clinic to evaluate and discuss risks and benefits to treatment. Women must be commenced on Aspirin 75-150mg daily, from 12 weeks gestation in accordance with the NICE Hypertension and Pregnancy Guideline (2019).	Compliant
9. Preterm Birth:	9.1	Senior clinicians must be involved in counselling women at high risk of very preterm birth, especially when pregnancies are at the thresholds of viability.	Compliant

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

11. Obstetric Anaesthesia: 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 all unwell postnatal women have timely consultant review. Postnatal wards must be adequately staffed at all times	12.1	All trusts must develop a system to ensure consultant review of all postnatal readmissions, and unwell postnatal women, including those requiring care on a non-maternity ward	Compliant
	12.2	Unwell postnatal women must have timely consultant involvement in their care and be seen daily as a minimum.	Compliant
	12.3	Postnatal readmissions must be seen within 14 hours of readmission or urgently if necessary.	Compliant
	12.4	Staffing levels must be appropriate for both the activity and acuity of care required on the postnatal ward both day and night, for both mothers and babies.	Compliant
13. Bereavement Care: Trusts must ensure that women who have suffered pregnancy loss have appropriate bereavement care services.	13.1	Trusts must provide bereavement care services for women and families who suffer pregnancy loss. This must be available daily, not just Monday to Friday.	Compliant
	13.2	All trusts must ensure adequate numbers of staff are trained to take post-mortem consent, so that families can be counselled about post-mortem within 48 hours of birth. They should have been trained in dealing with bereavement and in the purpose and procedures of post-mortem examinations.	Compliant
	13.3	All trusts must develop a system to ensure that all families are offered follow-up appointments after perinatal loss or poor serious neonatal outcome.	Compliant
	13.4	Compassionate, individualised, high quality bereavement care must be delivered for all families who have experienced a perinatal loss, with reference to guidance such as the National Bereavement Care Pathway.	Compliant
14. Neonatal Care: There must be clear pathways of care for provision of neonatal care. This review endorses the recommendations from the	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

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.	14.3	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	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

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	15.2	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	Mar 23	Mar 23	May 23	May 23	July 23	July 23	Sep 23	Sep 23	Nov 23	Nov 23
Total Number of Recommendations (interim and final report combined)	97	100%	98 *	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	12	n/a
Compliant	46	54.1%	56	65.1%	61	71.0%	65	75.6%	66	76.7%	68	79.0%	68	79.1%
Partial Compliance	36	41.4%	27	31.4%	23	26.7%	19	22.1%	18	20.9%	17	19.7%	18	20.9%
Non compliance	3	3.5%	3	3.5%	2	2.3%	2	2.3%	2	2.3%	1	1.1%	0	0

*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 Women and Families	Q9	Independent Senior Advocate Role to report to Trust and LMNS.	n/a Awaiting appointment
	Q10	Advocate must be available to families attending clinical follow up meetings.	n/a Awaiting appointment
	Q11	Identify a non-executive director for oversight of maternity services – specific link to maternity voices and safety champions.	Compliant
	Q12	National Perinatal Mortality Review Tool (PMRT) in use to required Ockenden standard (compliant with CNST).	Compliant

	Q13	Robust mechanism working with and gathering feedback from service users through Maternity Voices Partnership (MVP) to design services.	Compliant
	Q14	Bimonthly meetings with Trust safety champions (obstetrician and midwife) & Board level champions.	Compliant
	Q15	Robust mechanism working with and gathering feedback from service users through MVP to design services.	Compliant
	Q16	Identification of an Executive Director & non-executive director for oversight of maternity & neonatal services.	Compliant
IEA 3: Staff Training & Working Together	Q17	Evidence of multidisciplinary team (MDT) training and working validated by LMNS 3 times a year. All professional groups represented at all MDT and core training.	Compliant
	Q18	Twice daily (over 24hrs), 7-days a week consultant-led multidisciplinary ward rounds.	Compliant
	Q19	Trust to ensure external funding allocated for the training of maternity staff is ring-fenced.	Compliant
	Q20	Effective system of clinical workforce planning (see section 2).	Compliant
	Q21	90% attendance for each staff group attending MDT maternity emergencies training session (with LMNS oversight and validation).	Compliant
	Q22	Twice daily (over 24hrs), 7-days a week consultant-led multidisciplinary ward rounds	Compliant
	Q23	Evidence of multidisciplinary team (MDT) training and working validated by LMNS 3 times a year. All professional groups represented at all MDT and core training.	Compliant
IEA 4: Managing Complex Pregnancy	Q24	Maternal Medicine Centre (MMC) Pathway referral criteria agreed with trusts referring to NUTH for specialist input	Compliant
	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.	Compliant
	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.	Compliant
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

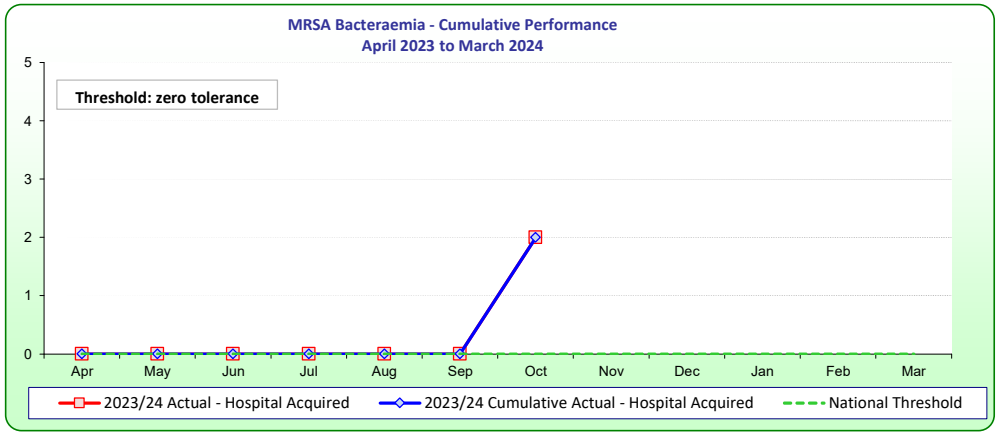
	Q41	Enable equal participation in all decision-making processes and Trust has method of recording this.	Partial Compliance
	Q42	Women's choices following a shared & informed decision-making process must be respected and evidence of this recorded.	Partial Compliance
	Q43	Robust mechanism working with 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.	Compliant
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

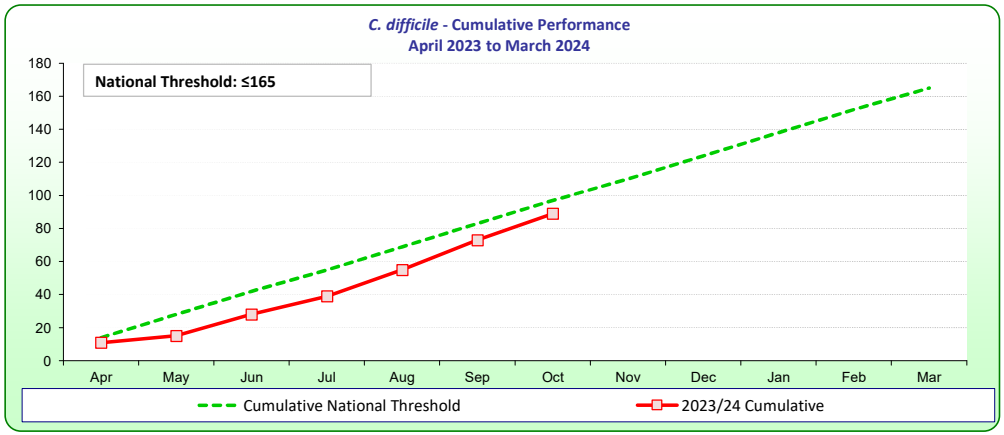
The Newcastle upon Tyne Hospitals
NHS Foundation Trust

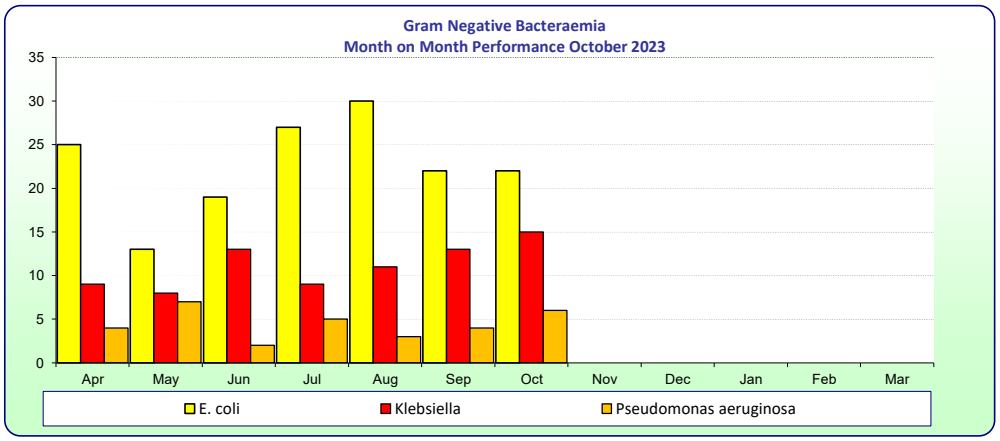
Healthcare-Associated Infections Report
October 2023

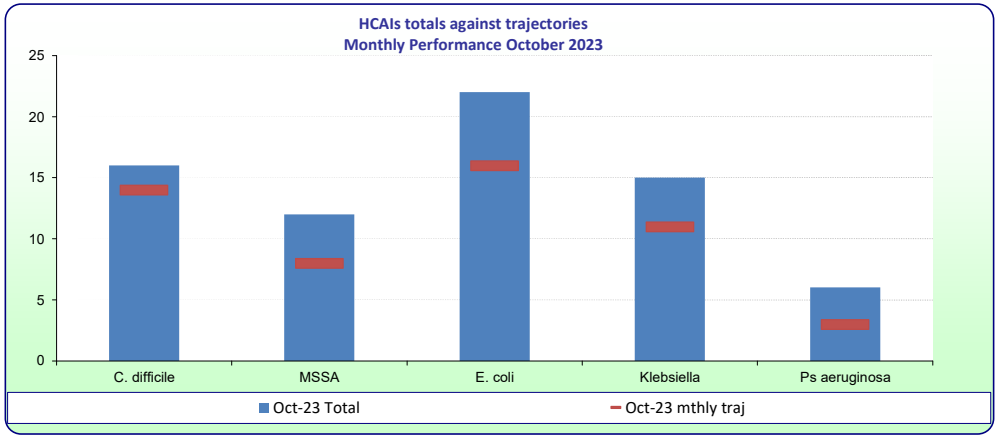
Healthcare-Associated Infection Report October 2023

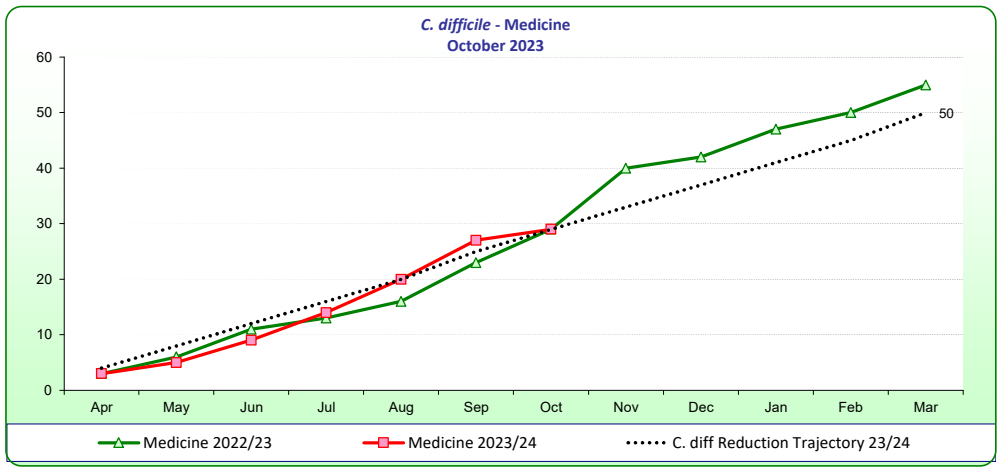
The Newcastle upon Tyne Hospitals NHS Foundation Trust

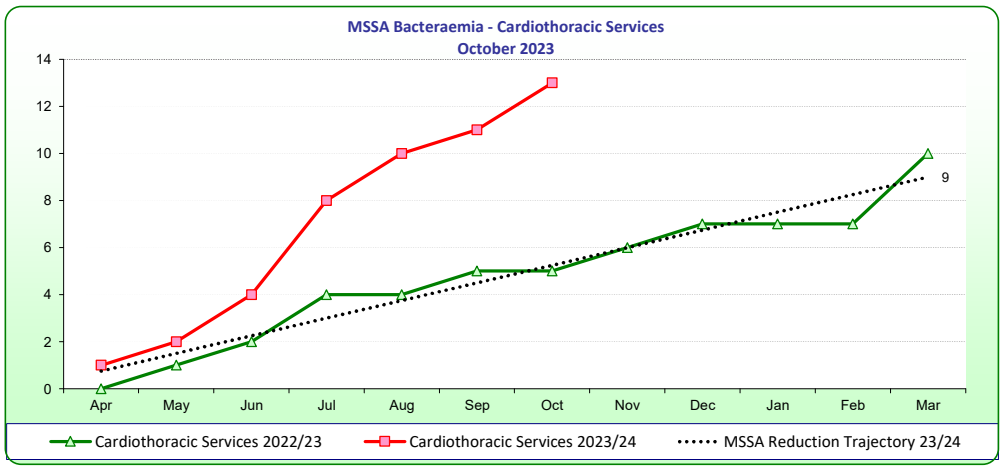






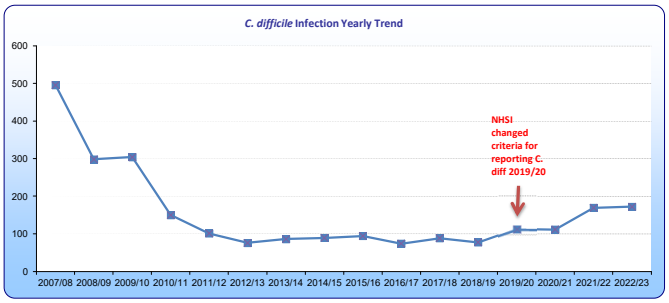


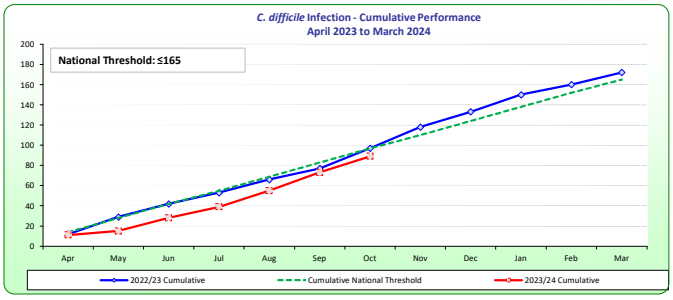


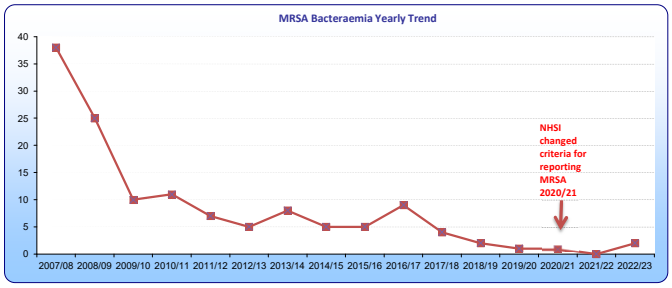


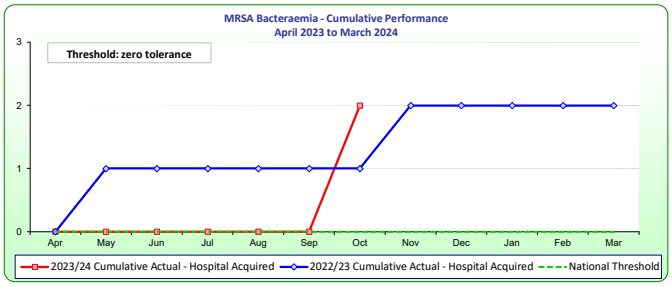
Healthcare-Associated Infection Report October 2023

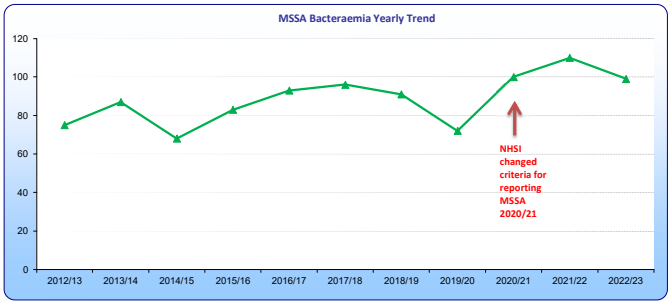
The Newcastle upon Tyne Hospitals NHS Foundation Trust

