The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Public Trust Board of Directors' Meeting

Thursday 25 January 2024, 13:15 – 16.00

Venue: Freeman Boardroom for Board members only, all others to dial in via MS Teams

Agenda

Item		Lead	Paper	Timing
1.	Apologies for absence and declarations of interest	Kath McCourt	Verbal	13:15 – 13:16
2.	Minutes of the Meeting held on 30 November 2023 and Matters Arising	Kath McCourt	Attached	13:16 - 13:18
3.	Chair's Report	Kath McCourt	Attached	13:18 – 13:23
4.	Chief Executive's Report	Jim Mackey	Presentation	13:23 – 13:33
Strategic items:				
5.	Patients: People Story *Catherine Carr, Head of Nursing to present this item*	Maurya Cushlow	Attached	13:33 – 13:43
6.	Patients: CQC Report	Maurya Cushlow	Verbal	13:43 – 14:00
7.	Patients: Mental Health Strategy *Dr Sarah Brown, Honorary Associate Medical Director for Mental Health, to attend and present*	Andy Welch	Verbal	14:00 – 14:15
8.	People: Industrial Action Update	Andy / Martin	Verbal	14:15 – 14:25
9.	Performance: Performance Report	Vicky McFarlane-Reid & Martin Wilson	Attached	14:25 – 14:35
10.	Partnerships: Development of collaborative working arrangements	Kath McCourt/Jim Mackey	Verbal	14:35 – 14:45
Business Items:				
11.	Director reports: a. Medical Director; including: (i) Consultant Appointments (ii) Guardian of Safe Working Quarterly Reports (Quarters 1 and 2 2023/24)	Andy Welch	Attached & BRP	14:45 – 15:00
	Refreshment Break			**15:00 – 15:10**
	b. Executive Chief Nurse; including: (i) Maternity Update Report	Maurya Cushlow	Attached & BRP	15:10 – 15:20

c.	Director of Quality & Effectiveness: (i) CNST (ii) Mortality / Learning from Deaths Q2 report	Angela O'Brien	Attached & PRIVATE BRP	15:20 – 15:30
d.	Healthcare Associated Infections (HCAI)	Julie Samuel	Attached & BRP	15:30 – 15:40

Items to receive and any other business: 15:40 – 16:00

12.	Update from Committee Chairs	Committee Chairs	BRP
13.	Integrated Board Report	Martin Wilson	BRP
14.	Meeting Action Log	Kath McCourt	BRP
15.	Any other business	All	Verbal

Date of next meeting:
Public Board of Directors – Thursday 28 March 2024

Professor Kath McCourt, Interim Chair

Sir Jim Mackey, Chief Executive Officer

Mr Andy Welch, Medical Director/Deputy Chief Executive Officer

Ms Maurya Cushlow, Executive Chief Nurse

Dr Vicky McFarlane-Reid, Director for Commercial Development and Innovation

Mr Martin Wilson, Chief Operating Officer

Mrs Christine Brereton, Chief People Officer

Mrs Caroline Docking, Director of Communications and Corporate Affairs

Mrs Angela O'Brien, Director of Quality & Effectiveness

Ms Julie Samuel, Director of Infection Prevention and Control

Mr Jonathan Jowett, Non-Executive Director/Chair of People Committee

Mr Graeme Chapman, Non-Executive Director/Chair of Quality Committee

Mr Bill MacLeod, Non-Executive Director/Chair of Audit Committee

Ms Jill Baker, Non-Executive Director/Chair of Charity Committee

Miss Christine Smith, Non-Executive Director/Chair of Finance Committee

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

PUBLIC TRUST BOARD OF DIRECTORS MEETING

DRAFT MINUTES OF THE MEETING HELD 30 NOVEMBER 2023

Present:	Professor Sir J Burn *[Chair]*	Chairman
	Dame J Daniel	Chief Executive Officer [CEO]
	Mr A Welch	Medical Director/Deputy Chief Executive Officer [MD/DCEO]
	Mrs J Bilcliff	Chief Finance Officer [CFO]
	Ms Maurya Cushlow	Executive Chief Nurse [ECN]
	Dr V McFarlane Reid	Executive Director of Business, Development & Enterprise [EDBDE]
	Ms J Baker	Non-Executive Director [NED]
	Ms S Edusei	NED
	Mr J Jowett	NED
	Mr B MacLeod	NED
	Professor K McCourt	NED
	Mrs L Bromley	NED
	Miss C Smith	NED
	Mr G Chapman	NED

In attendance:
Mrs C Docking, Assistant Chief Executive [ACE]
Mrs A O'Brien, Director of Quality and Effectiveness [DQE]
Mrs L Sewell, Interim Chief Information Officer [ICIO]
Mrs C Brereton, Chief People Officer [CPO]
Mr R C Smith, Director of Estates [DoE]
Dr M Wright, Deputy Medical Director [DMD]
Mrs N Kenny, Deputy Chief Operating Officer [DCOO]
Mrs K Jupp, Trust Secretary [TS]
Mrs J Samuel, Director of Infection Prevention Control [DIPC]
Mr G Vincent, Associate Medical Director – Quality and Patient Safety
Mr J Isaacs, Associate Medical Director – Research
Ms C Wroe, Clinical Director Clinical Research Network (CRN) North East & North Cumbria (NENC)

Observers:
Mrs P Yanez, Lead Governor
Dr A Dearges-Chantler, Public Governor
Professor P Home, Public Governor
Ms E Rowen, Staff Governor
Mr S Volpe, Health Reporter – Chronicle Live

Secretary:	Mrs G Elsender	Corporate Governance Officer and PA to the Chairman and Trust Secretary

Note: The minutes of the meeting were written as per the order in which items were discussed.

23/22 STANDING ITEMS:

i) Apologies for Absence and Declarations of Interest

Apologies were received from Mr Martin Wilson, Chief Operating Officer (COO), Professor David Burn, Associate Non-Executive Director (ANED) and Mrs P Smith, (ANED).

There were no new declarations of interest raised.

It was resolved: to (i) **receive** the apologies for absence and (ii) **note** that there were no new declarations of interest.

ii) Minutes of the previous meeting held on 26 September 2023 and matters arising

The minutes of the meeting held on 26 September 2023 were accepted as a true record of the business transacted.

It was resolved: to **agree** the minutes as an accurate record and to **note** there were no matters arising.

iii) Chairman's Report

The Chairman presented his report highlighting key events including presenting the People at Our Heart Award to Gillian Reid, Nurse Specialist/Lead, whose team cares for the health needs of circa 700 children in social care, representing the Trust at the Kaleidoscope of Cultures evening celebrating our cultural diversity and attendance at the Armed Forces Network celebration to recognise our reservists.

The Chairman reflected on his role for the last 6 years noting the unprecedented challenges in the last three years; a pandemic, energy crisis and severe cost of living rise, all of which have placed extra burdens on staff and the population. In addition, the final Care Quality Commission (CQC) inspection reports were awaited and the Chairman acknowledged that further work would be required in addressing the recommendations raised.