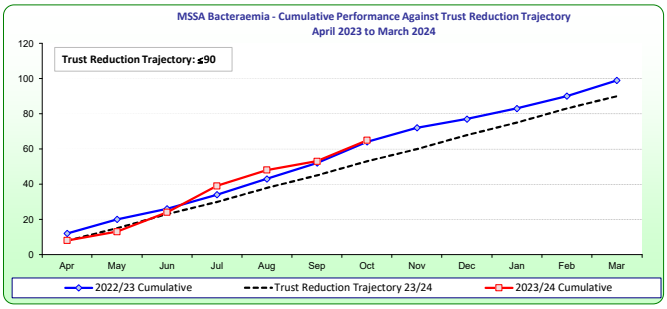


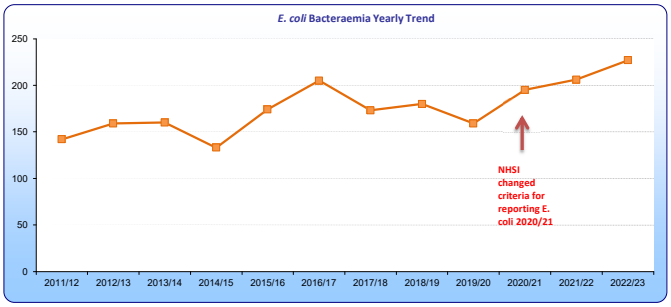


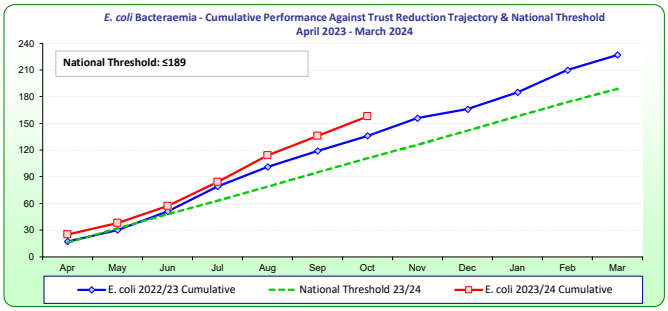


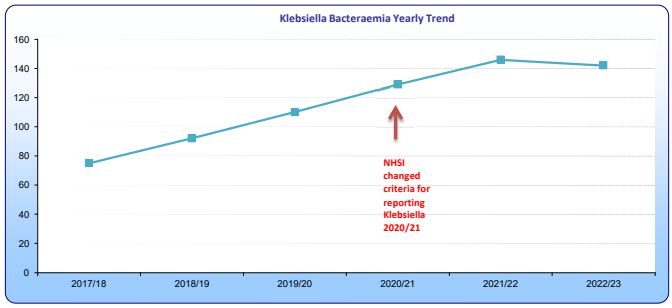


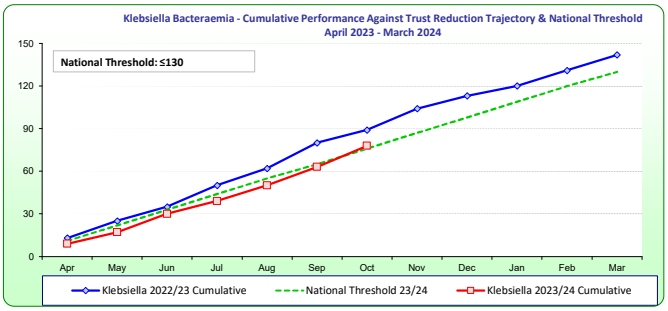


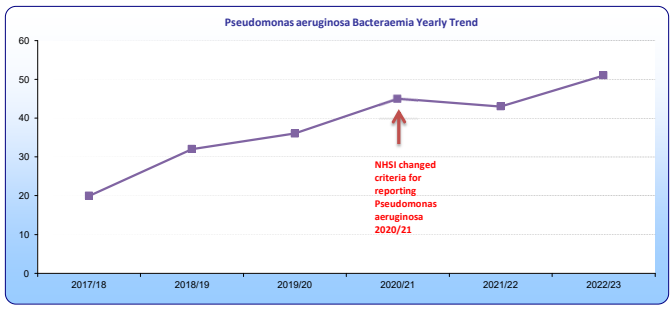


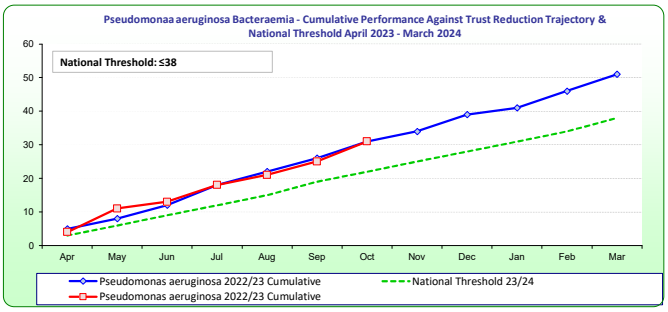












Bacteraemia / Infections

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	0	0						3
MRSA Bacteraemia - Trust-assigned (objective 0)	0	0	0	0	0	0	2						2
MSSA Bacteraemia - Healthcare Associated (local objective ≤90)	8	5	11	15	9	5	12						65
E. coli Bacteraemia - Healthcare Associated (National Threshold ≤189)	25	13	19	27	30	22	22						158
Klebsiella Bacteraemia - Healthcare Associated (National Threshold ≤130)	9	8	13	9	11	13	15						78
Pseudomonas aeruginosa Bacteraemia - Healthcare Associated National Threshold ≤38)	4	7	2	5	3	4	6						31
C. diff - Hospital Acquired (national threshold ≤165)	11	4	13	11	16	18	16						89
C. diff related death certificates	2	0	1	0	0	1	0						4
Part 1	2	0	1	0	0	1	0						4
Part 2	0	0	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	1	3	4	1						13
Patients affected	1	2	6	1	6	12	6						34
COVID-19 - Hospital Acquired	1	1	1	0	5	0	2						10
Patients affected	2	3	2	0	11	0	6						24

Healthcare Associated COVID-19 cases (reported to DH)	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Cumulative
Hospital onset Probable HC assoicated (8-14 days post admission)	23	8	6	1	30	25	28						121
Hospital onset Definite HC assoicated (≥15 days post admission)	39	20	7	0	32	37	46						181

Outbreaks	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Cumulative
Norovirus Outbreaks	2	1	0	0	0	1	0						4
Patients affected (total)	18	8	0	0	0	5	0						31
Staff affected (total)	4	7	0	0	0	3	0						14
Bed days losts (total)	126	3	0	0	0	0	0						129
Other Outbreaks	0	0	1	0	0	0	0						1
Patients affected (total)	0	0	18	0	0	0	0						18
Staff affected (total)	0	0	6	0	0	0	0						6
Bed days losts (total)	0	0	51	0	0	0	0						51
COVID Outbreaks	8	2	1	0	8	5	5						29
Patients affected (total)	38	18	4	0	63	37	43						203
Staff affected (total)	0	4	0	0	0	1	0						5

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	11:36	11:53						12:33
Laboratory Turnaround Time	03:23	03:08	02:55	01:53	02:10	01:56	01:42						02:26
Total to Result Availability	17:10	17:03	14:48	14:02	14:51	13:32	13:35						15:00

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%	88%	90%						92%
Standard IPC Precautions (incl HH, ANTT, PPE) Audit Trust Total	96%	96%	93%	94%	91%	89%	91%						93%
Invasive Device Care Audit Trust Total	95%	96%	92%	93%	93%	92%	95%						94%
Matron Checks (IP; OP/Community/Dental; Theatres) Trust Total	94%	96%	91%	97%	93%	92%	95%						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%	85%	90%						92%
Standard IPC Precautions (incl HH, ANTT, PPE) Audit Acute only Total	96%	95%	93%	94%	91%	89%	91%						93%
Invasive Device Care Audit Acute only Total	96%	96%	92%	93%	93%	92%	96%						94%
Matron Checks (IP; OP/Community/Dental; Theatres) Acute only Total	94%	96%	91%	97%	92%	92%	95%						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%	100%	95%						97%
Standard IPC Precautions (incl HH, ANTT, PPE) Community only Total	91%	100%	95%	93%	92%	96%	91%						94%
Invasive Device Care Audit Community only Total	78%	100%	100%	100%	100%	100%	78%						94%
Matron Checks (OP/Community/Dental) Community only Total	98%	99%	99%	100%	98%	95%	100%						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%	95%	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	NYA	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.

Aug/Sep 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

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	30 November 2023						
Title	North East and North Cumbria (NENC) Provider Collaborative Governance – Update for NHS Foundation Trust Boards						
Report of	Matt Brown, Managing Director – NENC Provider Collaborative						
Prepared by	Matt Brown, Managing Director – NENC Provider Collaborative						
Status of Report	Public	Private	Internal				
	☒	☐	☐				
Purpose of Report	For Decision	For Assurance	For Information				
	☐	☐	☒				
Summary	This update outlines the governance arrangements for the NENC Provider Collaborative, specifically focusing on the responsibility agreement with the Integrated Care Board (ICB) and strategic partnership agreed with NEC's.						
Recommendation	The Trust Board are asked to note the progress.						
Links to Strategic Objectives	1. Partnerships – we will be an effective partner, developing and delivering integrated care and playing our part in local, regional, national, and international programmes.						
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☒	☐	☐	☐	☐	☒	☒
Link to Board Assurance Framework [BAF]	N/A						
Reports previously considered by	New report.						

ENC 8

North East and North Cumbria
Provider Collaborative

North East and North Cumbria Provider Collaborative Governance

Update for NHS Foundation Trust Boards

October 2023

1. Purpose and Requirement

1.1. Annex A provides an update for NHS FT Boards on progress with the Collaborative, specifically focusing on governance requirements.

2. Context

2.1. Over summer 2022 Trust Boards received from the Collaborative an outline of governance and associated requirements, setting out how the Collaborative would operate and take decisions. The information shared including the aims and aspirations of the Collaborative, the MoU and Operating Model. It flagged that there were discussions ongoing with ICB on a prospective responsibility agreement.

2.2. This update for Trust Boards confirms the ICB responsibility agreement (as well as noting the strategic partnership arrangement with NECS), therefore ensuring Boards have a full picture of Collaborative governance and working arrangements.

3. Recommendation

3.1. The Provider Leadership Board is asked to sign this off and agree to circulation to Boards.

Matt Brown
Managing Director
North East and North Cumbria Provider Collaborative
26th September 2023

North East and North Cumbria Provider Collaborative

North East and North Cumbria Provider Collaborative Governance

Update for NHS Foundation Trust Boards

October 2023

1. Purpose

1.1. The purpose of this note is to update Boards on the governance arrangements for the NENC Provider Collaborative (the Collaborative) specifically focusing on the responsibility agreement (RA) with the ICB and the strategic partnership agreed with NECs.

1.2. Trust Boards are asked to note progress in these areas.

2. Context

2.1. In July 2022 the Collaborative provided an update to Trust Boards noting the agreement for the 11 Foundation Trust's in NENC to formally work together set out in the 'Collaboration Agreement'. This agreement was supported by an aims and aspirations document as well as an operating model. All Trust Boards approved these by September 2022.

2.2. In presenting the formal collaborative approach it was noted that the final element of these arrangements was a responsibility agreement (RA) with the ICB which was under discussion at that point in time. That agreement is now in place for 2022/3, with the following summarising the requirements and the full RA attached at appendix A.

3. Responsibility Agreement

3.1. NHSE guidance on the functions and governance of the integrated care board (August 2021) stated that:

> *Provider collaboratives will agree specific objectives with one or more ICBs, to contribute to the delivery of that system's strategic priorities. The members of the collaborative will agree together how this contribution will be achieved.*
>
> *The ICB and provider collaboratives must define their working relationship, including participation in committees via partner members and any supporting local arrangements, to facilitate the contribution of the provider collaborative to agreed ICB objectives.*

3.2. To meet this requirement the Collaborative and ICB have established a responsibility agreement (RA) which defines and describes the working relationship between the ICB and the Collaborative. It provides a framework for building an ongoing relationship recognising that:

- The ICB and the Collaborative share a vision and purpose, with common aims and objectives to improve the health and wellbeing of the people of the North East and North Cumbria.

- This is a supportive relationship which will evolve over time.
- The agreement sets out the agreed remit of the Collaborative in relation to the delivery of the NENC Integrated Care Strategy.

3.3. The RA also covers ways of working both in terms both formal and informal and how resources will be secured both to undertake programmes of improvement and for investments. It is an annual arrangement that will be reviewed and refreshed in year, with an agreement for 24/5 to be in place for 1st April 2024.

3.4. The RA recognises that the Collaborative's Provider Leadership Board will determine programme governance structures required to deliver the agreed work programme, ensuing where appropriate links are made with the relevant NHS England regional and national programme teams. Where agreed programmes of work are mapped to the delivery of ICB goals and objectives within the Integrated Care Strategy and when complete, the Five Year Forward Plan, the Collaborative will report progress through to the ICB via the ICB programme management system.

3.5. The RA recognises that areas of work will evolve over time and there will be a need to respond to emerging and ad hoc requirements. However it does set out the specific work programmes agreed between the ICB and the Collaborative for 2023/4, which are summarised below:

i. Delivery of a comprehensive elective recovery plan and programme, including leading the work of the ICS with the Getting It Right First Time Programme.

ii. Delivery of a diagnostics plan and programme.

iii. Support the development of the overarching ICB clinical strategy, as part of which, taking a lead on the strategic approach to secondary and tertiary clinical services to address quality and sustainability issues across the sector. This will include ad hoc clinical service improvement work and the oversight of relevant clinical networks.

iv. Continued implementation of the aseptic manufacturing hub.

v. Leadership of the FT capital programme, supported by agreed capital priorities and goals for estates, equipment and digital.

vi. Delivery of a strategic workforce programme on behalf of the FT providers, linking to the ICB programme and to include action on agency spend and bank arrangements.

3.6. The RA established a Collaborative operational budget of £1.3m for 2023/4. This is comprised of:

- £600K contribution from the NECS (on behalf of ICB)
- £200K roll over of underspend from previous years
- £500K contribution from Trusts.

4. Strategic Partnership with NECS

4.1. As part of evolving working arrangements the Collaborative has agreed to form a strategic partnership with NECS. This recognises the role and support which NECS has offered in the establishment of the Collaborative and the ongoing alignment of priorities and work areas for the Collaborative and NECS focusing on, specifically:

- The deployment of resources and support across system programmes and areas, covering people, digital and analytical requirements;
- The identification of economies of scope and scale in corporate, clinical and clinical support services;
- The delivery of system priorities where there is appropriate congruence (e.g. elective recovery);
- The building of capacity and capability to ensure future resilience through the identification, development and deployment of digital tools and AI to the mutual benefit of the partners;
- Developing population-based approaches to the management of patients to facilitate better care, outcomes and utilisation of resources;
- Mutual development of skills, leadership and associated development for clinical and non-clinical staff.

4.2. This relationship will enable the Collaborative to draw upon the capabilities of NECS and its wider expertise and experience via its comprehensive supply chain as well as being able to shape the direction and development of NECS' strategic direction and priorities.

5. Recommendation

5.1. The FT Boards of the eleven NENC Provider Collaborative members are asked to:

i. Note the Responsibility Agreement between the ICB and Collaborative
ii. Note the strategic partnership between the Collaborative and NECS

Matt Brown
Managing Director
North East and North Cumbria Provider Collaborative
26th September 2023

Appendix A: Responsibility Agreement

NHS
North East and North Cumbria
Provider Collaborative

NHS
North East and
North Cumbria

PROVIDER COLLABORATIVE RESPONSIBILITY AGREEMENT

2023/24

1 PURPOSE

This Responsibility Agreement defines and describes the working relationship between the North East and North Cumbria (NENC) Integrated Care Board (ICB) and the NENC Foundation Trust Provider Collaborative (the Collaborative). It provides a framework for building an ongoing relationship and collaboration, which recognises that:

- The ICB and the Collaborative share a vision and purpose, with common aims and objectives to improve the health and wellbeing of the people of the North East and North Cumbria.
- This is a supportive relationship which will evolve over time.
- The agreement sets out the agreed remit of the Collaborative in relation to the delivery of the NENC Integrated Care Strategy.
- It also covers ways of working both in terms both formal and informal and how resources will be secured both to undertake programmes of improvement and for investments.

2 BACKGROUND

The Provider Collaborative provides a formal mechanism for collective decision making across all 11 FTs on important 'whole system' issues in NENC. The Collaborative will act on behalf of and take decisions representing the collective view of our 11 FTs, through an approach that will be additive, tackle unwarranted variation and enhance working at Place.

The Collaborative began working together in 2019 with

arrangements formally endorsed by Trust Boards over the summer of 2022.

3 MEMBERSHIP OF THE PROVIDER COLLABORATIVE

The Members of the Collaborative are all of the foundation trusts (FTs) within NENC:

- County Durham and Darlington NHS FT
- Cumbria, Northumberland, Tyne and Wear NHS FT
- Gateshead Health NHS FT
- Newcastle Upon Tyne Hospitals NHS FT
- North Cumbria Integrated Care NHS FT
- North East Ambulance Service NHS FT
- North Tees and Hartlepool NHS FT
- Northumbria Healthcare NHS FT
- South Tees Hospitals NHS FT
- South Tyneside and Sunderland NHS FT
- Tees, Esk and Wear Valleys NHS FT

3 REMIT

3.1 General

The Collaborative will identify and deliver a programme of mutual benefit and that:

- Contributes to the delivery of the NENC Integrated Care Strategy, in particular its long term goal of 'Better Health and Care Services' by identifying opportunities to improve the quality and sustainability of the health services in the Region, towards a goal of all statutory organisations regulated by the Care Quality Commission being rated either 'Good' or 'Outstanding'.

- Supports the efficient and effective use of resources within its member organisations, with a focus on opportunities to collaborate and/or share resources and to identify and reduce unwarranted variation

- Undertakes collective strategic workforce planning in collaboration with national and regional teams

- Develops opportunities to act as 'anchor institutions', including supporting economic development by leveraging their power as large employers and purchasers.

- Supports the achievement of the integrated care strategy goals of 'longer, healthier life expectancy' 'fairer outcomes'.

3.2 Specific work programmes agreed between the ICB and the Collaborative for 2023/24

- Delivery of a comprehensive elective recovery plan and programme, including leading the work of the ICS with the Getting It Right First Time Programme.

- Delivery of a diagnostics plan and programme

- Support the development of the overarching ICB clinical strategy, as part of which, taking a lead on the strategic approach to secondary and tertiary clinical services to address quality and sustainability issues across the sector. This will include ad hoc clinical service improvement work and the oversight of relevant clinical networks.

- Continued implementation of the aseptic manufacturing hub

- Leadership of the FT capital programme, supported by agreed capital priorities and goals for estates, equipment and digital

- Delivery of a strategic workforce programme on behalf of the FT providers, linking to the ICB programme and to include action on agency spend and bank arrangements

3.3 As appropriate the Provider Collaborative and the ICB will identify in issues and opportunities where a collective provider response is required. This could include specific service issues (for example development and deployment of response to CMDU) to cross cutting issues (e.g. developing an approach to repatriations).

3.4 The ICB will support the Collaborative in its work which will include access to appropriate resourcing for system objectives as well access to appropriate data and analytics to inform work, where the ICB holds this information, on the principle of 'do it once'. The ICB will also ensure appropriate officer involvement in Collaborative work programmes as agreed with the Collaborative.

4 GOVERNANCE ARRANGEMENTS

It is recognised that these arrangements may evolve over time.

The Provider Collaborative operates as a formal partnership of all 11 NHS Foundation Trusts (FTs) in NENC. It is a whole system collaborative acting, at scale across multiple FTs with individual FTs continuing to work with each other in collaborative arrangements on a geographical or sectoral basis and play full roles within their relevant place-based partnerships, working closely with local communities and partner organisations.

It is underpinned by a formal collaboration agreement, operating under a provider leadership model, with formal mechanisms for collective decision making across all FTs on important 'whole system' issues. The Collaborative will act on behalf of and take decisions representing the collective view of our 11 FTs, rather than being a separate formal entity. Individual organisations remain accountable in line with NHS governance and regulatory requirements.

The PLB will determine the programme governance structure required to deliver the agreed work programme, ensuing where appropriate links are made with the relevant NHS England regional and national programme teams.

Where agreed programmes of work are mapped to the delivery of ICB goals and objectives within the Integrated Care Strategy and when complete, the Five Year Forward Plan, the Collaborative will report progress through to the ICB via the ICB programme management system.

5 RESOURCES

Based on the work programme contained within this agreement, the resources for 23/24 are set out below in summary, together with the funding sources.

Costs banded at top of grade, or actual where available.

Post	WTE	Band	Annual cost £k	23/24 cost £k
Managing Director (hosted by NUTH)	1.0	VSM	130	130
Director of Elective Recovery & Transformation (NHSE)	0.4	VSM	60	60
Elective Programme Director (NECS)	1.0	8D	605	605
Corporate Programme Director (NECS)	1.0	8D		
Senior Development Lead (NECS)	1.0	8D		
Senior Project Manager (NECS)	1.0	8A		
Programme Support Officer (NECS)	1.0	5		
Mutual Aid Lead (STSFT)	0.4	8A	30	30
Project Support Officer (NECS)	1.0	5	60	60
Senior Programme Support Officer (Gateshead)	1.0	6	55	30
Subtotal (filled)			***940***	***915***
Vacant				
Clinical Programme Lead	1.0	8C	95	70
Project Manager	4.0	7	240	180
Performance & Intelligence Lead	0.6	8A	45	30
Finance Lead	0.2	8A	15	10
Comms Lead	1.0	6	60	45
Administrative Assistant	1.0	3	30	20
Clinical Leadership & Backfill			30	30
Subtotal (vacant)			***515***	***385***
Non pay (inc corporate support eg HR, finance)			30	30
Total Costs			**1,485**	**1,330**
Income				
Carry over from 22/23				180
NECS contribution				500
ICB contribution				100
FT contribution (£550k/11 = **c£50k per FT**)				550
Total Income				**1,330**

Note – the right-hand column, denoted 23/24 cost (£k), takes account of likely actual in-year costs, for example due to recruitment taking place mid-year

Separate funding streams are in place in 23/24 for:

- Aseptics Project Director

- Aseptics Project Manager
- Cancer Programme Manager
- Diagnostics Programme

There will be other potential posts through the Provider Collaborative, such the Digital Diagnostics Implementation Leads, pharmacy and procurement opportunities e.g., diabetic devices.

In addition, the ICB and will support the Collaborative in the following ways:

- A shared approach to the use of BI resources, including a commitment to 'do once and share'
- Support from the ICB Programme Management Office, and access to a suite of project management and quality improvement tools
- Support for the team, with a link executive and team (the Chief of Strategy and Operations)

6 AGREEMENT

Insert signature	Insert Signature
Ken Bremner	Sam Allen
Chair, Provider Collaborative	CEO, Integrated Care Board
Insert Date	Insert Date

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	30 November 2023						
Title	Update from Committee Chairs						
Report of	Non-Executive Director Committee Chairs						
Prepared by	Mrs Gillian Elsender, PA to Chairman and Trust Secretary / Corporate Governance Officer Miss Molly Bowater, Corporate Governance Administrator						
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 September 2023: • People Committee – 17th October 2023 • Audit Committee – 24th October 2023 • Charity Committee – 16th November 2023 • Quality Committee – 21st November 2023 • Finance Committee – 29th November 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 September 2023.

UPDATE FROM COMMITTEE CHAIRS

1. PEOPLE COMMITTEE

A meeting of the People Committee took place on 17th October 2023. During the meeting, the main areas of discussion included:

- An update on Industrial action from the Head of HR.
- The new and emerging risks.
- An update on Medical and Dental staffing from the Medical Director.
- The Fit for the Future update was delivered by Chief Operating Officer and the Chief People Officer.
- The Chief People Officer discussed the People Priorities Delivery update as well as Leadership Development, Talent and Succession Planning.
- The Assistant Chief Executive delivered an update on the Communications Strategy and an external engagement update.
- The People and Culture dashboard was presented by the Head of Human Resources.
- Minutes of the following Groups were received:
    - Learning and Education Group (19th June 2023)
    - Sustainable Health Care Committee (7th September 2023)
- The following Reports were received:
    - Freedom to Speak Up Guardian Report.
    - Guardian of Safe Working Report.

The next formal meeting of the Committee will take place on 19th December 2023.

2. AUDIT COMMITTEE

A meeting of the Audit Committee took place on 24th October 2023. During the meeting, the main areas of discussion included:

- Updates from the Committee Chairs regarding risk and assurance by exception.
- The Chief Operating Officer and the Assistant Chief Executive led on a discussion in relation to the assurance from management as to the processes in place for responding to the CQC inspection reports.
- The Head of Corporate Risk and Assurance Manager presented the Board of Assurance Framework and an update on the Risk Management Module procurement exercise was included.
- The Charity External Audit report and Annual Financial Statements were discussed and a Director of Robson Laidler attended to present the audit report.
- An update on the Scheme of Delegation, Standing Financial Instructions and Standing Orders Updates was presented by the Trust Secretary and Deputy Chief Finance Officer, with the proposed amendments approved.
- The Internal Audit Progress Report was presented by the Chief Auditor.
- The Counter Fraud Activity Report was presented by the Fraud Team Specialist Manager, which included the fraud response log.

- The External Audit update including the Final Auditors Annual Report from 2022/23 was presented.
- A review of the following items was presented by the Deputy Chief Finance Officer and the Assistant Finance Director:
    - Schedule of approval of single tender action and breaches and waivers exception report (there was 2 quarters of waiver reports for this meeting).
    - Debtors and creditors balances.
    - Schedule of losses and compensation.
- The minutes of the following meetings were received:
    - Finance Committee- 26th July 2023 (FINAL) and 25th September 2023 (DRAFT).
    - People Committee- 22nd June 2023 (FINAL) and 22nd August 2023 (FINAL).
    - Quality Committee- 18th July 2023 (FINAL).

The next meeting of the Committee will take place on 23rd January 2024.

3. CHARITY COMMITTEE

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

- Grant Programmes presented by the Associate Director of Funding and Partnerships, including:
    - Grants for committee approval
    - Summary of Grants agreed since the last committee meeting
- The Charity Director provided an update on strategy and governance which included VAT, Liabilities and the Investment task Group.
- Annual Reports and Accounts.
- The Charity Director provided an update Team Growth and Accommodation, and the Draft Reserves policy.
- The following grants were approved:
    - Identifying & Responding to Health Needs in Asylum / Refugee families – Specialist Public Health Nurse 0-19 Service - £129,756
    - Learning Disability: Engagement, Quality Checks and Easy Read with Skills for People - £79,700
    - Phagenyx dysphagia medical device speech and language therapy - £52,155
    - MRI compatible DVD players - £28,600
    - RVI Leazes Wing Level 3 Junior Doctors Rest Room Refurbishment – Up to £700,000
    - Henderson Suite Refurbishment - £209,000
- The Financial Accountant for the Charitable Funds provide and update on the financial reports, Summary of Investments to June 2023 including Summary Investment Report.
- The Chair discussed the Dashboard re Operational KPI's and Communication, along with the Charity Risk Assessment, Connected Charities Checklist, and the Minutes of Associated Meetings as follows:
    - Great North Children's Hospital - 18th May 2023
    - Charity Committee Away Day - 10th October 2023

The next meeting of the Committee will take place on 12th February 2024.

4. QUALITY COMMITTEE

A meeting of the Quality Committee took place on 16th November 2023. During the meeting, the main areas of discussion included:

- The Management group Chair Reports were presented as follows:
  - Patient Safety Group by Vascular Consultant Surgeon
  - Clinical Outcomes and Effectiveness Group Chairs regular report by Consultant Anaesthetist
  - Compliance and Assurance Group Annual Report by Consultant Clinical Geneticist
  - Patient Experience and Engagement Group (PEEG) Chairs Report by Executive Chief Nurse
- The Director of Quality and Effectiveness presented the Quality Account Report.
- The Deputy Chief Nurse raised provide an update on the wards of concern.
- Quality and Performance Board Reports were discussed by the Director of Quality and Effectiveness and Consultant Microbiologist.
- Consultant Anaesthetist of Pre-Operative and Critical Care, and Implementation Lead of Patient Safety and Risk delivered a presentation on the National Patient Safety Strategy Update including Patient Safety Incident Response Plan.
- Updates on the current CQC position were provided by the Executive Chief Nurse and Director of Quality and Effectiveness.
- Quarter 2 reports as noted below were presented by Executive Chief Nurse and Deputy Chief Nurse:
  - Safeguarding
  - Learning Disability
- Dr Alexa Clark joined the meeting to present the End of Life and Palliative Care Bi-Annual Report.
- Leadership walkabouts updates and legal updates were received.
- Minutes of the following meetings were received.
  - Clinical Outcomes and Effectiveness Group- 11th August 2023
  - Compliance and Assurance Group- 20th July 2023
  - Patient Experience and Engagement Group- 22nd August 2023

The next meeting of the Committee will take place on 16th January 2024.

5 FINANCE COMMITTEE

A meeting of the Finance Committee took place on Wednesday 29th November 2023. During the meeting, the main areas of discussion included:

- An overview of the Month 7 Finance position including CIP and Capital Expenditure provide by the Chief Finance Officer and the Director of Estates.
- The Executive Director of Business, Development & Enterprise provided an update on the month 7 performance data.

- Commercial Strategy update by The Executive Director of Business, Development & Enterprise.
- Tenders (PR) and Business Cases (BC) for approval included:
    - Outpatient Pharmaceutical Dispensing Service (PR)
    - PSDS Works (PR)
    - Data Circuits (PR)
    - Pharmacy Immunoglobulin Deliveries (PR)
    - MRI Scanner (PR) & (BC)
    - Rapid Gas Isolator (BC)

- Receipt of minutes from:
    - Capital Management Group 12 September 2023 & 13 October 2023
    - Commercial Strategy Group 8 September 2023
    - Community Diagnostics Centres Strategic Oversight Group 29 August 2023 & 4 October 2023

Report of Molly Bowater
Corporate Governance Administrator
24 November 2023

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	30 November 2023						
Title	Integrated Board Report						
Report of	Angela O'Brien - Director of Quality and Effectiveness.						
Prepared by	Gavin Snelson - PSIRF Implementation 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 September 2023, the numbers of Trust onset C.difficile infections (n=18), E.Coli Bacteraemias (n=22), Klebsiella Bacteraemias (n=13) are all above the median line.
2. Since April 2023, there has been a sustained reduction under the median of inpatient acquired pressure ulcers (n=73).
3. Since June 2023, there has been a sustained reduction under the median of patient falls per 1000 bed days (n=197).
4. There were 9 Serious Incidents (SIs) reported in October 2023.
5. There was one Never Event were reported in October 2023, bringing the number of Never Events reported to date in 2023/24 to 8.
6. There were 1,972 responses to the Friends and Family test from the Trust in September 2023 (published October 2023).
7. The Trust has opened 138 formal complaints in July to September (Q2), which is an increase of 16% from the previous quarter.
8. The 2022-23 Annual Sharps Report highlighted an 8.7% increase in sharps incidents from the previous year.
9. Analysis of ATAIN in Quarter 2 (July/Aug/September) shows 6% of unplanned admissions of term babies were classed as avoidable which is an increase from the previous quarter (2.6%).
10. Staff turnover has decreased from 16.68% in October 2022 to 11.02% in Oct 2023, against a target of 8.0%.
11. At the end of October 2023, mandatory training compliance stands at 92.75% and appraisal compliance was 80.69%.
12. The Trust is reporting an adverse variance of £10.9 million against the agreed financial plan for the period ending 31 October 2023.

The Board of Directors is asked to receive the report.

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Integrated Board Report

Quality, People and Finance

November 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 continued to increase into October 2023. In addition to our patients being delayed in accessing assessment and packages of care and access to mental health beds, we have experienced increased activity and wider system pressures with an increased frequency of escalations in other Emergency Departments (EDs). COVID is being managed in the same way as any other infection, and there has been small number of Flu cases reported. Quarter 3 performance to date has dropped below the revised national standard of 76% with a difficult October, but the overall year to date performance remains slightly above this. There remains good management of ambulance handovers but there has been an increase in 12 hours trolley waits. There has been no significant adverse impact on the elective programme which is dynamically reviewed for the week ahead and on the day. Plans continue to progress aimed at increasing bed capacity as part of the winter plan to sustain recovery and ensure safe flow of emergency patients.

Report Highlights

1. Throughout the month of September 2023, the numbers of Trust onset C.difficile infections (n=18), E.Coli Bacteraemias (n=22), Klebsiella Bacteraemias (n=13) are all above the median line.

2. Since April 2023, there has been a sustained reduction under the median of inpatient acquired pressure ulcers (n=73).

3. Since June 2023, there has been a sustained reduction under the median of patient falls per 1000 bed days (n=197).

4. There were 9 Serious Incidents (SIs) reported in October 2023.

5. There was one Never Event were reported in October 2023, bringing the number of Never Events reported to date in 2023/24 to 8.

6. There were 1,972 responses to the Friends and Family test from the Trust in September 2023 (published October 2023).

7. The Trust has opened 138 formal complaints in July to September (Q2), which is an increase of 16% from the previous quarter.

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10. Staff turnover has decreased from 16.68% in October 2022 to 11.02% in Oct 2023, against a target of 8.0%.

11. At the end of October 2023, mandatory training compliance stands at 92.75% and appraisal compliance was 80.69%.

12. The Trust is reporting an adverse variance of £10.9 million against the agreed financial plan for the period ending 31st October 2023.

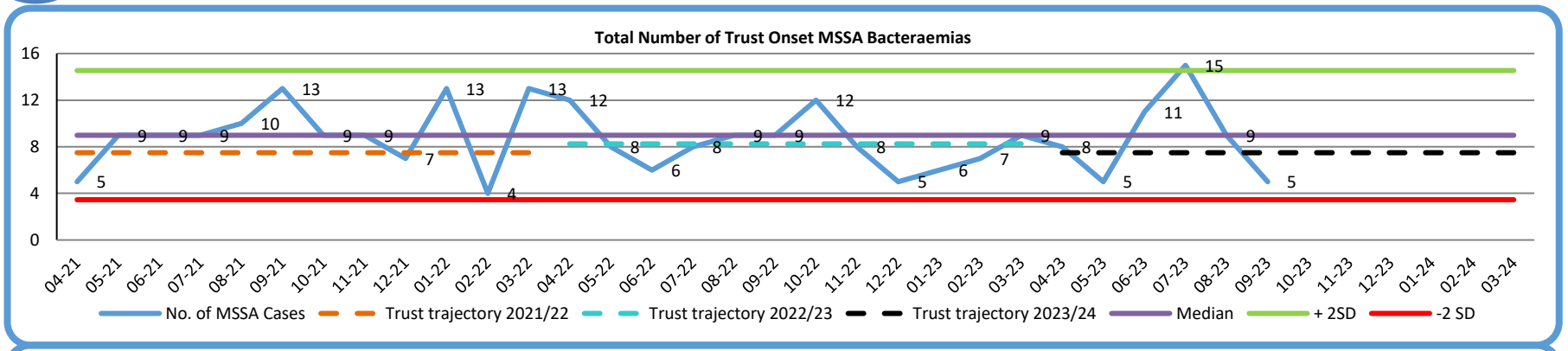
Contents: November 2023

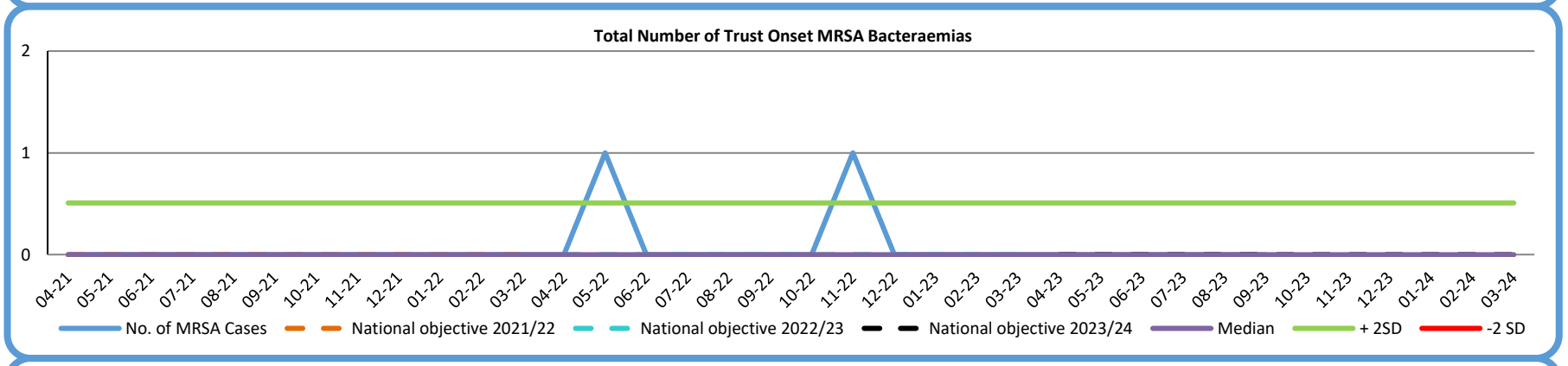
Quality

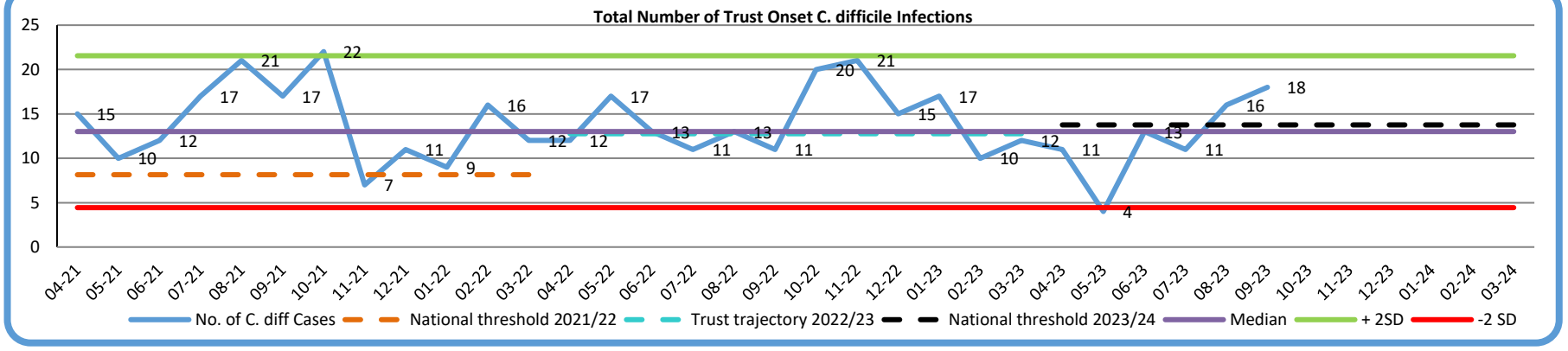
People

Finance

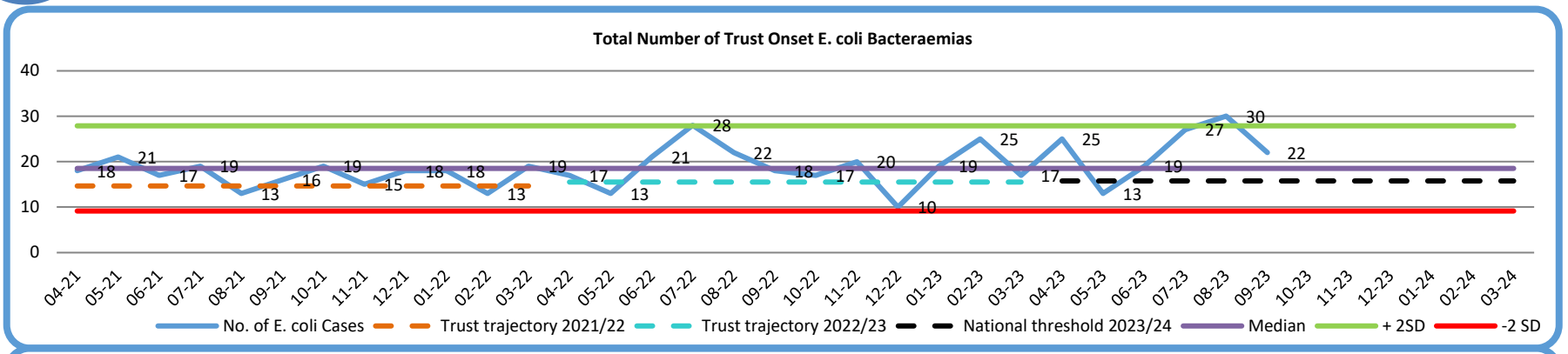
Quality: Healthcare Associated Infections 1/2