The Chairman noted the importance of working collectively to support each other during the challenges faced.

It was resolved: to receive the report.

iv) Chief Executive's Report

The CEO reflected on the past five at the Trust describing her journey since joining the organisation, noting the significant focus on culture change and the infrastructure in place to support this including Freedom to Speak Up champions (FTSU), diversity networks and over 1,300 staff who have been trained in quality improvement methods.

The CEO was enormously proud of the clinical outcomes for patients which were documented in the Board reports, Royal College reviews and national organisations websites.

The CEO noted the strengths in research and innovation which have been recognised by the designation as an Academic Health Science Centre. She highlighted that Clinical trials and research are fundamental to improving healthcare and finding even more effective treatments. The National Institute for Health and Care Research (NIHR) confirmed an injection of £3million in new funding, which will allow expansion in vital research and diagnostic work with partners including Newcastle University.

The CEO noted the new management structure of eight clinical boards also now in place and was confident the foundations for a better way of working in the future had been established.

The CEO continued to work to hand over the responsibility of leadership to Sir Jim Mackey, and wished him well in his new role, noting that it had been a real privilege to serve as the Trust CEO.

It was **resolved:** to **receive** the report.

23/23 **STRATEGIC ITEMS:**

i) Patients: Digital People Story

i. Response to CQC draft report and Notice of Proposal

The ECN introduced the digital people story which shared the experience of a family who had sought asylum in Newcastle, particularly focusing on their access to health services, and improvement work which is ongoing in response to the learning from their experience.

The digital story shared the collaborative work of organisations across the city who support families and asylum seekers and highlighted the work underway to obtain City of Sanctuary status for the 0-19 service.

Mrs Bromley noted that Newcastle College had introduced English for Speakers of Other Languages (ESOL) courses to asylum seekers should this be of interest to the family.

It was **resolved:** to **receive** the digital people story.

ii) Patients: Patient Safety Strategy Bi-Annual Report, including Patient Safety Incident Response Framework (PSIRP) Plan

Mr G Vincent, Associate Medical Director – Quality and Patient Safety delivered a short presentation highlighting key points:

- The introduction of the PSIRF was a significant change in the NHS in relation to patient safety and will replace the Serious Incident Framework.

- The Trust will transition to the new framework on 1st January 2024.
- The 4 key aims of the framework are: compassionate engagement and involvement, system-based approaches, proportionate responses and learning and improvement.
- Improvement resource will be directed on those areas where the most value will be obtained.
- Three key priority areas to be focussed on as part of the plan over the next 12-18 months are (1) action on abnormal results (radiology), (2) lost to follow up from internal referrals and (3) omissions and errors in thromboprophylaxis leading to VTE.
- The policy and plan will be reviewed every 12-18 months.

Mr Chapman noted the importance of this piece of work which would capture learning at all levels to proactively strengthen current processes.

Mr Chapman questioned what governance arrangements and support was in place to underpin the cultural change to which Mr Vincent advised that the leadership teams within the Clinical Boards would be involved in promoting civility and compassion and to promote consistency across the Clinical Boards with continual review and reflection. He added that the plan will be updated regularly based on new learning, any change in the risk profile and ongoing improvements. In this way the PSIRP will become part of the wider safety management system approach.

The DQE added that incident reporting processes will be separate to Human Resource capability processes and the most important outcome from the introduction of the PSIRP will be the learning from incidents. This will help to remove the general fear of reporting patient safety incidents and the subsequent blame culture.

Mr MacLeod recognised the importance of the reporting of 'near miss' incidents to which Mr Vincent confirmed that these would also be captured via PSIRF, the learning of which will be used as a preventative measure. He added that it was important to note that whilst accountability was still fundamental it must be within a 'just culture'.

Miss C Smith questioned if there were any issues preventing the delivery of the plan to which Mr Vincent noted that it would take time to embed and it will require more resource working on the safety management system across all departments, however it must be seen as an organisational priority.

It was **resolved:** to **approve the** PSIRP for implementation from 1 January 2024.

[Ms C Wroe and Mr J Isaacs joined the meeting. Mr Vincent left the meeting]

i) <u>Partnerships</u>

i. <u>Clinical Research Network Update</u>

Ms Wroe delivered a short presentation on the changes to the current Clinical Research Networks (CRN's) which will end in October 2024 and be replaced by NIHR Research Delivery Networks. These will be different in geography, structure and functionality to the current CRN's. The geography will be 12 Regional Research Delivery Networks (RRDNs) with

a national coordinating centre and matches NHS England (NHSE) regions and Integrated Care Board (ICB's) more closely.

The purpose of the RRDN's will be to support the effective and efficient initiation and delivery of funded research across the health and care system in England. They will also provide the infrastructure to enable the strategic development of research delivery capability and capacity at organisational, regional and national levels and the tools to monitor the delivery of individual studies but will not seek to performance manage all studies on its portfolio.

The RDN Coordinating Centre will provide a joint RDN leadership function with the 12 RRDNs and the Department of Health and Social Care (DHSC) so that the RDN as a whole, functions as a single organisation with a shared vision and purpose across England.

In response to a question from Mr Chapman about specialist studies in Newcastle, Ms Wroe advised that the NIHR RCN specialised in ageing studies.

It was **resolved:** to **note** the update.

ii. Home Grown Research

Mr Isaacs delivered a short presentation on the organisations home grown (or sponsored) research highlighting key points:

- Research is synergistic with high quality care and is essential for progress and reputation.
- Research can help solve key problems, e.g. manpower
- Research needs to become part of daily conversations to improve care quality whilst innovating and enhancing reputation.
- Newcastle Hospitals perform well in the research infrastructure but there is a whole host of different research and the ambition is to serve in them all in comparison to Shelford Group partners. Research is funded by a number of bodies but important to note that home grown innovation comes from within and can further shape the research agenda. Such research is often pioneering and enhances clinical outcomes and safety.
- Active studies have attracted £18m in funding spread across a number of disciplines.
- There are a number of initiatives to facilitate home-grown research including Dragon's Den, reforming research capability funding, working with Newcastle Hospitals Chairty, enhancing training opportunities and reinvestment.
- Newcastle Hospitals is one of the leading UK Centres for commercial research recruitment.
- A strong research culture enhances patient outcomes & safety.
- Several schemes and opportunities exist or are being developed to maximise opportunities.
- Reinvestment of research income is essential to a healthy research culture.

Mr Chapman queried how research was incorporated into job plans to which Mr Isaacs confirmed that some consultant job plans included allocated time for research where outcome measures were available.

The ECN noted that research is one of the pillars of the Nursing, Midwifery and Allied Health Professionals (NMAHP) strategy and the Trust had been successful with securing grant funding from Newcastle Hospitals Charity. Ms Baker highlighted the requirement to use the Charity logo when Charity funding had been utilised.

It was **resolved**: to **receive** the update.

[Ms C Wroe and Mr J Isaacs left the meeting]

ii) People: People Programme Update

The CPO presented the report providing an update on the development of the People Programme. The following points were noted:

- Since September work has continued on the development of the Trust's People Strategy and People Programme, the focus of which has been to listen and to act on what staff are saying, using different sources of information such as ESR, Staff Survey and the Flourish Programme to gather intelligence and data.
- Following a review of the data and intelligence there were four strong themes emerging, being Leadership and Management, Behaviours and Civility, Health and Wellbeing and Feeling Valued.
- Focus groups have been arranged and will continue in to December. Initial feedback had identified some key themes being civility, leadership and health and wellbeing. Information from the focus groups will help inform the development of the People Programme.
- The feedback gained through this stage of engagement will be triangulated with other key feedback sources such as the Staff Survey 2022 and 2023, FTSU Guardian (FTSUG) and the CQC Report.
- Once the data has been triangulated, this will be fed into the steering groups for co-designing an options appraisal in January 2024. The outcome of the steering groups options appraisal on actions required will be fully costed and presented to the People Programme Board.
- The People Programme Board, chaired by the CPO, will focus on quick wins, using the Hive engagement tool, and overarching pieces of work will be rolled out and feedback gathered.
- There has been good engagement from all staff.

The DIPC was keen to learn how the focus groups would represent the whole composition of the Clinical Boards to which the CPO noted that a number of 'Town Halls' had taken place in Clinical Boards with a broad section of staff attending. There was also some focused work underway, reaching out to underrepresented groups. Analysis work was also being undertaken to identify those areas where staff are not speaking up in order to implement some targeted work. Further, there was also the Speak Up system to provide anonymous feedback.

The CPO added that some staff are not comfortable about speaking up in front of other Trust staff, therefore some of the focus groups have been facilitated by an external facilitator to ensure psychological safety.

It was noted that an invitation could be extended to NEDs to attend the focus groups however after listening to representatives of the EDI Steering Group it was felt this may not provide an environment for staff to feel psychologically safe. As such a number of representatives from each of the focus groups would be invited to a further session which could be attended by both Executive Directors and NEDs.

Ms Baker noted that staff wellbeing was of interest for the Newcastle Hospitals Charity as the organisation has a responsibility to look after staff, however it needed a framework on what to prioritise. She added that discussions were ongoing with the CPO.

The Chairman also suggested involvement of the Governors, to which that CPO noted that she had previously presented two updates to the Council of Governors and would continue to do so as the programme developed.

It was **resolved**: to **receive** the report.

iii) Performance

i. Performance Report

The EDBDE presented the report providing an overview Trust's continuing recovery of elective activity as well as performance against both contracted national access standards and the priorities for the year outlined by NHSE as part of the 2023/24 planning round. The following points were noted:

- The October performance was particularly challenged, in part due to the rounds of junior doctor and consultant industrial action held.
- Across 2023/24 to date outpatient procedures measured at 104% of 2019/20 levels, below the expected trajectory of 107%. However, work continued to clear the backlog of coding activity related to ophthalmology procedures which should improve cumulative activity delivery levels over the coming months.
- Newcastle Hospitals delivered performance below the revised 4-hour Accident & Emergency (A&E) arrival to admission/discharge target, with performance standing at 73.8% against the 76% target. This was the first month that the Trust has failed to achieve the 76% target.
- The Trust failed all nine cancer standards in September 2023, including the 28 Day Faster Diagnosis Standard (FDS) for the second successive month. This is largely due to the continuing high levels of demand on the Skin service, although some technical issues also continued with the dermatoscopes used in primary care, impacting on the tele-dermatology pathway that has previously been delivering improvements.
- At the end of October the Trust had 13 patients waiting >104 weeks, all waiting for spinal surgery. 246 patients had a waiting time of >78 weeks, with the majority of these waiting for non-Spinal care – the Trust had been asked by NHSE to reduce waiters in this category to zero by the end of June 2023.

Ms Edusei questioned if the Day Treatment Centre performance was operating to anticipated levels to which the EDBDE noted that whilst the centre was working well there was still some capacity to increase although there had been an increase in the number of

specialties utilising the Centre. Work was now underway to encourage current overnight elective activity to move to day case where safe to do so. The DCOO added that work was ongoing within the Change Board to align sessions to job plans to maximise utilisation.

It was resolved: to **note** the performance detailed within the month 7 performance report.

23/24 BUSINESS ITEMS:

i) Director Reports

a. Medical Director

The MD highlighted salient points with the following being noted:

- All Clinical Boards have made good progress in establishing their Quality Oversight Groups (QOG) including appointment to the medical lead roles and staff were very enthusiastic.
- Work continues towards delivery of a Trust Cancer Strategy in early 2024.
- A concerted effort has been made to review the case notes of the 215 patients not treated within 104 days of referral between the period 1 June to 31 October. From which 1 case was identified as having potential harm.
- BSI Audit/Compliance Report – Cancer Centre - A few minor areas of potential weakness were identified during this visit in relation to effective investigation and appropriate action relating to non-conformity and identification of equipment requiring calibration.
- There are currently plans for further industrial action and the Trust remains prepared.
- It is intended that Urgent & Emergency Care patient flow will be facilitated by Speciality patients going to the appropriate unit, General Practitioner (GP) referrals attending the appropriate unit, enhanced streaming, senior decision making, effective discharge and ambulatory day care unit.
- The Joint Medical School Foundation visit to take place F1 and F2 with undergraduate performing particularly well, describing a high performing team. All trainees approached would recommend the Trust as a place to work.

Professor McCourt commended the positive outcome noting the hard work of both the MD/DCEO and Ifti Haq, Director of Medical Education.

Ms Edusei took assurance from the review of case notes for patients not treated within 104 days.

It was **resolved:** to **receive** the report.

i. Consultant Appointments

It was **resolved:** to **receive** the report.

ii. Annual Emergency Preparedness Resilience and Response Report

The MD/DCEO advised that there had been changes in the standards which meant that compliance had been more challenging in some areas.

It was **resolved:** to **receive** the report. Mr MacLeod, as the NED lead for EPRR, took assurance of the Trust's preparedness processes following attendance at a recent simulation exercise.

b. Executive Chief Nurse Report

The ECN presented the report highlighting key points:

- Spotlight on the Nursing, Midwifery and Allied Health (NMAHP) Professional Strategy split into 6 key priorities. Despite all the challenges faced by staff over the last year, teams are starting to embed the principles of the strategy across the Trust. A celebratory event took place in early November which included sharing over 100 poster presentations of NMAHP led Quality Improvement (QI) projects. Building on the Trust's reputation as a national leader in research is a key priority and in August 2022 it launched the NMAHPs Researcher Development Institute (RDI) thanks to a major £3.2m grant from Newcastle Hospitals Charity. Since then 13 NMAHP RDI Fellows have been welcomed and the Trust has supported peers at regional and national level.
- A new Ward Managers had been developed which had generated national interest.
- 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. 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.
- Regarding the PLACE surveys, some issues had been identified in relation to the hospital food provision which would need to be followed up.
- 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.