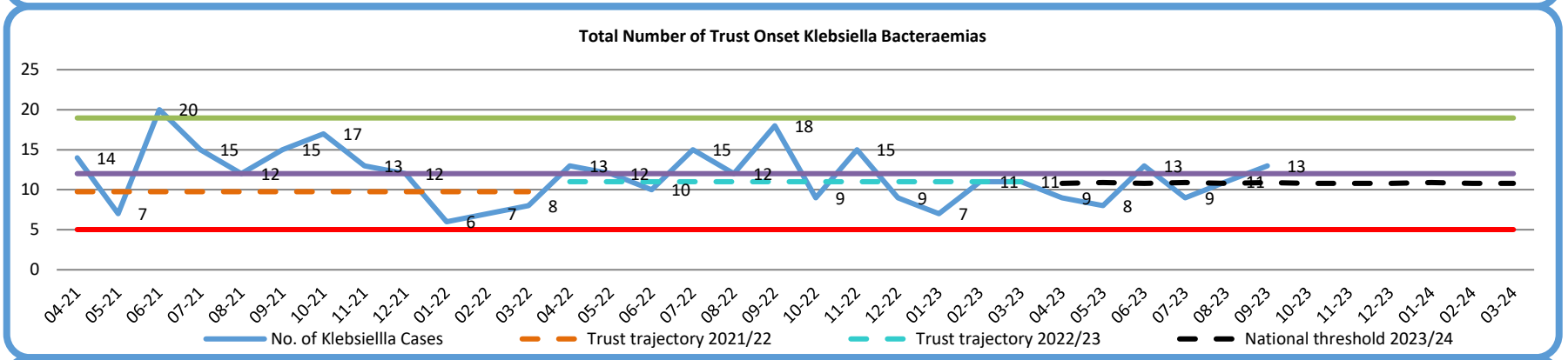


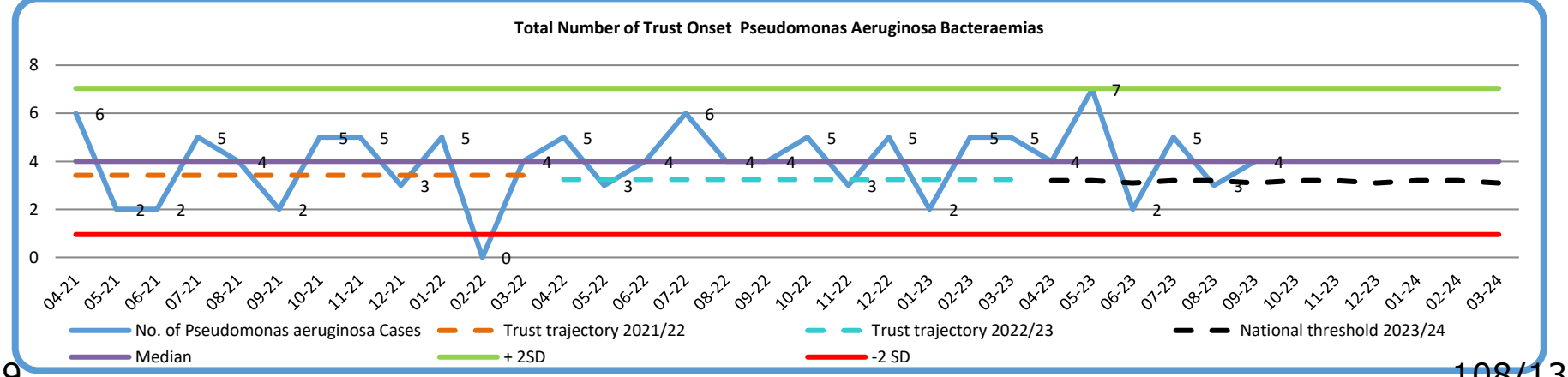




Quality: Healthcare Associated Infections 2/2



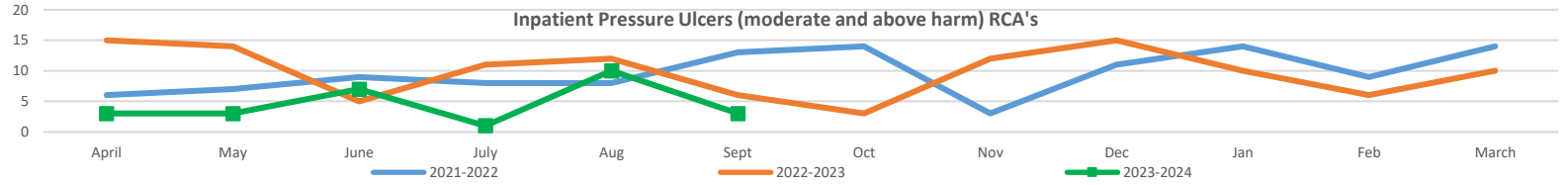


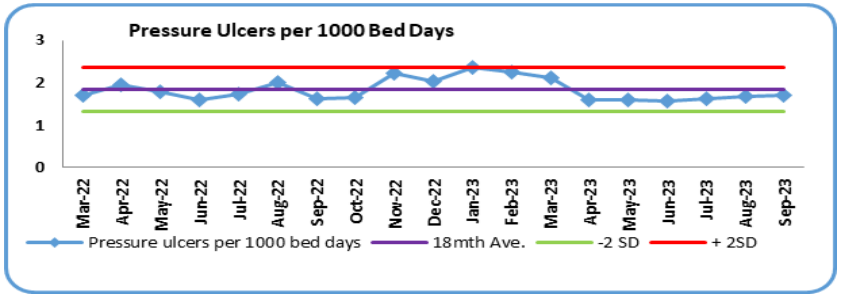


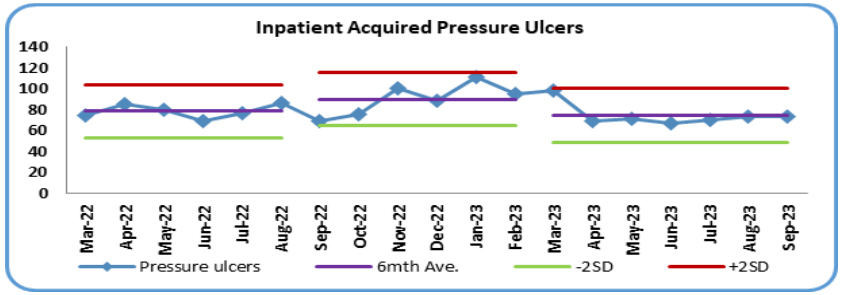
Quality: Harm Free Care – Pressure Damage

Current position:

- There has been a 10% reduction in inpatient acquired pressure ulcers in the past 6 months compared to the same period (April to September) in 2022. The monthly average being 70 in 2023 compared to the monthly average of 78 last year.
- There was a peak in January 2023 of 111 cases, followed by 95 in February and 98 in March. From April we have reported a significant and sustained reduction both in terms of total numbers and per 1,000 bed days.
- The number of pressure ulcers causing serious harm also reduced in September, over all the number of serious incidents has reduced by 57% between April and September compared to the same period in 2022.







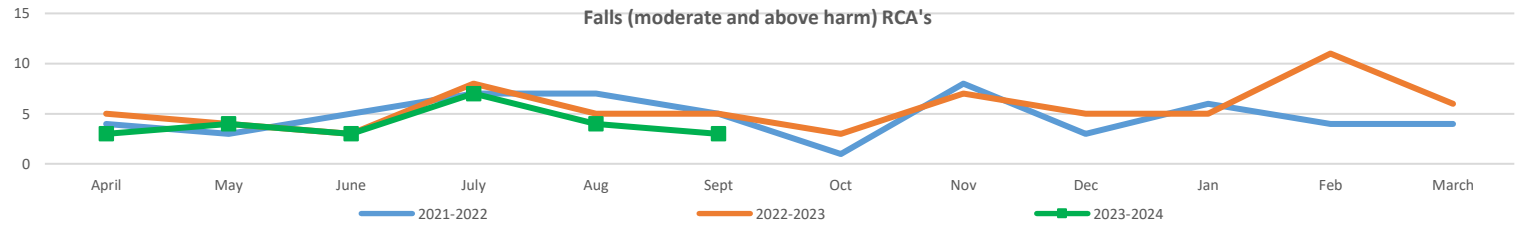
Current actions in place:

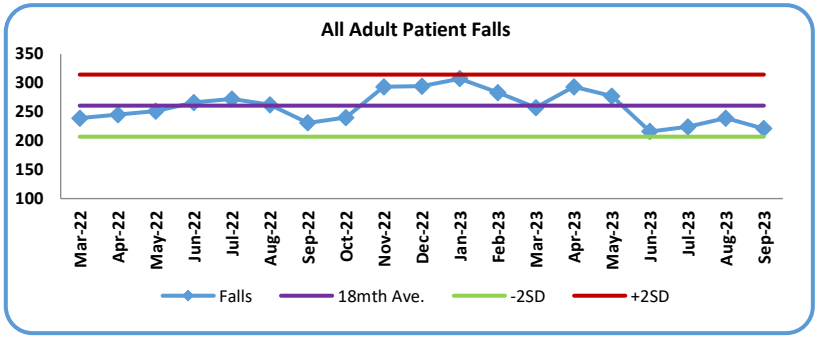
- On a monthly basis, each inpatient ward area receives their harm free care dashboard to guide local improvement and inform good practice.
- All areas (excluding the Great North Childrens Hospital (GNCH)) were given a 20% improvement trajectory for 2022-23.
- The Tissue Viability Team identify areas of high incidence, undertaking focussed work where required. This includes staff education as well as examining themes of Root Cause Analysis' (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 RVI23 and then FH13) followed in August by FH14 to introduce a new risk assessment tool called PURPOSE T replacing 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 demonstrate good utilisation of the tool, although daily skin assessment completion, which is a key component of Purpose T, 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 (FH21) and then maternity areas, with a planned complete Trust rollout early next year.

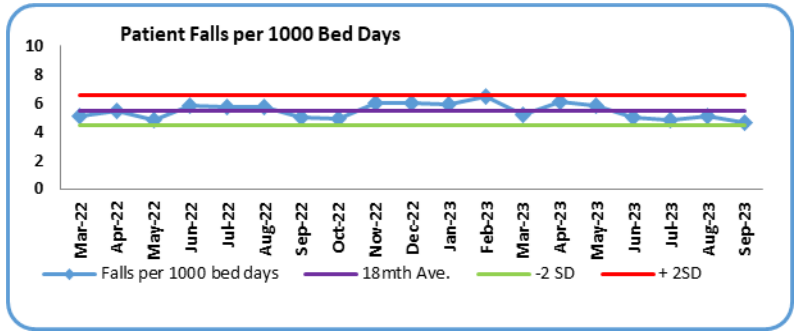
Quality: Harm Free Care - Falls

Analysis of data has demonstrated the following key points:

- Falls have remained at low levels since June 2023, with a noted reduction in comparison to last year of 4% with 221 falls in September 2023.
- The monthly average for falls has also fallen from 255 to 245 over the past 6 months.
- This downward trend is also reflected in adult in patient falls with falls per 1,000 bed days being at its lowest point in September.
- Falls resulting in significant harm has also continued to fall following a peak in July.



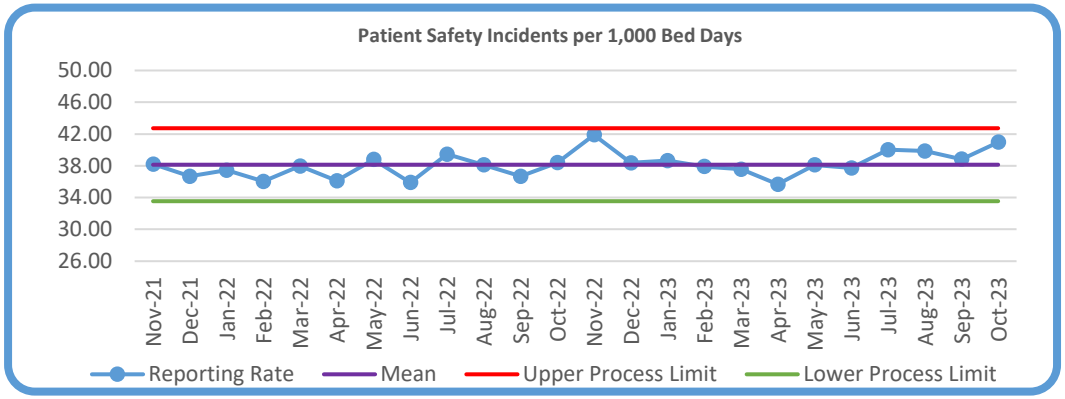




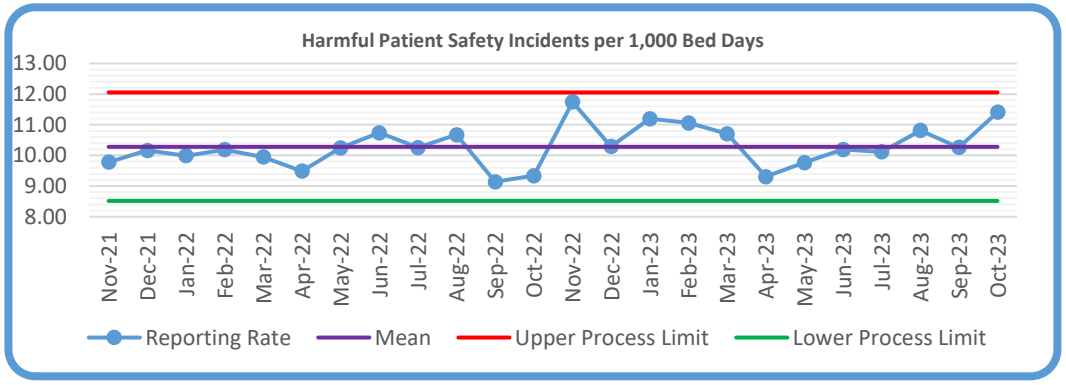
Current actions in place:

- The Falls Co-ordinator reviews ward level data on a monthly basis. Wards with the highest incidence of falls, contributory factors are reviewed with learning and solutions being identified. The aim is 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. A pilot of prompt cards issued to staff to remind them of ECO levels has commenced on RVI44, FH17 will undertake a similar pilot as part of learning identified in an RCA.

Quality: Incident Reporting

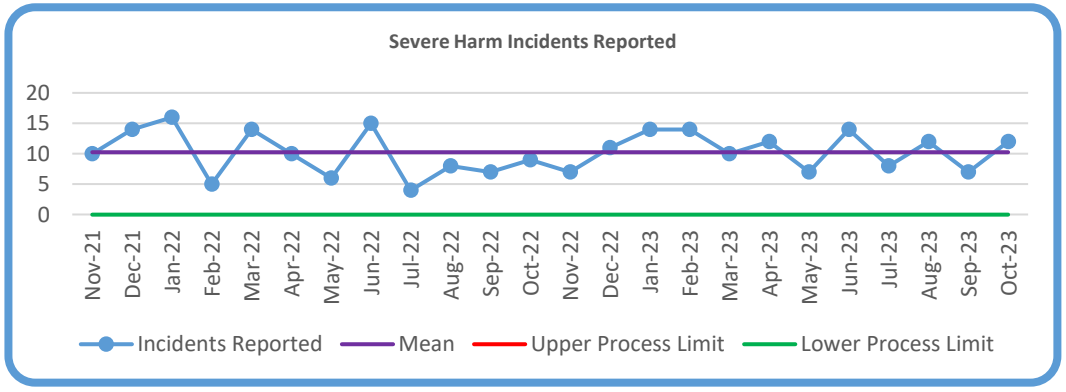


All patient incidents: The number of patient safety incidents per 1,000 bed days reported in October 2023 has risen. This is similar to the trend seen in from July to October 2022 where a downward trend from July to September was followed by an increase in incidents reported in October. This might indicate a seasonal pattern, although it is acknowledged that the overall number of incidents is higher in 2023 compared to that same time period in 2022.



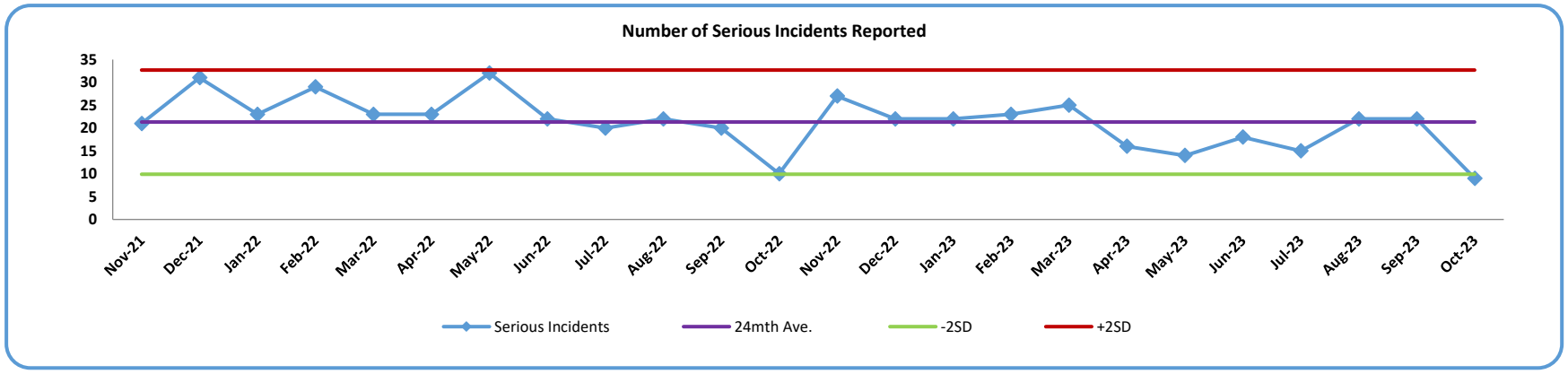
Harmful incidents: The number of *harmful patient safety incidents per 1,000 bed days has risen in October 2023. This is similar to the increase seen between December 2022 and January 2023 and is likely to reflect the high occupancy levels seen across the Trust.
Severity grading of reported incidents 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.*

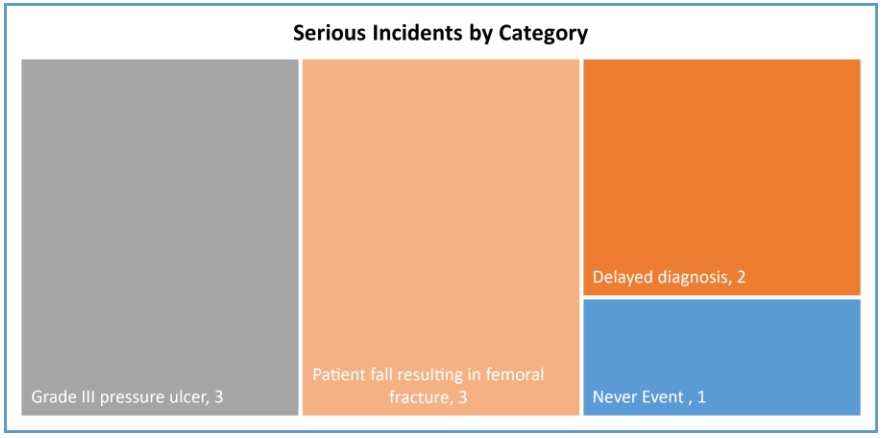


Severe harm incidents: There were 12 patient safety incidents reported that resulted in severe harm in October 2023, which is the same number that was reported in August. It can be seen from the chart that severe harm incidents have consistently fluctuated around the mean since March 2023.
Severity grading of reported incidents may be modified following investigation and is therefore subject to change in future reports.

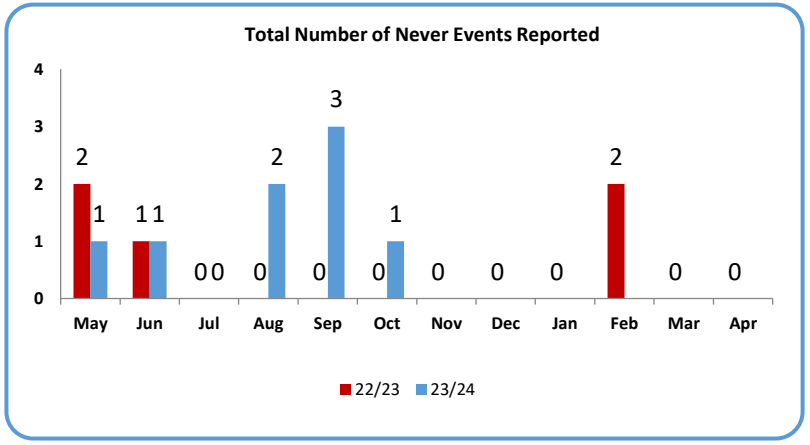
Quality: Serious Incidents and Never Events



There were 9 Serious Incidents (SIs) reported in October 2023, which is 1 lower than the number reported in October 2022 and the lowest number that have been reported in 2023. The statutory requirement Duty of Candour (DoC) applies to patient safety incidents that occur when providing care and treatment that results in moderate, severe harm or death and requires the Trust to be open and transparent with patients and their families. The DoC process has been initiated for all cases reported in October 2023.

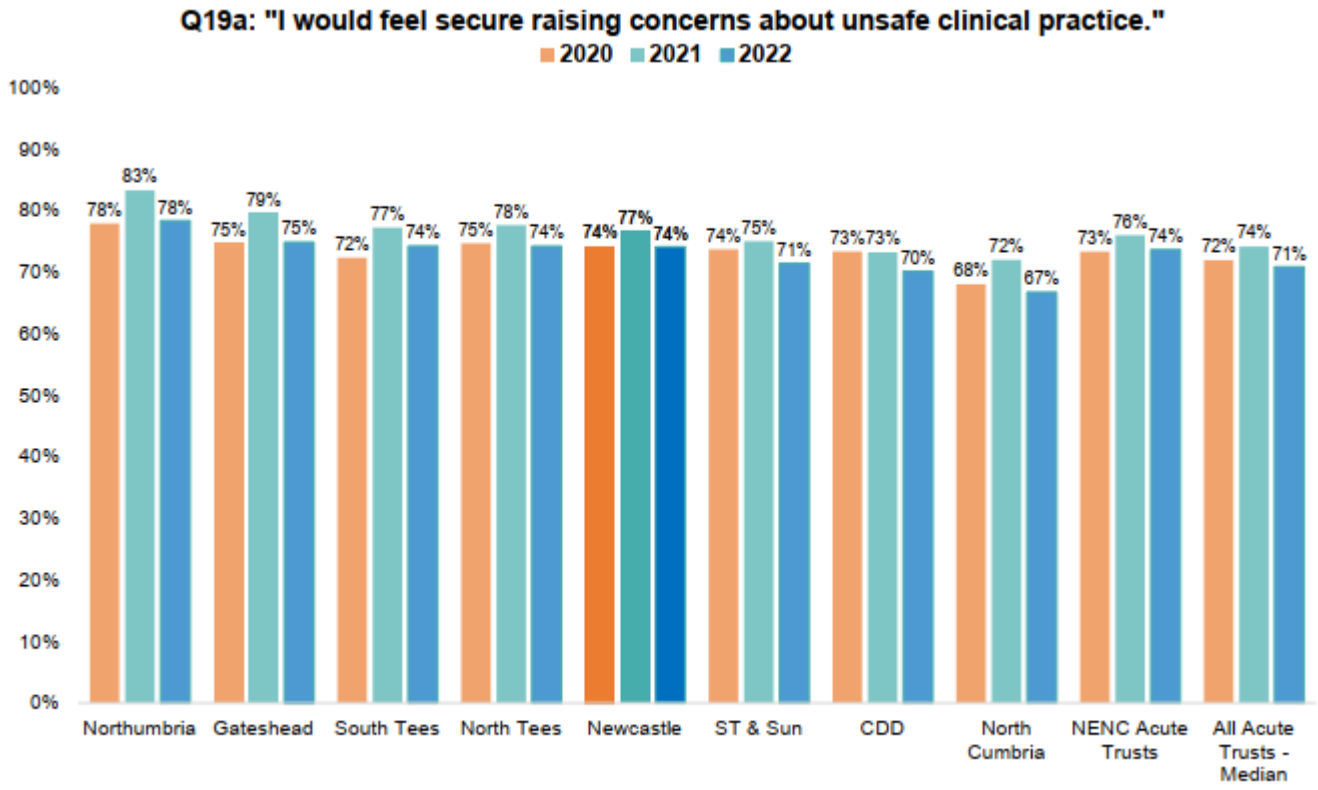


The categories of reported SIs for October 2023 are displayed in the table above. The highest number of SIs relate to Grade III pressure ulcers and patient falls resulting in femoral fracture, of which there were 3 of each.



One Never Event were reported in October 2023, bringing the number of Never Events reported to date in 2023/24 to 8. All cases prior to the newly reported Never Event have been presented to the Integrated Care Board (ICB) as part of the usual Quality Review Group meeting and work is well underway to investigate and identify actions to minimise the risk of these events happening in the future.

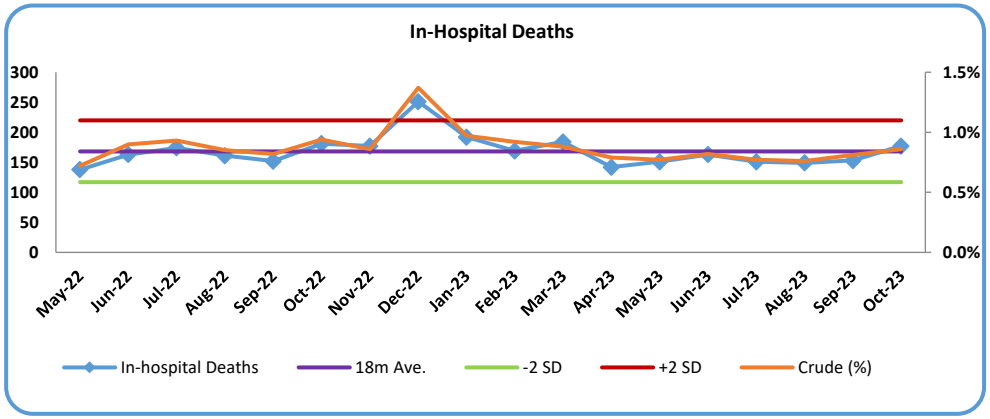
Quality: Safety Reporting Metrics



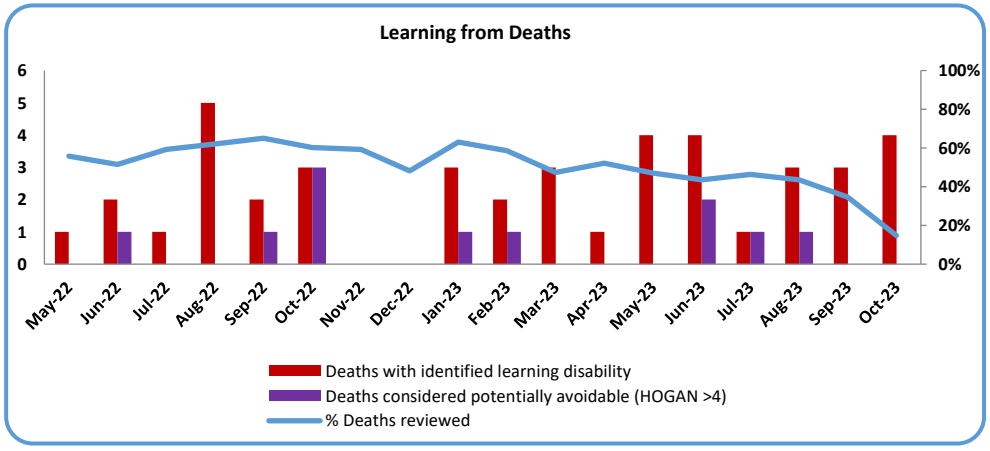
Our safety reporting metrics taken from previous NHS Staff Surveys show that in 2022 74% of staff within Newcastle Hospitals would feel secure about raising concerns about unsafe clinical practice. This is the same as the regional average for acute Trusts and higher than the national statistic of 71%. This indicates that while there is room for improvement, there is a positive culture around reporting patient safety events within the Trust when compared to other NHS organisations across England.

Quality: Mortality Indicators (1/2)

In-hospital Deaths: In total there were 177 deaths reported in October 2023, which is slightly higher that the amount reported 12 months previously (n=168). The crude death rate is 0.86%. Nationally the deaths were high in December 2022, with influenza reported to be the main cause of death.

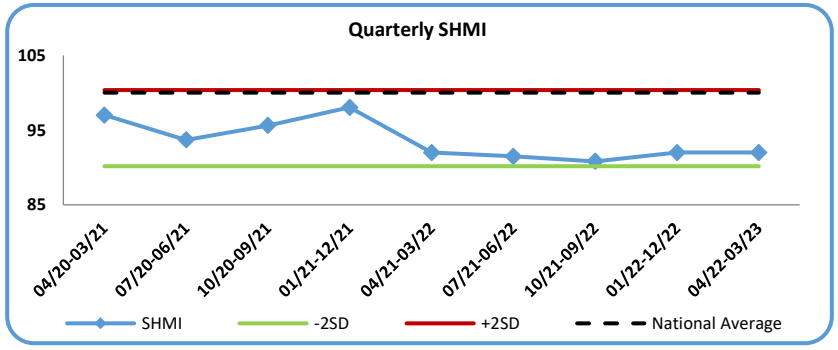


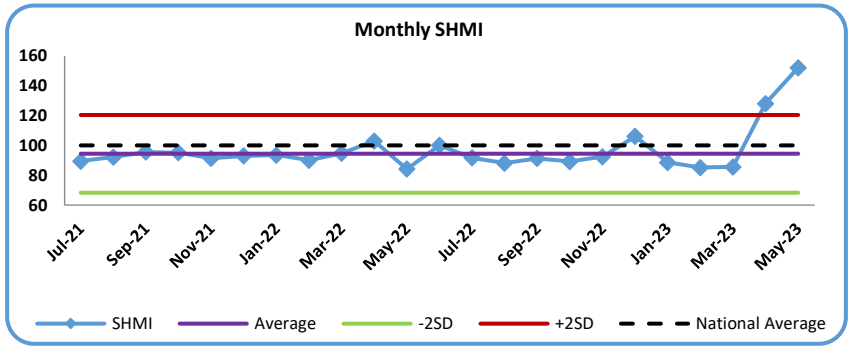
Learning from Deaths: Out of the 177 deaths reported in October 2023, 26 patients have, to date, received a level 2 mortality review. However, these figures will continue to rise due to ongoing M&M meetings held over the forthcoming months. All figures will continue to be monitored and modified accordingly. Four patients had an identified learning disability. No patients had a HOGAN grading ≥4.



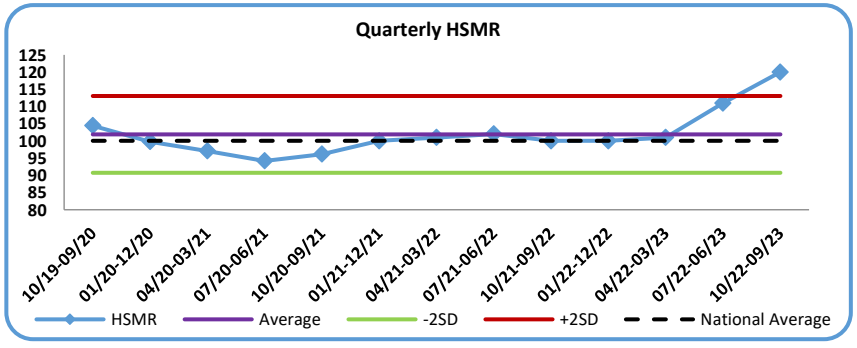
Quality: Mortality Indicators (2/2)

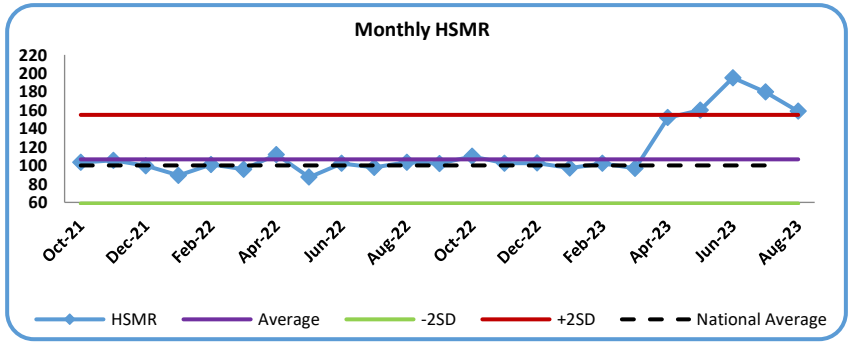
SHMI: The latest published quarterly SHMI data from NHS England shows the Trust has scored 92 from months April 2022 to March 2023. This is below the national average and is within the "as expected" category. Monthly SHMI data is published up to May 2023. As expected, the SHMI has shown an increase. This is due to an ongoing technical issue where secondary diagnoses are not being uploaded into the Trust commissioning data set. SHMI and HSMR are heavily dependent on secondary diagnosis, due to using this information to risk adjust.



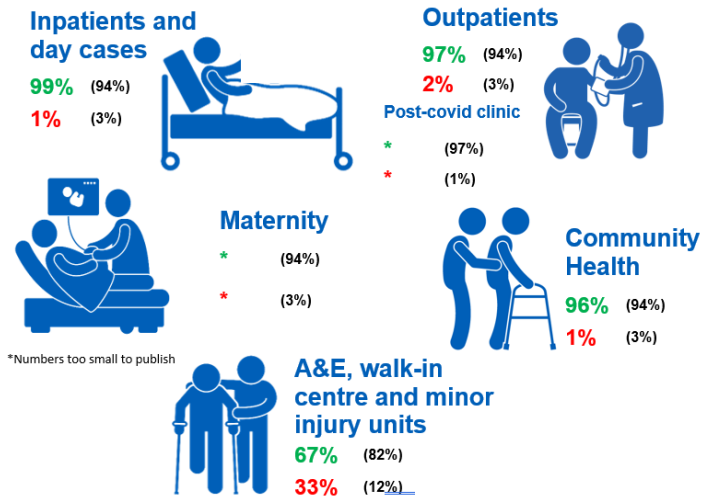


HSMR: The HSMR data shows a 12-month rolling score by quarter which is published up to September 23, as well as monthly data published up to August 2023. Both have shown a recent increase due to the issue raised above. Information Services are working on this as a priority. A new upload into the commissioning data set is planned within the next few weeks which is expected to address this issue retrospectively and prospectively.





Quality: FFT and Complaints



Friends and Family Test

There were 1,972 responses to the Friends and Family test from the Trust in September 2023 (published October 2023) compared to 2,268 in the previous month.

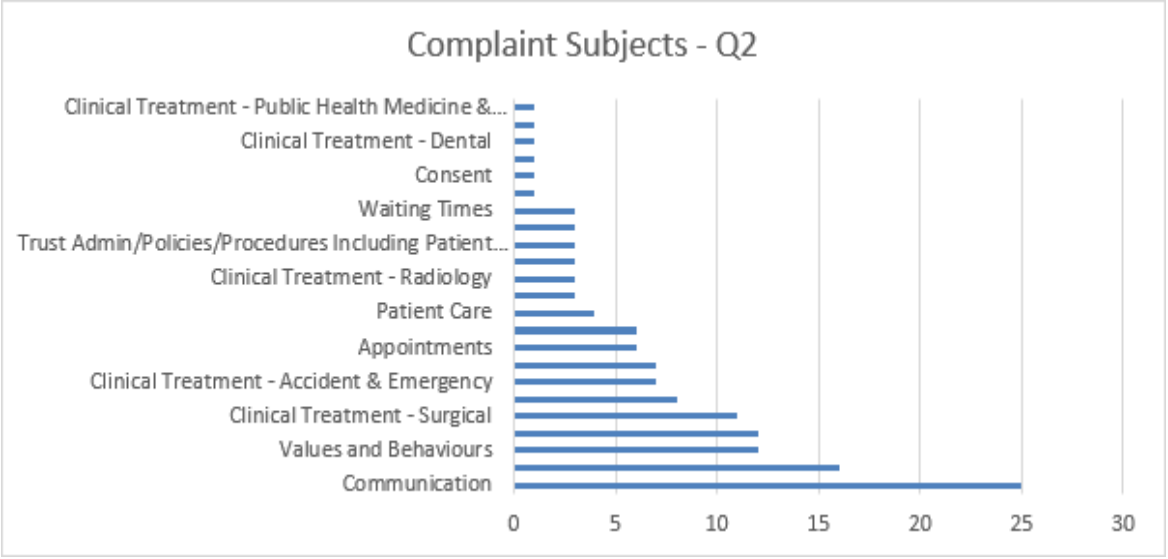
The infographic shows the proportion of patients who give a positive or negative rating of the care they received. The national average results are shown in brackets for comparison.