Mrs Bromley questioned the key benefits of enacting Deprivation of Liberty Standards (DoLS) applications to which the ECN advised that in doing so, leads to the correct level of care in place for the patient in order to manage their needs.

It was **resolved:** to **receive** the report.

i. Nursing and Midwifery Staffing

The ECN noted the following points:

- Nurse staffing continues to be affected by the nationally recognised workforce pressures alongside a sustained increase in patient acuity and dependency.

- Nurse vacancy levels have improved however there was a higher proportion of newly qualified staff compared with experienced staff, which meant that further training was required.

Mrs Bromley questioned the positioning of educational support for staff in Wards with a higher proportion of newly qualified staff to which the ECN confirmed that a group of clinical educators was in place.

- The Trust uses the Safer Nursing Care Tool (SNCT) and the Safer Nursing Care Tool for Children and Young People (SNCT C&YP) as the evidence-based establishment-staffing tool. This process is aligned to national guidelines and links in to both HR and finance. The overall message is that the staffing establishment is broadly fit for purpose although there is some additional support required where there is enhanced or more complex care.
- In relation to the midwifery workforce, the Trust has a longstanding permanent approval to over-recruit by 20wte, which allows for increased levels of maternity leave, additional core competency training, and to ensure a consistent, sustainable position within the large midwifery workforce. It was noted that the number of training places commissioned nationally for paediatric nurses was too low for the demand e.g. within areas such as paediatric intensive care.

It was **resolved:** to **receive** the report.

ii. Maternity Update

The ECN presented the report and highlighted:

- An update on the actions arising from the CQC maternity inspection undertaken in January 2023 as part of the national maternity inspection programme, the results of which were published on the 12 May 2023. The two key domains of 'safe' and 'well-led' were inspected resulting in an overall rating for the Maternity service as 'requires improvement'. A rating of 'good' was declared for well-led and 'requires improvement' for safe.
- An update on the Trust's position in relation to the recommendations from both the interim and final Ockenden reports. Full compliance is now demonstrated at 79.1% and 20.9% of recommendations remain partially compliant. A key area of challenge remained in relation to training compliance levels.
- An external Ockenden visit was held on 10 November 2023 and the verbal report following that visit was very positive. The report is anticipated within 21 days of the visit, and this will be referenced in the written report for the January Quality Committee meeting.
- Following implementation of the BadgerNet system, further work was required in ensuring appropriate interface with the observations system.
- A letter of concern had been received from the HSIB (which is now the MNSI) and several meetings have taken place to follow up the issues raised in the letter. Further granular detail had been obtained on some of the concerns, many of which point towards the need for some cultural improvement work. Discussions are taking place to agreed how the improvement work will be undertaken across the maternity service.

It was **resolved**: to **receive** the report.

c. Director of Quality & Effectiveness

i. Maternity Incentive Scheme (MIS) Year 5 CNST Compliance

The DQE presented the report noting this was the third update report regarding the 10 safety actions in the Year 5 scheme which were published on the 31 May 2023.

The DQE provided assurance that the Trust was compliant in all of the safety actions with the exception of safety action 8 which related to in-house multi-professional training. Achieving full compliance with the training requirements continued to be the most significant challenge for Year 5 due to demand pressures.

Discussions had taken place with the Clinical Board Finance Manager regarding recruitment and additional funding. As referenced earlier, approval had been granted to overrecruit for 20 whole time equivalents but with the additional training requirements it was unlikely to the Trust would be able to meet the overall CNST requirements by 5th December.

It was noted that NHS Resolution has reduced its compliance rate from 90% to 80%.

It was resolved: to (i) **receive** the report and (ii) **approve** the CNST self-assessment to date.

ii. Quality Account

The report provided assurance to the Board that improvements are being made and, where necessary, appropriate measures are in place to address any deviation from the anticipated mid-year position. The paper outlined a six-month review of progress, with significant progress made despite the challenges outlined in the report.

It was **resolved**: to receive the report.

d. Healthcare Associated Infections (HCAI)

The DIPC highlighted the following key points in relation to Infection Prevention Control (IPC):

- Two MRSA bacteraemia have been attributed to the Trust in October 2023 and were related to intra-vascular devices. This takes the Trust total to three against a target of zero.
- MSSA blood stream infections remain over local trajectory. The Vascular Access Team is working with IPC team and clinical teams to improve staff knowledge around line care documentation and ongoing management. IPC and Clinical Boards maintain oversight through the clinical standards dashboard and thematic analysis from post infection reviews.
- Gram Negative Blood Stream Infection (GNBSI) rates are over trajectory and remain high priority for targeting IPC initiatives. Continence, vascular specialist teams, IPC and clinical areas work together to identify areas with high rates and target

initiatives towards improving bladder health and device management. This remains challenging as specialist teams are small and this is an additional role hence our key focus is to empower harm free care leads and clinical teams on wards and departments through education.

- *Clostridioides Difficile* infections (CDI) remain under national trajectory, numbers have remained static since August. IPC /Infection specialists and antimicrobial groups are working collaboratively with clinical teams to improve diarrhoea care management and antimicrobial prescribing. This will continue to be a high priority until sustained reduction is achieved.
- The process of incorporating IPC into the PSIRF is under way with plans for full implementation by January 2024.

It was **resolved:** to **receive** the report.

ii) Charity Annual Report and Accounts {FOR APPROVAL]

The ACE presented the Charity Annual Report and Accounts for approval noting:

- That the Charity accounts are included in the full Group accounts but were audited by different external auditors. The new auditors had identified some matters which had not been highlighted previously in relation to retail accounting and VAT.
- The Annual Report provided a comprehensive overview of what the Charity has achieved over the last year.
- The Charity Impact Report will be ready within the next couple of weeks.

Ms Baker noted that the smallest grant awarded was for £10 and the biggest was for £1.8M which demonstrated the Charity's diversity.

It was **resolved:** to **Approve** the Annual Report and Accounts.

23/25 ITEMS TO RECEIVE AND ANY OTHER BUSINESS:

i) Provider Collaborative Governance

The update outlined the governance arrangements previously approved for the NENC Provider Collaborative, specifically focusing on the responsibility agreement with the ICB and the strategic partnership agreed.

It was **resolved:** to **receive** the update.

ii) Update from Committee Chairs

The report was received, with the following additional points to note:

Audit Committee
Mr MacLeod advised that there were no matters to escalate from the Audit Committee.

Quality Committee

Mr Chapman noted the increasing number of requirements in relation to training and mentoring.

People Committee
Mr Jowett highlighted the need to be aware of the ongoing development work in progress within the HR team to develop the People Programme and the People priorities.

Finance Committee
Miss Smith noted robust conversations on financial planning and performance, as well as the approval of a number of business cases for investments for the Trust. Eric Valentine, Public Governor observed the Committee meeting.

Charity Committee
Ms Baker noted the level of grants awarded together with the level of donations received.

It was **resolved:** to **receive** the report.

iii) Integrated Board Report

It was **resolved:** to **receive** the report.

iv) Meeting Action Log

The action log was received and the content noted.

v) Any Other Business

Mr Jowett expressed his gratitude on behalf of the Board members to the CEO and Chairman, who were attending their last formal Board meeting today prior to leaving the organisation. Both were wished well in their future endeavours.