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

*numbers too small to publish

The Trust has opened 138 formal complaints in July to September (Q2), which is an increase of 16% from the previous quarter. The Trust has received, on average, 46 formal complaints per month, which is an increase of 5% for the same quarter in the previous financial year but is consistent with the overall average for 2022/23.

The table opposite summarises the complaint themes for Q2, with communication being the primary concern.



Quality: Health and Safety (1/2)

Staff Safety: Sharps Incidents (Thematic Review)

The 2022-23 Annual Sharps Report highlighted an 8.7% increase in sharps incidents from the previous year. Reasons for this sustained increase are multi-factorial and likely to include:

- Staff fatigue and significant service demand in the aftermath of the pandemic.
- The impact of industrial action meaning that some staff were deployed to alternative clinical areas where they may not have been as familiar with the devices used. This is in addition to increased pressures on remaining staff, to deliver safe care with a reduced workforce.
- Increased reporting of incidents across all categories.
- Supply issues affecting the usual sharps products used within the Trust. This meant staff were using devices that they may not be as familiar with, consequently increasing the risk of sharps injury.

Chart A: demonstrates sharps incidents reported since April 2021, illustrating a majority of sharps injuries involved used (dirty) sharps. None of the incidents reported met the threshold for reporting to the HSE under RIDDOR. Chart C demonstrates the number of incidents per Clinical Board.

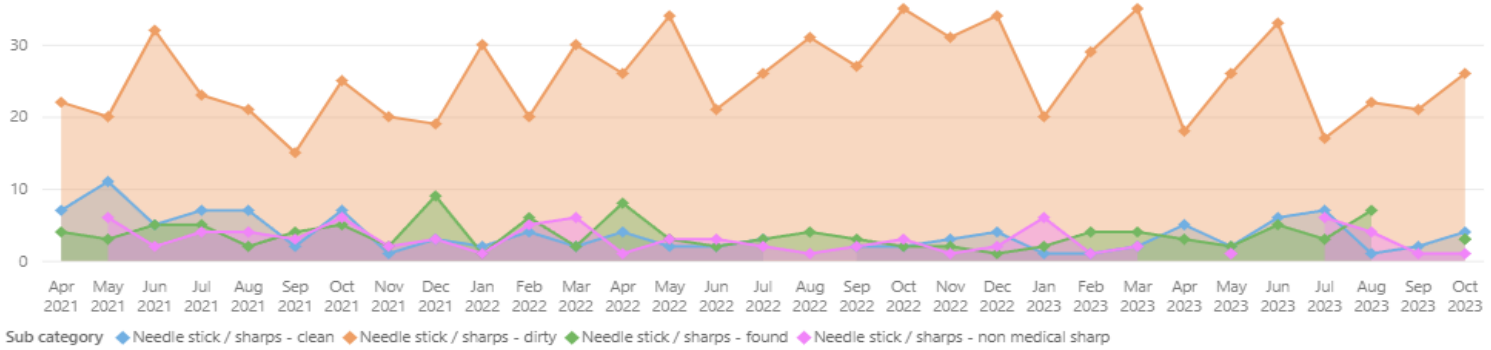


Chart B: Needlestick by Severity – Last 12 Months

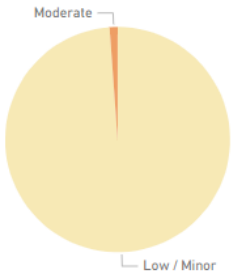
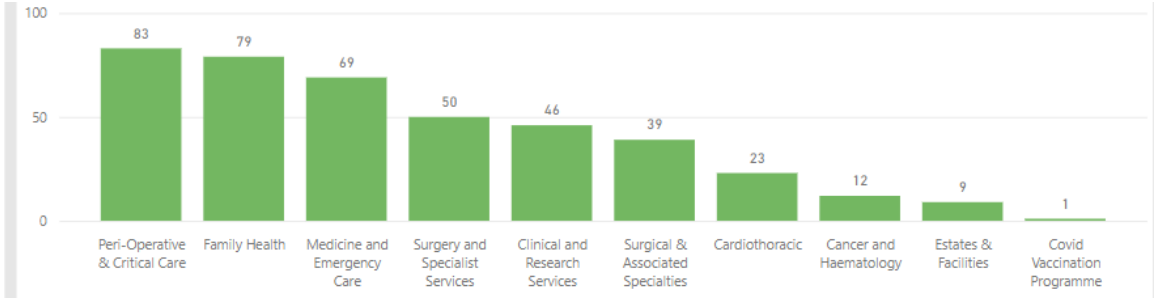


Chart C: Needlestick Incidents by Clinical Board Last 12 Months



Quality: Health and Safety (2/2)

Regulatory Responsibilities:

Sharps injuries are a well-known risk in the health and social care sector. Sharps contaminated with an infected patient's blood can transmit more than 20 diseases, including hepatitis B, C and human immunodeficiency virus (HIV). 'Sharps' are needles, blades (such as scalpels) and other medical instruments that are necessary for carrying out healthcare work and could cause an injury by cutting or pricking the skin. The safe use of sharps is legislated by the **Health and Safety (Sharp Instruments in Healthcare) Regulation 2013** and covers a number of areas including:

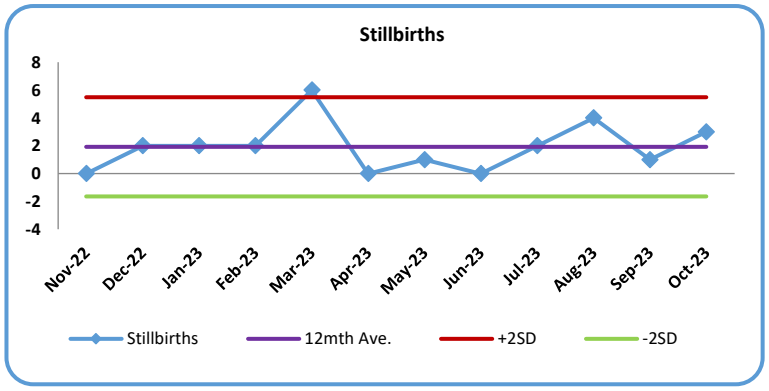
- The safe use and disposal of sharps.
- Training requirements.
- Procedures for responding to sharps injury.

The Health and Safety Executive can undertake regulatory inspections in relation to the safe use of sharps.

Safer Sharps Review Group /Trust-wide Initiatives:

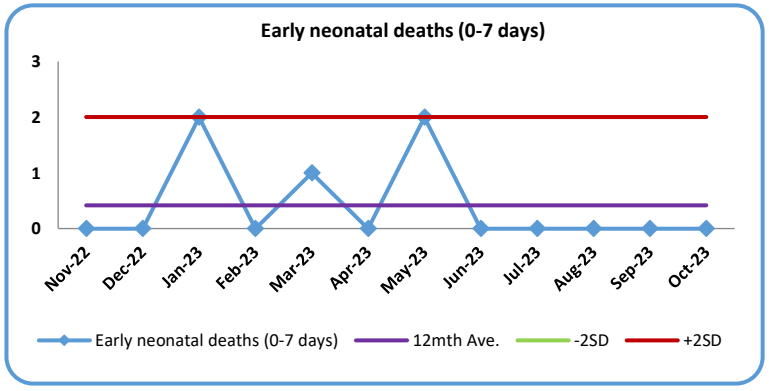
- Trust Occupational Health Services (OHS) and the Clinical Governance & Risk Department (CGARD) continue to jointly monitor incidents involving sharps injuries. This ensures consistent reporting and the provision of accurate compliance data with the staff sharps injury OHS pathway alongside comprehensive support and treatment for those staff affected.
- An eLearning module is currently under development, with a plan for this to be launched in 2023/2024. A paper to support the module becoming mandated is also planned to be submitted to the Leaning, Education and Training Group.
- CGARD have developed a comprehensive incident data dashboard, which will enable clinical teams to analyse 'real-time' incident data to help identify themes and trends. This has already provided information to facilitate change and reduce incidents e.g. changes in practice including Diabetes staff not accessing patients own equipment via their personal diabetes cases / bags. It has been challenging to provide this data within the context of Trust activity i.e., number of sharps injuries per sharps use or per patient contact. This remains a work in progress that will continue into 2023/24.
- The non-safer sharps risk assessments have been updated and modified using a template recently approved by the Health and Safety Executive as part of a focussed inspection within another Trust.
- The quarterly self-assessment Health and Safety Compliance Audit includes a specific area around the safe use of sharps. In the last audit (Q1 2023-24) the compliance score was 98%. This is further scrutinised as part of the Health and Safety Inspection Programme and any gaps from either programme are fed back into the Safer Sharps Review group for further consideration.
- The clinical waste department actively reviews the way the Trust disposes of all sharps, considering not just safety but also the Trust's environmental footprint. These developments are discussed in the SSRG (Safer Sharps Review Group) by the Trust waste manager.

Quality: Maternity (1/3)



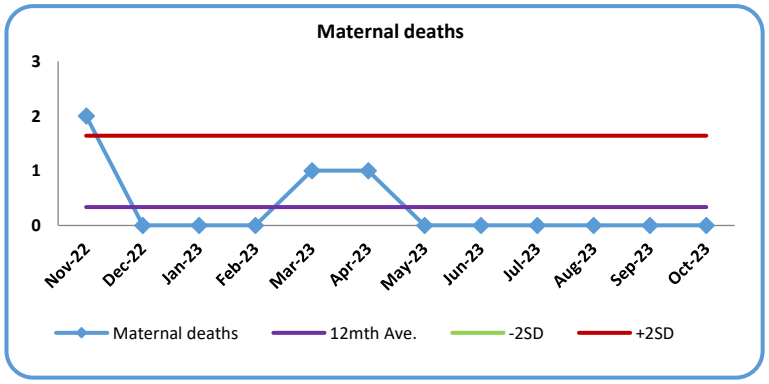
Stillbirths

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 therefore 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 three stillbirths in October 2023.



Early Neonatal Deaths

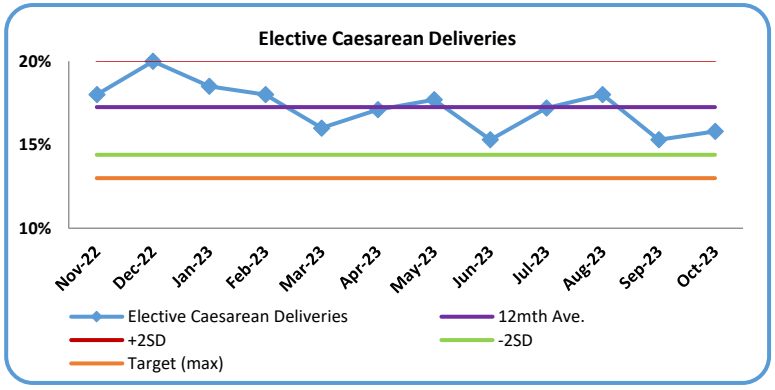
These figures are for term infants (born between 37 and 41 weeks) who delivered at the Trust but sadly died within the first week of life. These deaths are reported to the Child Death Review panel (as are all neonatal deaths regardless of gestation) who will have oversight of the investigation and review process. Neonatal deaths of term infants are also reported to HSIB (Healthcare Safety Investigation Branch) and the Coroner. A postmortem examination may be requested to try and identify the cause of death. In October 2023 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 October 2023.

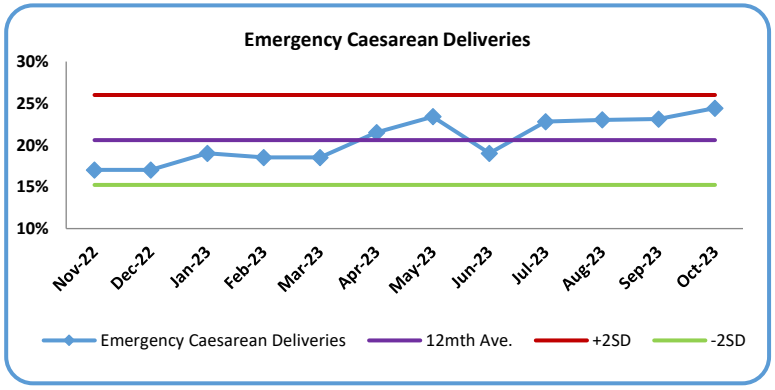
Quality: Maternity (2/3)



Elective Caesarean section

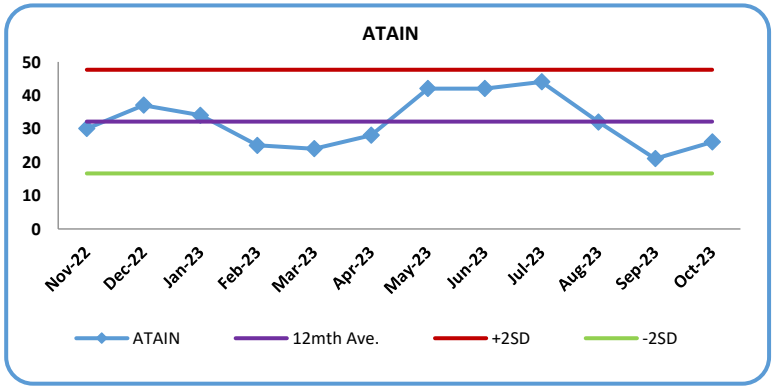
Maternity at the Trust is an outlier for elective Caesarean section compared to other UK Trusts. However, the rates are comparable to that of other tertiary centres in the UK.

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

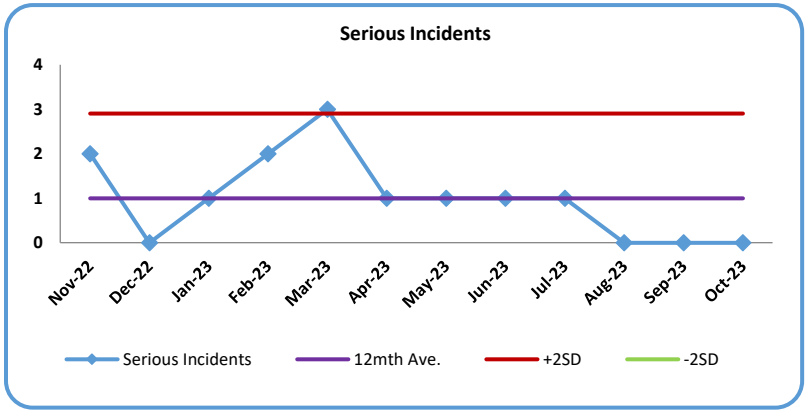
The emergency Caesarean section rate is comparable to other Trusts. Maternity is a consultant led service with dedicated consultant presence on Labour Ward 8am-10pm daily, consultant led multi-disciplinary ward rounds occur twice daily. The majority of obstetric consultants remain onsite overnight, from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



ATAIN

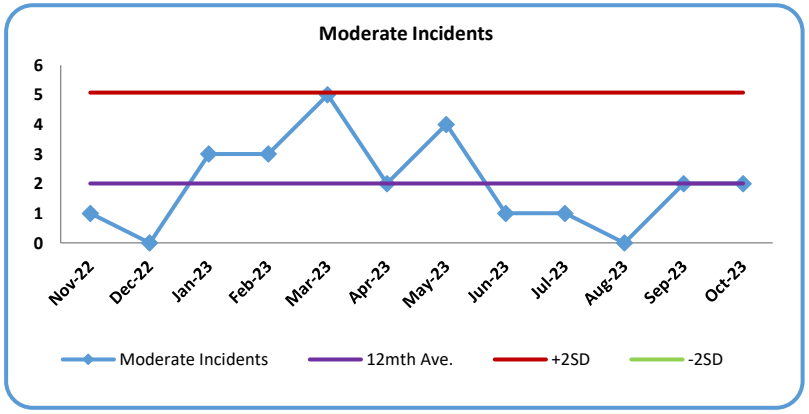
All unplanned admissions of term babies (37 – 41 weeks) into the neonatal unit are reviewed at a weekly multi-disciplinary meeting and a quarterly report is produced and shared. Following review, some cases will be investigated in more detail if they have been identified as a Serious Incident. There were 26 term admissions in October, audit for which is not yet complete. Analysis of Quarter 2 (July/Aug/September) admissions shows 6% were classed as avoidable which is an increase from the previous quarter (2.6%). A key theme is optimising thermal support for the newborn, learning from Quarter 1 and Quarter 2 has been shared with staff. Further support for staff is planned through the re-introduction of 'Vulnerable Infants' training.

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 October 2023.



Moderate incidents

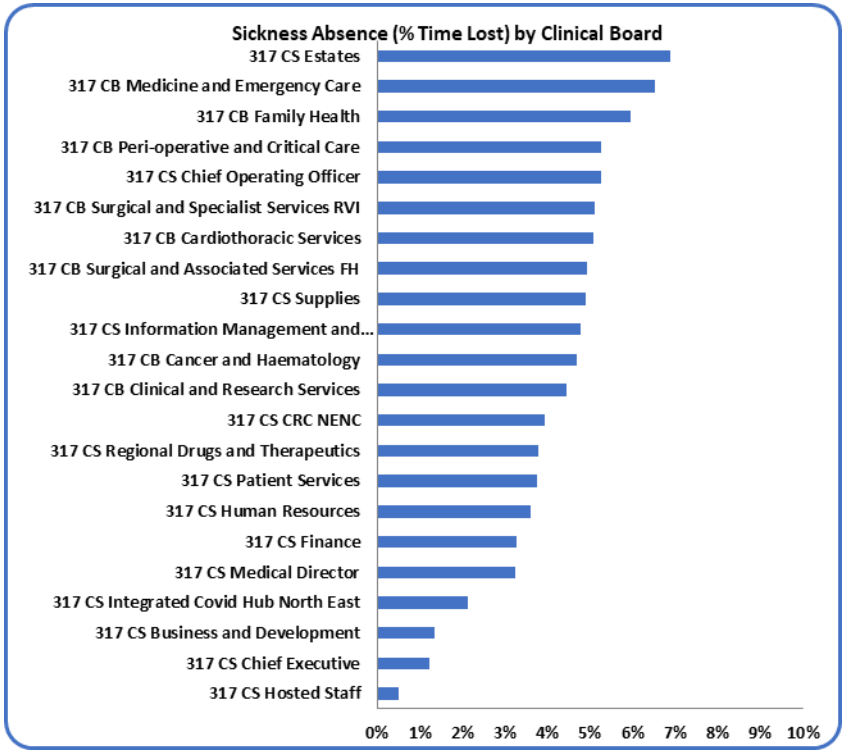
There were two moderate (and above) incidents reported in Maternity this month. All incidents are carefully reviewed by the Maternity Governance team and are graded appropriately after completion of a rapid review (48hr report). In the past 12 months, the majority of the moderate graded incidents were 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.