Date and Time of Next Meeting

The next formal meeting of the Board of Directors is scheduled for **Thursday 25 January 2024** at the **Freeman Hospital Boardroom.**

There being no further business, the meeting closed at 15:51

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	25 January 2024						
Title	Chair's Report						
Report of	Professor Kath McCourt, Interim Chair						
Prepared by	Professor Kath McCourt, Interim Chair Gill Elsender, Corporate Governance Officer and PA to the Chairman and Trust Secretary						
Status of Report	Public	Private	Internal				
	☒	☐	☐				
Purpose of Report	For Decision	For Assurance	For Information				
	☐	☐	☒				
Summary	This report outlines a summary of the Chair's activity and key areas of recent focus since the previous Board of Directors meeting, including: • Governor activity • "Spotlight on Services" • Newcastle Hospitals Charity Arts Programme • Board Activity • Regional engagement with Foundation Trust Chairs of the North Integrated Care Partnership (ICB) • Engagement with the Integrated Care Board (ICB) Chair and Foundation Trust Chair Forum • Engagement with the NHS Confederation • The launch event for Patient Safety Incident Reporting Framework						
Recommendation	The Trust Board is asked to note the contents of the report.						
Links to Strategic Objectives	Patients – Putting patients at the heart of everything we do. Providing care of the highest standard focusing on safety and quality. Pioneers – Ensuring that we are at the forefront of health innovation and research.						
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☒	☐	☐	☐	☐	☒	☐
Link to the Board Assurance Framework [BAF]	No direct link however provides an update on key matters.						
Reports previously considered by	Previous reports presented at each meeting.						

CHAIR'S REPORT

EXECUTIVE SUMMARY

This report outlines a summary of the Chair's activity and key areas of focus since the previous Board of Directors meeting, including:

- Governor activity
- "Spotlight on Services"
    - Newcastle Hospitals Charity Arts Programme
- Board Activity
- Regional engagement with Foundation Trust Chairs of the North Integrated Care Partnership (ICB)
- Engagement with the Integrated Care Board (ICB) Chair and Foundation Trust Chair Forum
- Engagement with the NHS Confederation
- The launch event for Patient Safety Incident Reporting Framework

The Trust Board is asked to note the contents of the report.

CHAIR'S REPORT

This Board meeting marks my first as Interim Chair of the Trust. I would also like to formally welcome Sir Jim Mackey to the Trust as our new Chief Executive Officer and I am looking forward to working with him.

I chaired my first Council of Governors as Interim Chair on Thursday 7 December 2023. In addition to our regular agenda items, we were joined by Andy Pike, our Freedom to Speak Up Guardian (FTSU) who delivered a presentation on his role and the Freedom to Speak Up service in the Trust. The FTSU Guardian is an independent, impartial point of contact to support, signpost and advise staff who wish to raise concerns.

The meeting was well attended by our Governors and I look forward to continuing getting to know you and working collaboratively with you all.

In December we enjoyed a "Spotlight on Services" which was hosted by our Newcastle Hospitals Charity. We were joined by Katie Hickman, Arts Programme Manager who delivered a short presentation on the work undertaken and the embedding of the Arts programme within the Trust. The embedding of the programme as core Chairty activity, was hugely timely as the drive for arts and health programmes increases with the new Creative Health Review launched in early December by the All-Party Parliamentary Group on Arts, Health and Wellbeing.

I chaired a Board Development Session on 14 December 2023 which focused on:

- The latest developments in system work and the impact for Newcastle Hospitals.
- A stocktake on the CQC inspection position and discussion on oversight and governance arrangements going forward.
  I am actively working with colleagues to address the actions arising from the CQC inspections.
- Discussion of current issues within Clinical Boards and how these will be governed.
- A briefing on the newly established Medical Staffing/Local Negotiating Committees.
- An update on Medical Education and Training.

At a regional level, I have engaged with both Foundation Trust Chairs and the Integrated Care Board (ICB). At the meeting on the 12 December 2023, we received updates on the priorities of the Provider Collaborative, finance and performance.

On a national level I participated in a Chairs meeting in December hosted by NHS Confederation where we were joined by May Li, Interim Director of Efficiency, NHS England and Ed Jones, Senior Policy Advisor, NHS Confederation. The session focused on productivity linking in to the governments productivity review which is shaped around three workstreams - prevention, Artificial Intelligence (AI)/digital, and administration.

On Thursday 18 January I was delighted to be invited to the launch event of or new Patient Safety Incident Reporting Framework, a new approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

RECOMMENDATION

The Board of Directors is asked to note the contents of the report.

Report of Professor Kath McCourt
Interim Chair
25 January 2024

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	25 January 2024						
Title	People Story						
Report of	Maurya Cushlow, Executive Chief Nurse						
Prepared by	Ian Joy, Deputy Chief Nurse Tracy Scott, Head of Patient Experience						
Status of Report	Public	Private	Internal				
	☒	☐	☐				
Purpose of Report	For Decision	For Assurance	For Information				
	☐	☒	☒				
Summary	This People Story outlines the process, learning and patient feedback from the opening of a 27 bedded winter ward to support the Trusts winter resilience plan. Each year, the Trust plans and executes a number of schemes to ensure there is appropriate capacity and resilience in place to manage winter pressures safely and effectively. This is with the aim of providing the highest possible standard of safe care to patients throughout the winter across community, acute and elective pathways. For a number of years, capacity has been increased by opening up a small number of non-commissioned beds on wards or opening up closed weekend beds, but we have not been able to achieve the opening of a fully staffed additional medical ward due to workforce challenges.						
Recommendation	To listen and reflect on learning and patient feedback from the opening of a winter ward to support the Trusts winter resilience plan.						
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 Learning and continuous improvement is embedded across the organisation						
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☒	☒	☐	☒	☒	☒	☐
Link to Board Assurance Framework [BAF]	No BAF risks identified.						
Reports previously considered by	This patient/staff story is a recurrent bi-monthly report.						

PEOPLE STORY

EXECUTIVE SUMMARY

This People Story, described during the Trust Board by Catherine Carr, Head of Nursing, outlines the process, learning and patient feedback from the opening of a 27 bedded winter ward to support the Trusts winter resilience plan.

The report outlines the process and support required to open up a ward in this way, demonstrating the important role all clinical and non-clinical boards play in delivering this aspiration. The ward opened with 15 patient beds and is now fully operational with all 27 beds open.

Since opening there have been a number of challenges which the ward and Clinical Board team have addressed responsively and pro-actively where possible. Despite the challenges, three weeks after opening the ward received its first patient feedback letter which is included in the report.

BACKGROUND

Each year, the Trust plans and executes a number of schemes to ensure there is appropriate capacity and resilience in place to manage winter pressures safely and effectively. This is with the aim of providing the highest possible standard of safe care to patients throughout the winter across community, acute and elective pathways. One way of achieving this, aligned to national requirements, is to where possible, increase the Trust's total inpatient medical bed capacity. For a number of years, capacity has been increased by opening up a small number of non-commissioned beds on wards or opening up closed weekend beds, but we have not been able to achieve the opening of a fully staffed additional medical ward due to workforce challenges.

Due to the improved nursing vacancy position over this calendar year, a decision was made in the summer to commence planning for the opening of a 27 bedded medical ward (Ward 12) at the Freeman Hospital between mid-December 2023 and the end of March 2024. To operationalise this, a task and finish group was convened, consisting of colleagues from the Medicine and Emergency Care Clinical Board, Operational Colleagues and members of the Senior Nursing Team.

To help achieve this aim, additional support was required; this was a collaborative effort across clinical, estates, pharmacy, HR and financial teams. To be able to safely staff 27 medical beds we required a total of 20 whole time equivalent (wte) registered nursing staff and 20wte Healthcare Support Worker staff. Clinical Boards were asked to release an agreed number of registered and non-registered staff to support the opening of the ward. Undoubtedly this was a big ask when Clinical Boards were still required to deliver core activity, therefore additional temporary recruitment to reduce any risk or pressure was supported.

Asking staff to support a temporary ward is always challenging. We know staff tend to feel more comfortable and confident working within their own teams and disciplines and will

feel anxious about being asked to work outside of their comfort zone. To support in preparation, staff were released two weeks prior to opening to undertake a combination of team building work, orientation on existing medical wards at the Freeman site in a supernumerary capacity and undertake additional training. Ward 12 initially opened with 15 patients to ensure any training or clinical concerns were addressed. The ward is now fully open to 27 beds. Additional oversight and quality monitoring is also in place to address early, any trends in clinical and outcome metrics.

Since opening there have been a number of challenges which the ward and Clinical Board team have addressed responsively and pro-actively where possible. Due to learning in the first two weeks the patient pathway was changed to ensure the acuity and dependency profile of patients was lower to match staff skill and experience. Some staff also shared concerns around working on the ward due to feeling that they still lacked some skill and experience therefore they have been supported to work in other established medical wards and swapped with other staff to ensure an effective skill mix. The learning from this year will be collated, with a de-brief in April to understand learning for future winter plans.
Despite the challenges, three weeks after opening, the ward received its first patient feedback letter which is outlined below.

"Dear Ms Sophie Blakey (Matron).

I wanted to take the opportunity to provide some feedback on my mum (anonymised) very recent stay on your ward.

I am aware many people are very quick to criticise but often don't take the time to compliment but I feel must. From her arrival, I was deeply impressed with the care and support, not only my mum received but from observing also the care others received too. I was fortunate to meet so many of your team, who are not only clinically skilful, of which I would expect, but also possessed many additional skills that were outstanding in their delivery.

I observed kindness, care, and compassion, most often delivered with warmth and a smile and welcomed the interactions with laughter often heard. I saw care provided with integrity, with a strong focus on patient advocacy. Ella stood out with her excellent skills and demonstrated this on every interaction. Particularly towards an extremely vulnerable patient, with personal care delivery made with the persons dignity and best interests in mind. I have no doubt Ella will be successful in whatever pathway she chooses.
I saw Elizabeth provide gentle encouragement that empowered the person to undertake personal care with gained confidence. I saw interactions where the value of each person as an individual was gained to understand the person's priorities with a focus on their abilities rather than their limits and or disabilities. There were multiple examples of your team practicing effective communication with each other, patients, and their families. I was a recipient of this on many occasions, not only on the ward but also on the telephone, thank you Elizabeth, Laura, Lauren and Vicky.

I witnessed and heard wonderful examples of compassion and empathy from your team, the kindness of John and his skills to focus on a person-centered care approach and how this directly improved the patients lived experience. The leadership on your ward was evident

every day I visited, I met many of your leaders who possessed leadership as personal characteristic rather than a job title or band level.

I would particularly wish to thank Molly who epitomised this and all mentioned above in her every action. Her calmness, commitment to excellence and her passion for her role shone in her attitude and actions. All those around her continually benefited from her professionalism and obvious exemplary skills and commitment to developing others. Thank you, Molly, for your kindness and for taking the time to ensure I was updated with all the information I needed.

I know there were many others who I spoke to who I would like to thank I hope I did when visiting.

Thank you to everyone for your skills and kindness"

This letter has been shared with all of the staff involved which has been gratefully received.

Despite the challenges faced and some of the concerns raised in opening up short term winter capacity, it is clear that the clinical and local leadership team have worked tirelessly to ensure patients experience the highest standard of individual care which is not just important for patients but also important to them to deliver.

RECOMMENDATION

To listen to the experience of opening and leading a temporary winter ward. This includes outlining some of the challenges faced and the learning undertaken which will lead the team to improve the approach in future years. Catherine will also reflect on the feedback received regarding care on the ward and the importance of sharing that with all staff involved.

Report of Maurya Cushlow
Executive Chief Nurse
25 January 2024

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	25 January 2024						
Title	Trust Performance Report						
Report of	Martin Wilson, Chief Operating Officer Vicky McFarlane-Reid, Director of Commercial Development & Innovation						
Prepared by	Elliot Tame, Senior Business Development Manager (Performance)						
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 elective recovery progress as well as performance against NHS England (NHSE) priorities for 2023/24 and key operational indicators.						
Recommendation	For assurance.						
Links to Strategic Objectives	Patients – Putting patients at the heart of everything we do. Providing care of the highest standard focussing on safety and quality. 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 pressures] Strategic Risk SO5.8 [Activity delivery] Details compliance against NHSE plan priorities for 2023/24. Details compliance against national access standards which are written into the NHS standard contract.						
Reports previously considered by	Regular report.						

TRUST PERFORMANCE REPORT

EXECUTIVE SUMMARY

This report provides an overview of the Trust's continuing recovery of elective activity as well as performance against both contracted national access standards and the priorities for the year outlined by NHS England (NHSE) as part of the 2023/24 planning round.