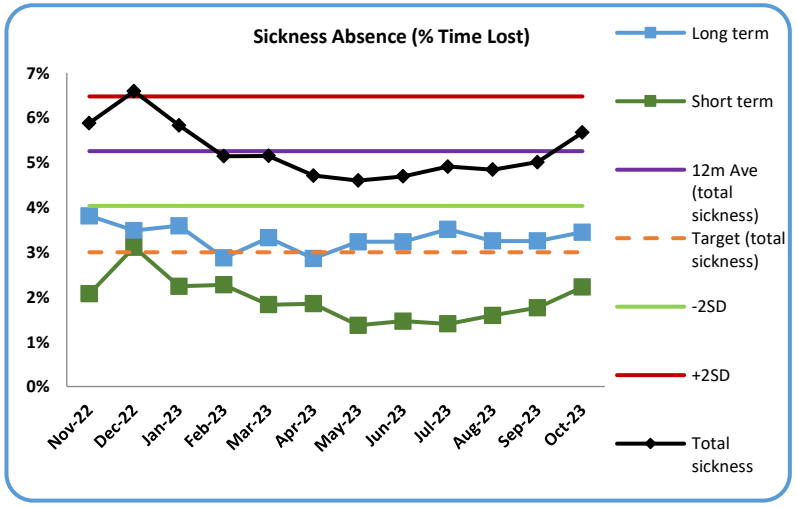
People: Sickness Absence 1/2

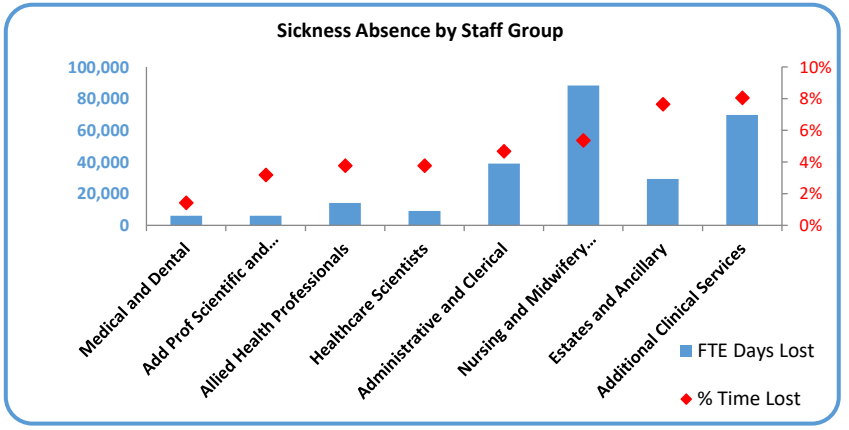
- Year to year comparison for sickness absence (including COVID-19 related sickness (rolling 12 months):

	Oct-22	Oct-23	
Long-term	3.06%	3.45%	↑
Short-term	2.90%	2.22%	↓
Total	5.96%	5.67%	↓

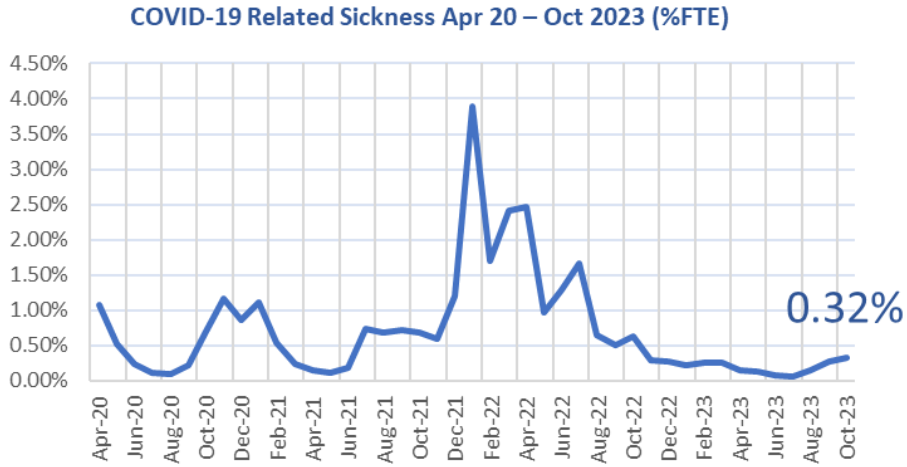
- 261,522 FTE working days were lost due to sickness (including COVID-19 related sickness) in the year to October 2023, compared to 323,935 for the previous year.
- Overall sickness absence (including COVID-19 related sickness) is 5.67%, which is down from end of October 2022 position of 5.96% (% FTE Time Lost).
- The top three reasons for non-COVID related sickness absence are Anxiety/stress/depression/other psychiatric illnesses (28%), Cold, Cough, Flu (16%) and Other Musculoskeletal (9%).

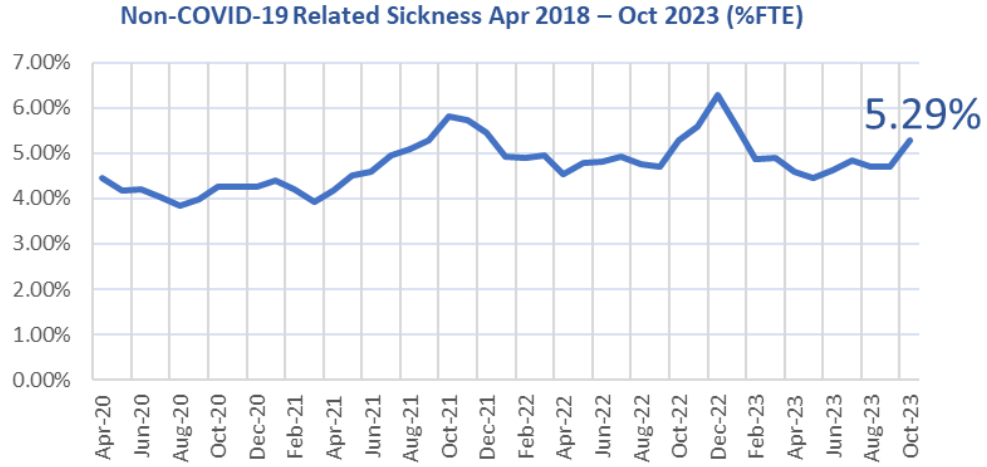


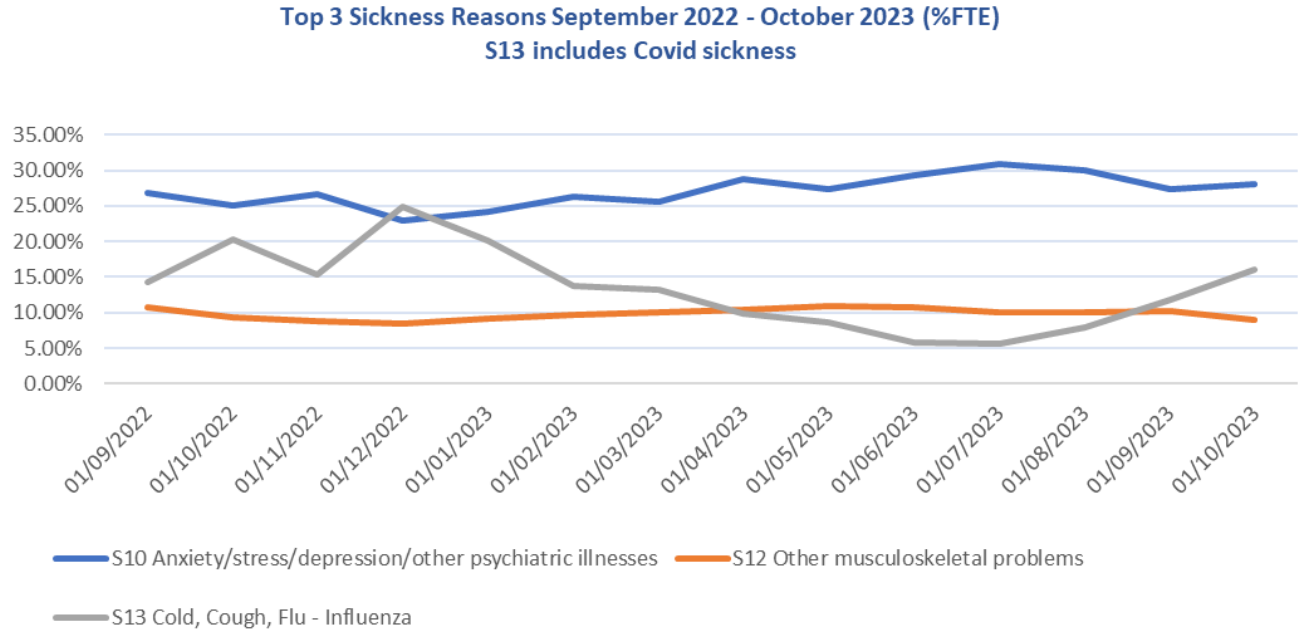




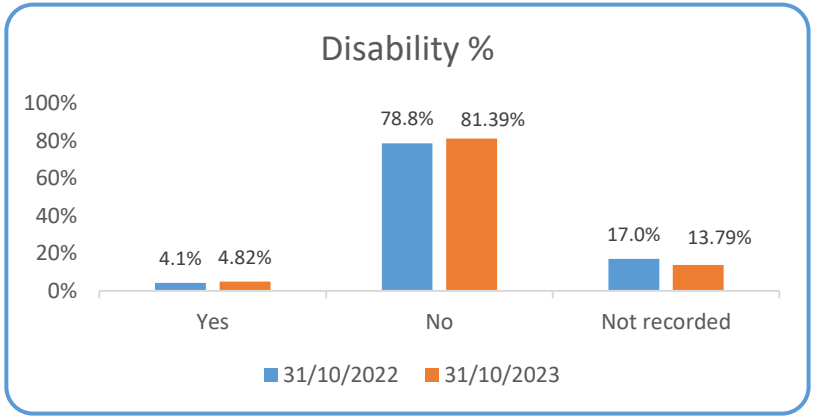
People: Sickness Absence 2/2

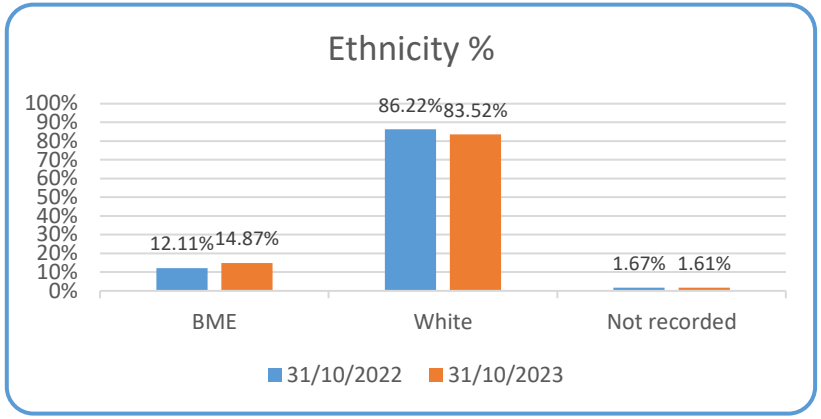


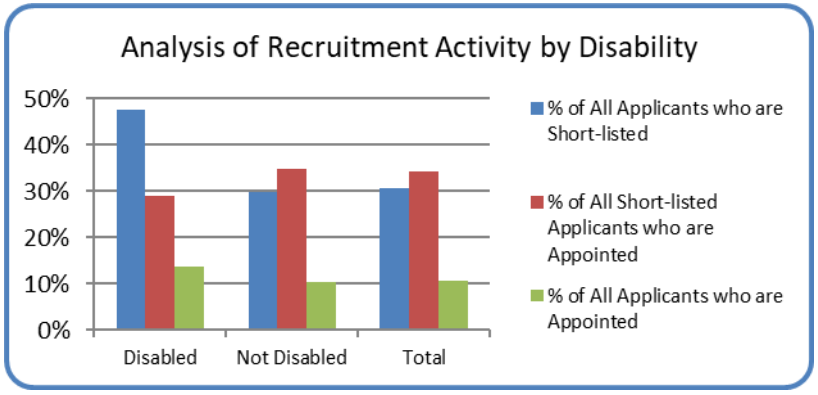


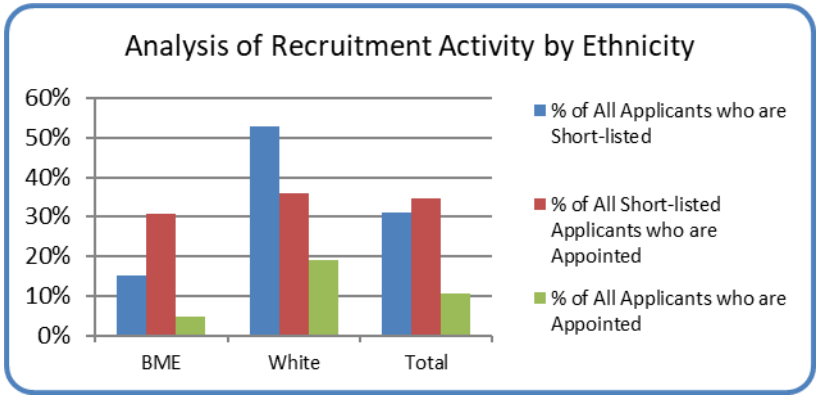


People: Equality and Diversity



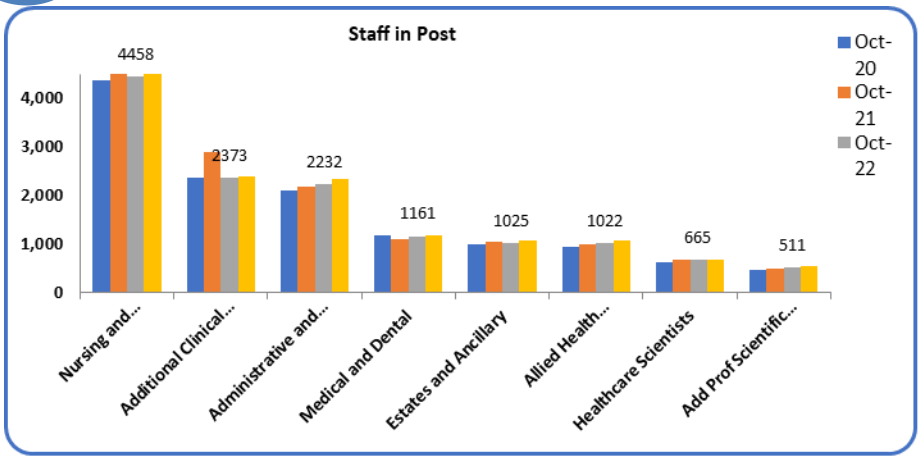


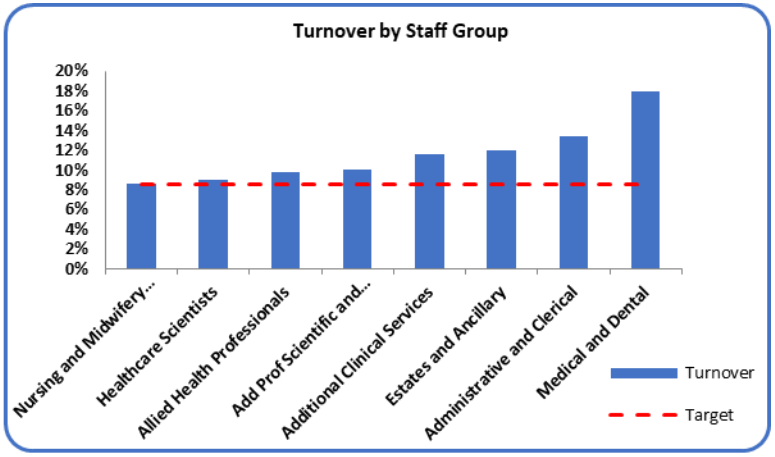


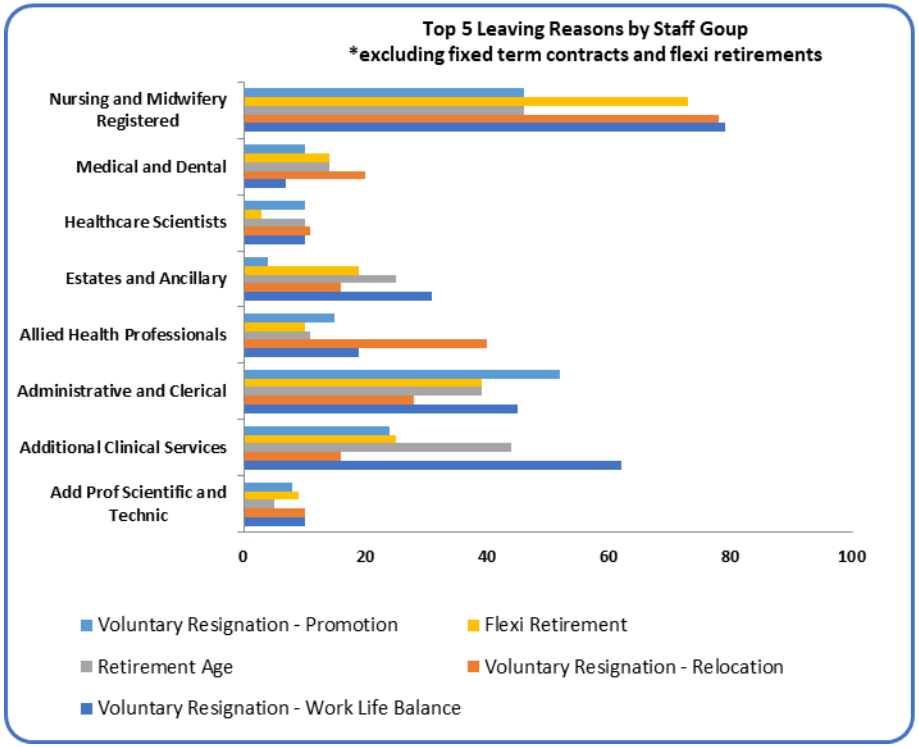


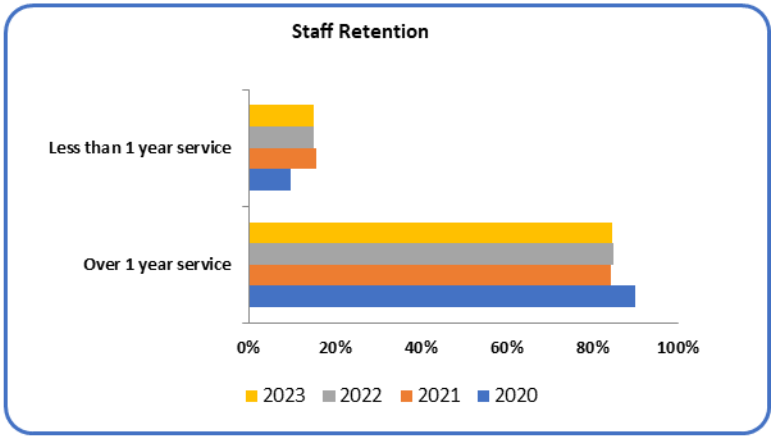
- The percentage of staff employed disclosing a disability has increased from 4.15% to 4.82% and the percentage of BAME staff has increased from 12.11% to 14.87%.