- Provisional data suggests activity delivery levels (volumes) in December were below both plan and the revised 103% target across all points of delivery except for New Outpatient appointments (106.2%) and Day Cases (103.2%). Cumulatively for 2023/24 to date (months 1-9) total activity delivery stands at 102.3% of the re-based 2019/20 baseline.
- The Trust delivered overnight elective delivery measured at 85.1%. Delivery has been impacted by ongoing industrial action as well as a significant increase in Adult General and Acute average bed occupancy, causing significant difficulties in maintaining patient flow.
- Across 2023/24 to date outpatient procedures measure at 107.2% of 2019/20 levels, just below the trajectory of 108.5%, but with some activity in December still to be coded. Performance has improved in recent months owing to the clearance of a backlog of coding activity related to ophthalmology procedures.
- Newcastle Hospitals delivered performance below the revised 4-hour A&E arrival to admission/discharge target, with performance standing at 72.5% against the 76% target. This was the third successive month that the Trust has failed to hit the target.
- The Trust failed all three newly consolidated cancer standards in November 2023, with metrics having been simplified into three clear targets - the 28 Day Faster Diagnosis Standard, 31 days from decision to treat to treatment (combined) and 62 days from referral to treatment (combined). This is largely due to the continuing high levels of demand on the Skin service, as well as late referrals from other organisations and ongoing diagnostic/theatre capacity issues. The Trust was escalated into Tier 1 interventions by NENC ICB/NHSE for cancer care in December as a consequence of this as well as the continuing distance between the volume of patients waiting over 62 days for treatment and the end of year 'fair-share' target (200) – at the end of December 314 patients were experiencing this length of wait.
- At the end of October the Trust had just 5 patients waiting >104 weeks, all waiting for spinal surgery. 322 patients had a waiting time of >78 weeks, with the majority waiting for non-Spinal care – the Trust had agreed a revised trajectory with NHSE to bring the number of patients waiting this length of time down to 167 by the end of March 2024, but has now gone further with the ambition to eliminate 78 week waits by the end of March 2024, as well as reduce 65WWs by a third.

The Board of Directors is asked to receive the report.

Trust Performance Board Report

Produced: January 2024
Data: December 2023

NHSE Plan Requirements 2023/24

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Metric	Requirement	Sep-23	Oct-23	Nov-23	Dec-23	RAG Rating: Dec-23*	
						Plan	Target
Cumulative Activity Delivery (Spec. Acute)							
Day Case	**103%** of 19/20 value-weighted activity (overall, monthly cumulative) **N.B. Currently being reported by volume, not VWA**	102.7%	102.8%	102.6%	**102.7%**	111.9%	103.0%
Elective Overnight		82.9%	82.5%	82.8%	**83.0%**	113.0%	103.0%
Outpatient New		97.9%	98.7%	99.5%	**100.2%**	104.5%	103.0%
Outpatient Procedures		110.8%	109.5%	109.6%	**107.2%**	108.5%	103.0%
Total		102.6%	102.5%	102.8%	**102.3%**	107.6%	103.0%
Urgent & Emergency Care							
A&E Arrival to Admission/Discharge	**>=76%** under 4 hours (by Mar-24)	76.1%	73.8%	73.1%	**72.5%**	70.0%	>=76%
Adult General & Acute Bed Occupancy	**<=92%**	88.9%	91.5%	91.3%	**86.9%**	88.7%	<=92%
Urgent Community Response Standard	**>=70%** under 2 hours	84.0%	79.6%	84.2%	**84.5%**	N/A	>=70%
Cancer Care							
>62 Day Cancer Waiters	Reduce to **<=200** (by Mar-24)	397	320	290	**314**	244	<=200
28 Day Faster Diagnosis	**>=75%** (by Mar-24)	68.8%	72.2%	**70.0%**	TBC	75.0%	75%
Elective Care							
>104 Week Waiters	**Zero**	14	13	12	**5**	2	0
>78 Week Waiters	**Zero**	229	246	269	**322**	5	0
>65 Week Waiters	**Zero** (by Mar-24)	1,515	1,575	1,533	**1,558**	610	0 (Mar-24)
>52 Week Waiters	**Reduction** (Zero by e/o Mar-25)	4,504	4,593	4,672	**4,549**	3,400	0 (Mar-25)
>12 Weeks Validation	**90%** (by Oct-23)	23.0%	38.0%	**44.7%**	TBC	N/A	90% (by Oct-23)
Diagnostics							
Diagnostic Activity**	Appropriate levels to reduce waits	106.9%	110.8%	105.1%	**113.6%**	113.0%	N/A
>6 Weeks Waiters	**<=5%** (by Mar-25)	21.8%	21.8%	23.9%	**30.1%**	N/A	<=5%
Outpatient Transformation							
PIFU Take-up	**>=5%** of all OP atts. (by Mar-24)	2.8%	3.0%	3.2%	**3.1%**	3.5%	5.0% (Mar-24)
Outpatient Follow-up Reduction	**<=75%** of 19/20	104.9%	104.8%	108.9%	**108.0%**	109.7%	<=75%

*** 1 month prior for 28 Day FDS**

** CT, MRI, Non-obs US, Endoscopy & ECHO.

Operational Standards

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Metric	Standard	Sep-23	Oct-23	Nov-23	Dec-23	RAG Rating: Dec-23*
Urgent & Emergency Care						
Ambulance Handovers	**Zero** over 60 mins	15	24	44	**65**	
A&E Arrival to Admission/Discharge	**>=76%** under 4 hours (by Mar-24)	76.1%	73.8%	73.1%	**72.5%**	
	<2% over 12 hours	1.2%	2.4%	1.6%	**3.0%**	
Urgent Community Response Standard	**70%** under 2 hours	84.0%	79.6%	84.2%	**84.5%**	
Cancer Care						
28 Day Faster Diagnosis	**75%** (by Mar-24)	68.8%	72.2%	**70.0%**	TBC	
31 Days (DTT to Treatment)	**96%**	83.2%	86.0%	**84.6%**	TBC	
62 Days (Referral to Treatment)	**85%**	51.2%	54.2%	**55.0%**	TBC	
Elective Care						
18 Weeks RTT	**92%**	66.9%	67.3%	67.0%	**65.5%**	
>65 Week Waiters	**Zero** (by Mar-24)	1,515	1,575	1,533	**1,558**	
>6 Weeks Diagnostic Waiters	**<=1%**	21.8%	21.8%	23.9%	**30.1%**	
Cancelled Ops. Rescheduled >28 Days	**Zero**	10	12	4	**16**	
Urgent Ops. Cancelled Twice	**Zero**	0	0	0	**0**	
Other						
Duty of Candour	**Zero**	0	0	0	**0**	
Mixed Sex Acommodation Breach	**Zero**	Data unavailable	128	114	**99**	
MRSA Cases	**Zero**	0	2	0	**1**	
C-Difficile Cases	**<=165** (FY Cumulative)	73	89	100	**111**	
VTE Risk Assessment	**95%**	96.3%	95.8%	**96.2%**	TBC	
Sepsis Screening Treat. (Emergency)	**>=90%** (of sample) under 1 hour	54.0%	56.0%	56.0%	**56.0%**	
Sepsis Screening Treat. (All)		55.0%	81.0%	81.0%	**81.0%**	

*** 1 month prior for Cancer Care**

Other Metrics (1/2)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Metric		Sep-23	Oct-23	Nov-23	Dec-23
Emergency Care					
Ambulance Arrivals		2,928	3,204	3,056	**3,127**
Ambulance Handovers <15 mins		63.4%	64.9%	62.6%	**61.5%**
Ambulance Handovers <30 mins		91.7%	91.9%	89.3%	**88.4%**
Ambulance Handovers <60 mins		99.5%	99.3%	98.6%	**97.9%**
Type 1 Performance (A&E 4 hour)		61.9%	58.2%	57.4%	**55.8%**
Type 1 Attendances (Main ED)		11,960	12,958	12,733	**12,362**
Type 2 Attendances (Eye Casualty)		1,482	1,622	1,497	**1,289**
Type 3 Attendances (UTC)		4,943	5,477	5,206	**5,413**
Patient Flow					
Covid Inpatients (average)		38	31	23	**21**
Emergency Admissions		6,093	6,522	6,464	**6,186**
G&A Bed Occupancy		88.9%	91.5%	91.3%	**86.9%**
Critical Care Bed Occupancy		63.9%	70.9%	66.6%	**64.7%**
Bed Days Lost (average)		38	33	23	**25**
Medical Boarders		69	67	79	**73**
Length Of Stay >7 Days		735	791	762	**742**
Length Of Stay >21 Days		329	330	338	**371**