People: Workforce 1/3









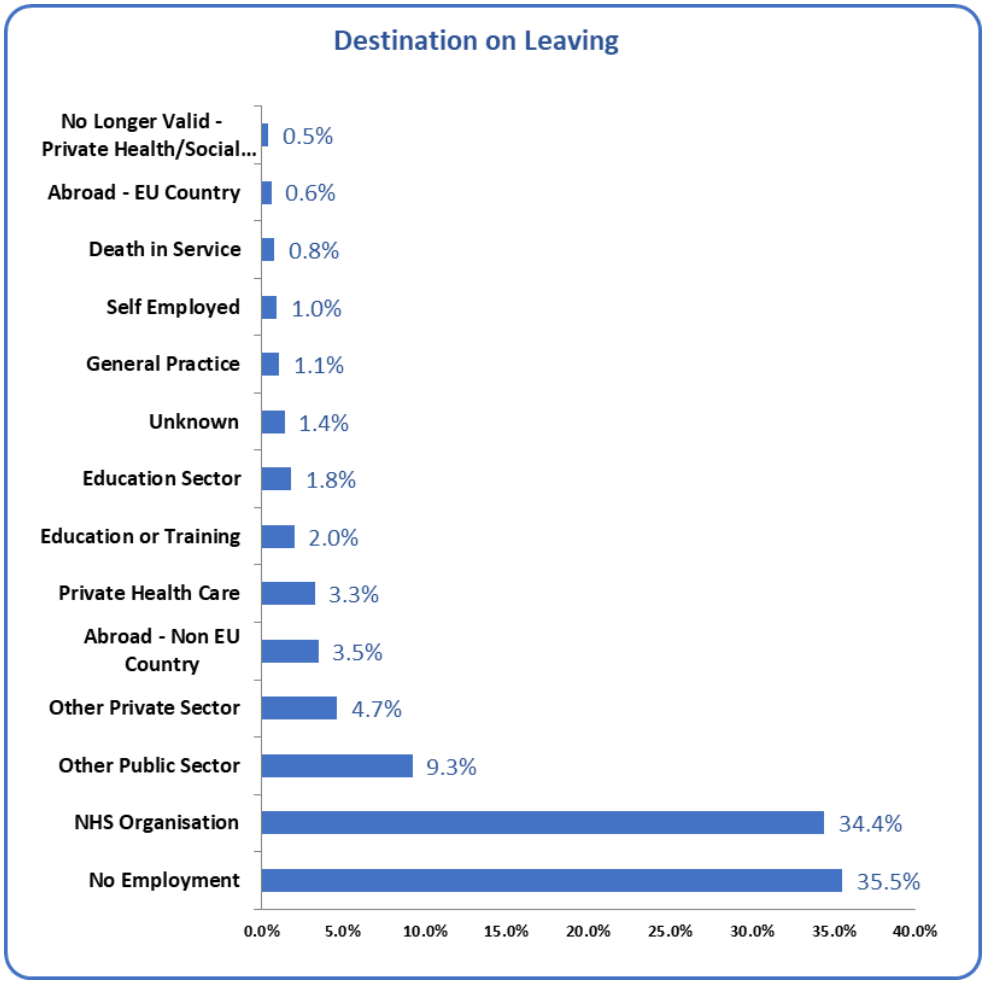
- Staff in post has increased by 4.18% since Oct 2022. The staff groups with the largest increase are Add Prof Scientific and Technical and Nursing and Midwifery Registered.
- Staff turnover has decreased from 16.68% in October 2022 to 11.02% in Oct 2023, against a target of 8.0%.
- The total number of leavers in the period November 2022 to October 2023 was 1,766.
- Retention for staff over 1 year service is 84.69%, an increase from 84.82% in October 2022.

People: Workforce 2/3

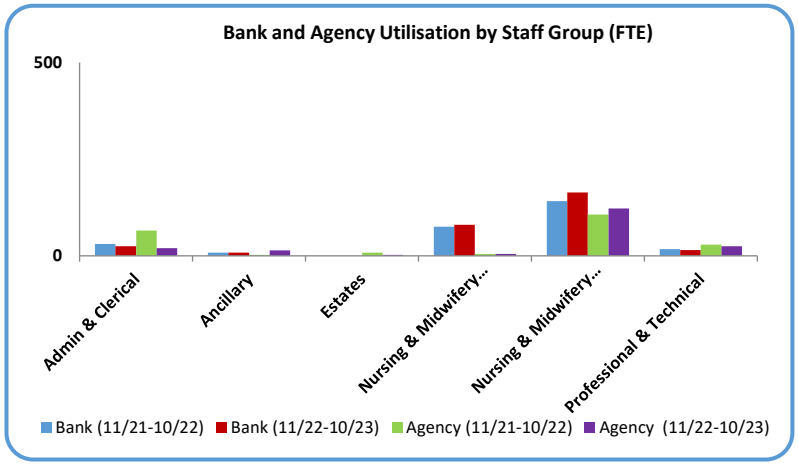
Turnover by Clinical Board

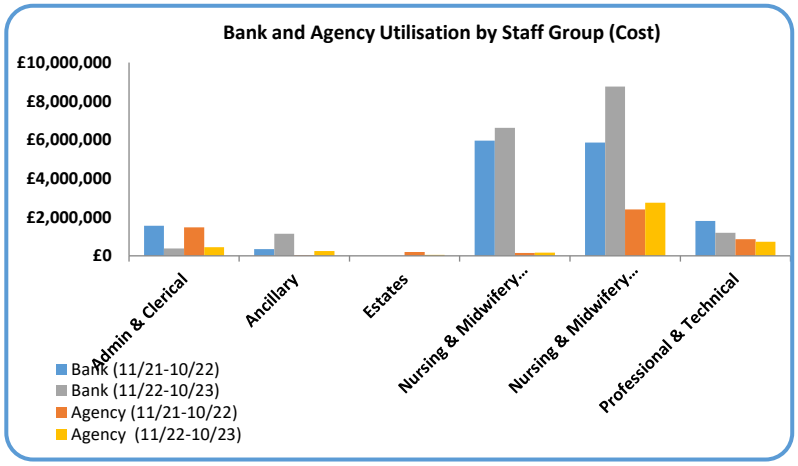
Clinical Board	Turnover
317 CS CRC NENC	4.38%
317 CS Chief Operating Officer	5.13%
317 CB Cancer and Haematology	7.98%
317 CS Regional Drugs and Therapeutics	8.45%
317 CB Peri-operative and Critical Care	8.78%
317 CS Business and Development	9.09%
317 CB Medicine and Emergency Care	9.12%
317 CS Patient Services	9.34%
317 CB Surgical and Associated Services FH	10.21%
317 CB Clinical and Research Services	10.54%
317 CB Surgical and Specialist Services RVI	10.67%
317 CB Cardiothoracic Services	11.38%
317 CS Estates	11.66%
317 CS Finance	12.61%
317 CS Supplies	12.66%
317 CB Family Health	14.00%
317 CS Information Management and Technology	14.31%
317 CS Human Resources	15.61%
317 CS Medical Director	16.22%
317 CS Chief Executive	16.51%
317 CS Integrated Covid Hub North East	30.43%
317 CS NHS COVID Vaccination Programme	36.62%
Trust Total	**11.02%**

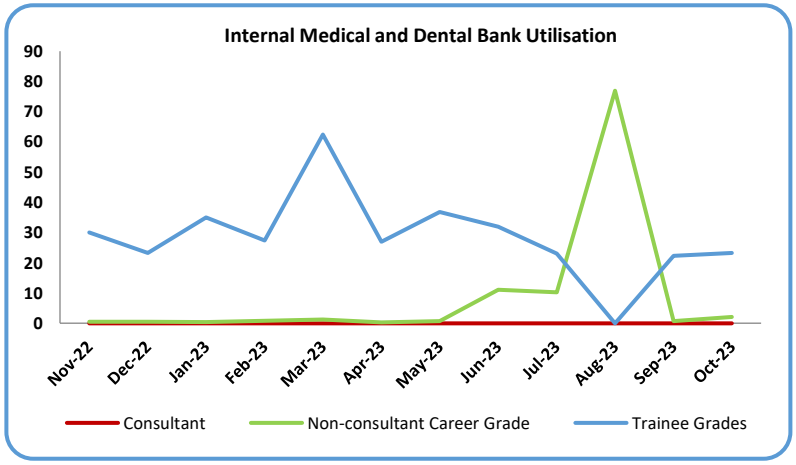
- 34.4% of leavers across the Trust disclosed they were going to another NHS organisation.



People: Workforce 3/3

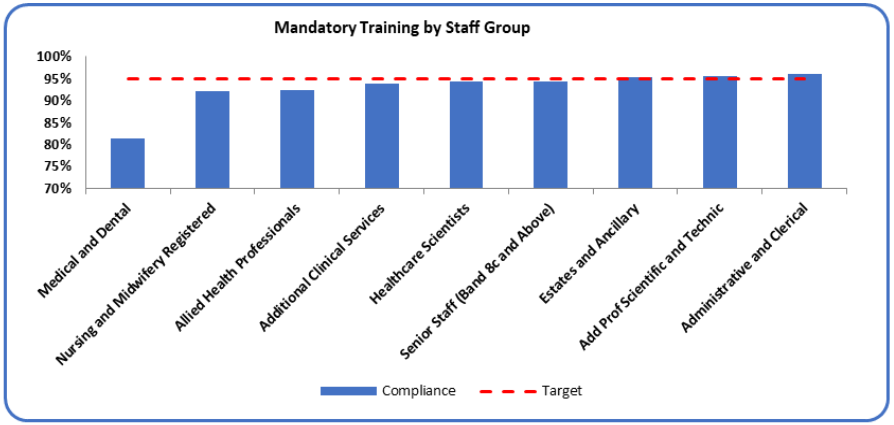


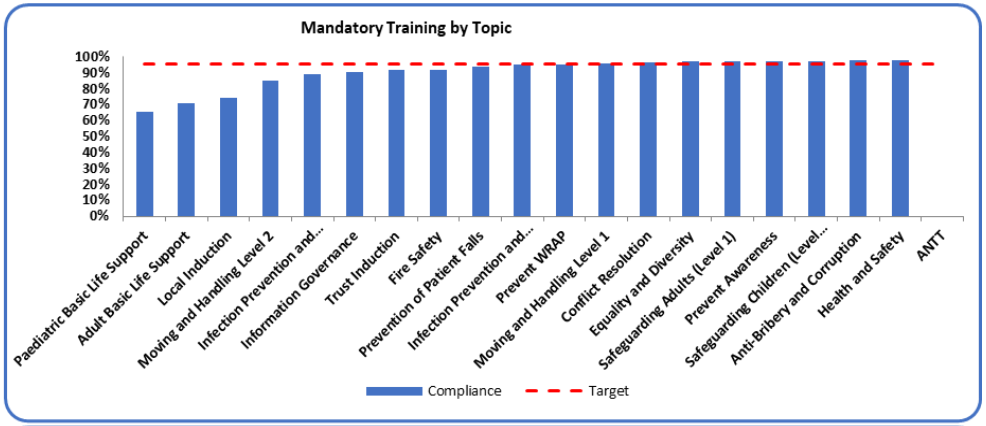


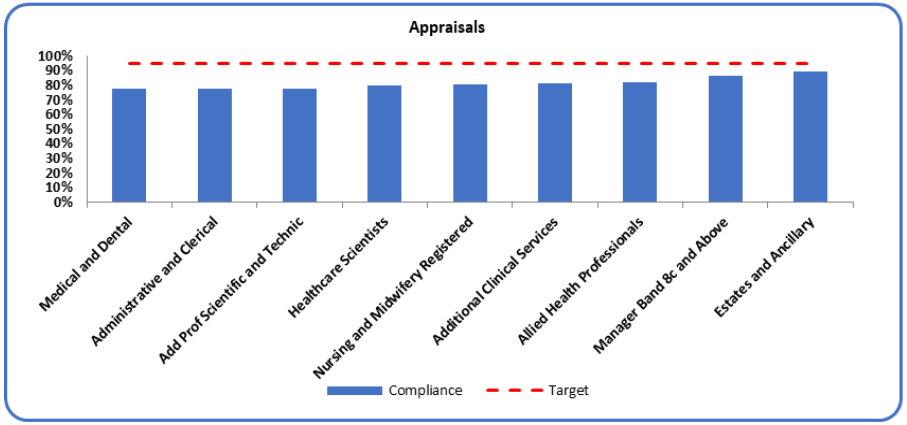


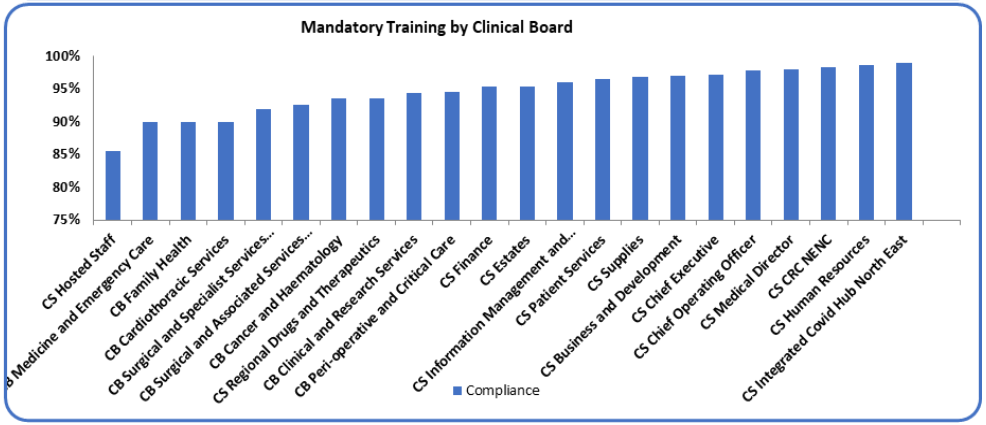
Comparing the periods November 2021 – October 2022 to November 2022 – October 2023, overall bank utilisation increased from 272 wte to 291 wte and agency utilisation has decreased from 213 wte to 186 wte.

People: Delivering Excellence in Education & Training







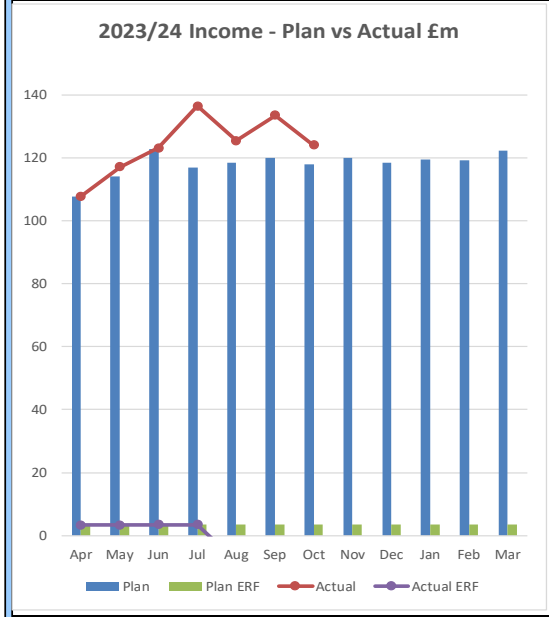


- Mandatory training compliance stands at 92.75% at end of October 2023, against an end of year target of 95%. The October 2022 position was 88.40%.
- Medical and Dental are the staff group with the lowest training compliance at 81.41% in October 2023 compared to 72.44% in October 2022.
- Appraisal compliance stands at 80.69%, at end of October 2023, against an end of year target of 95%,this is compared to 75.5% in October 2022. Interventions are in hand to improve this position.

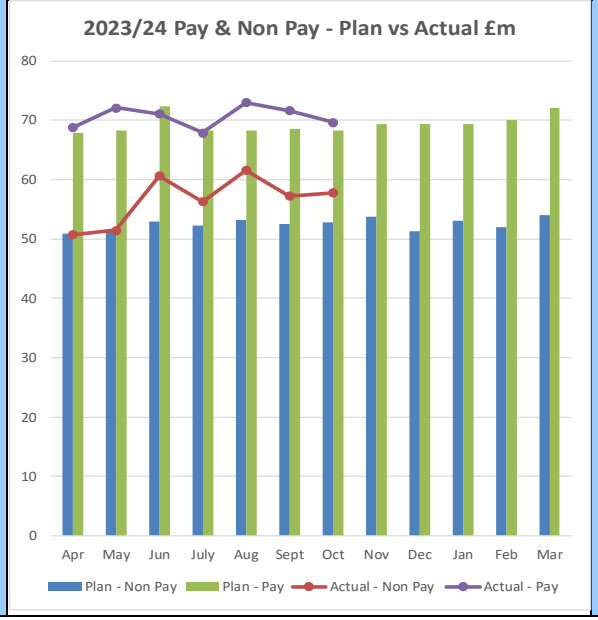
Finance: Overall Financial Position

Financial Overview as at 31st October 2023

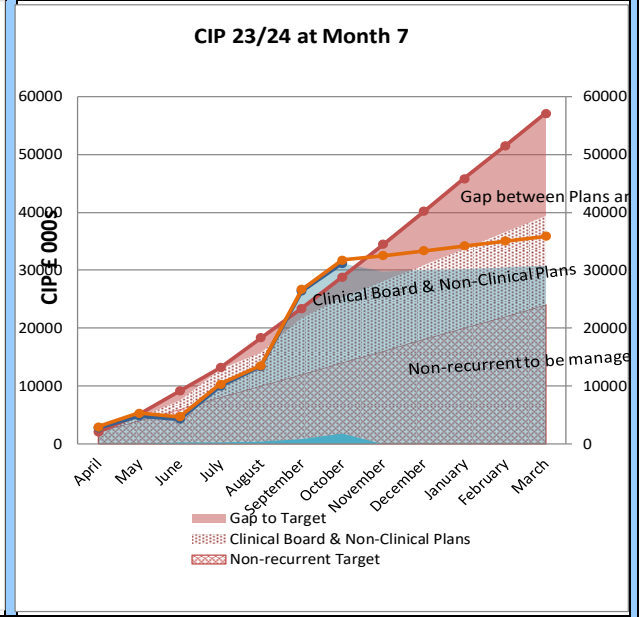
Income



Expenditure



Cost Improvement Analysis



Commentary

This page summarises the financial position of the Trust for the period ending 31st October 2023. The Trust has agreed a Financial Plan for 2023/24 with a break-even position. As at Month 7 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 £890 million and received income of £875 million, leaving a deficit of £15 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 October is £25 million and the year to date expenditure is £12 million creating a variance of £13 million to date. This is expected to catch up.

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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
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). 24.11.23 - Topic included on the Forward Plan for the 2024 Board Development Programme to be agreed with the new CEO and Interim Chair.
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). 24.11.23 - Royal College of Nursing Industrial Action Post incident report shared on 22 September 2023.
111	26 September 2023	PUBLIC	23/20BUSINESS ITEMS: d. Healthcare Associated Infections (HCAI)	Mr Chapman welcomed the report and suggested adding a trend line to the graphs for ease of reading which would identify either an increase or reduction of cases over time. This was noted by the DIPC. [ACTION01]	JS			24.11.23 - In Progress

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.