Other Metrics (2/2)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Metric		Sep-23	Oct-23	Nov-23	Dec-23
Planned Care					
2WW Referrals		2,859	2,761	2,539	**1,992**
Urgent Referrals		5,645	6,098	5,796	**5,020**
Routine Referrals		25,387	27,542	27,741	**21,221**
Specialist Advice Requests (% of New OP Atts.)		9.1%	8.5%	8.1%	**8.4%**
Day Case Activity (Specific Acute (SA))		10,267	11,160	11,238	**9,336**
Overnight Elective Activity (SA)		1,669	1,760	1,863	**1,515**
New Outpatient Attendances (SA)		21,328	24,408	23,905	**18,993**
Outpatient Procedure Activity (SA)		19,775	18,077	19,320	**11,061**
Review Outpatient Attendances (SA)		59,232	64,840	66,188	**56,529**
Diagnostic Tests		19,380	20,822	20,276	**17,325**
Outpatient DNA Rate		6.8%	7.1%	7.1%	**7.7%**
Virtual Attendances		13.3%	13.5%	13.4%	**13.7%**
RTT Waiting List Size		108,603	109,149	107,234	**104,965**

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	25 January 2024						
Title	Medical Director's Report						
Report of	Andy Welch, Medical Director/ Deputy Chief Executive Officer						
Prepared by	Andy Welch, Medical Director/ Deputy Chief Executive Officer						
Status of Report	Public	Private	Internal				
	☒	☐	☐				
Purpose of Report	For Decision	For Assurance	For Information				
	☐	☒	☒				
Summary	The Report highlights issues the Medical Director wishes the Board to be made aware of.						
Recommendation	The Board of Directors is asked to note the contents of the report.						
Links to Strategic Objectives	Putting patients at the heart of everything we do and providing care of the highest standard focusing on safety and quality.						
Impact (Please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☒	☐	☐	☐	☐	☐	☐
Link to Board Assurance Framework [BAF]	No direct link.						
Reports previously considered by	This is a regular report to Board. Previous similar reports have been submitted.						

MEDICAL DIRECTOR'S REPORT

EXECUTIVE SUMMARY

The following items are described in more detail within this report:

i) Quality & Patient Safety Update
ii) Cancer Update
iii) Industrial Action
iv) Mental Health Strategy

Included within the Board Reference Pack are the following documents to note:

i) Consultant Appointments
ii) Quarterly Guardian of Safe Working Report – Quarters 1 and 2

The Board is asked to note the contents of the report.

MEDICAL DIRECTOR'S REPORT

1. QUALITY AND PATIENT SAFETY

1.1 Board Quality and Safety (Q+S) Structure

Priorities in the last 6 weeks remain focussed on embedding quality governance arrangements as part of the Clinical Board re-structure and implementation of the Patient Safety Incident Response Framework (PSIRF) as previous.

All Clinical Boards have made good progress in establishing their Quality Oversight Groups (QOG) including appointment to the medical lead roles.

The QOGs will oversee all governance activity within the Board that fall within the four major domains as presented previously to Board.

i) Patient Safety
ii) Clinical Effectiveness
iii) Patient Experience
iv) Quality Improvement

In the last 6 weeks, Clinical Board colleagues have been tasked with structuring their areas at directorate and departmental level to consistently address these domains. This very large piece of work will in some areas require relatively little tweaking and alteration of existent groups and meetings whilst in others, a greater degree of work establishing new structures will be required.

This process is being pro-actively managed with support from the Associate Medical Directors (AMDs) and the Clinical Governance and Risk Department (CGARD) to Board Q+S leads and frequent meetings and oversight activity scheduled.

The QOG and governance tiers below are of course in service of actions and behaviours in our wards, theatres and clinics and the overall culture with respect to safety.

Care Quality Commission (CQC) scrutiny and oversight of these new structures and their impact at shop floor level will be high. Internal methods of measuring the impact of this work should be considered/ developed.

Clinical Boards will be accountable for embedding Getting it Right First Time (GIRFT) recommendations where appropriate, through the clinical governance structure with prioritisation of initiatives that are aligned with the Trust's safety priorities, performance and efficiency of services.

1.1.1 PATIENT SAFETY INCIDENT RESPONSE FRAMEWORK (PSIRF)

The transition to PSIRF from our current Serious Incident (SI) framework has now been pushed back to 29 January 2024 and the PSIRF launch event to the afternoon of 18 January

2024. The original transition and launch dates conflicted with junior doctor industrial action during December and January.

Work is beginning as previously notified with our three identified major safety priorities:

- Medication error relating to anti-coagulation.
- Failure of the internal referral process.
- Failure to act on abnormal results – radiology.

The principles of PSIRF also feed directly into how we aim to re-boot our safety culture in line with the Q+S Clinical Board restructure and mindful of the matters raised by CQC. PSIRF emphasises compassion in dealing with incidents both in regard patients and their families and importantly of staff in addition.

The PSIRF environment of compassion and a proportionate response to incidents provides the Trust with a great opportunity to transition the safety culture in some areas away to improve trust and engagement with reporting, moving towards the open and psychologically safe environment which is necessary.

2. CANCER UPDATE

2.1 Cancer Performance

	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23
2ww (93%)	76.1	75.8	77.2	49.8	65.6	66.3	48.8	75.4	75.2*
28D FDS (75%)		81.9	83.1	80.0	74.7	68.8	69.8	68.5	70.6*
62D (85%)	61.1	53.9	47.2	55.2	56.5	53.7	52.6	53.1	49.0*

*unverified as of 3 January 2024

Reducing waiting times is the principle focus of the cancer teams, although the most important clinical indicator must remain the 62 day target. All teams are endeavouring to provide treatment dates to patients. The main specialities contributing, numerically, to the backlog are skin, urology and upper GI including hepatobiliary.

There is work ongoing to reduce time to treatment from a number of perspectives including maximising efficiency of imaging, theatre efficiency, provision of additional theatre lists, review of day case options, a specific review of multi-disciplinary team (MDT) working and patient pathway in Hepato-Pancreato-Biliary (HPB) and a review of scheduling processes for first chemotherapy and radiotherapy appointments.

Radiology capacity remains a concern. The Radiology Team have increased provision for 2 Week Wait (2ww) work by 10% from December 2023. The aim is to continue to improve turnaround time for scanning and reporting of CT scans for patients on 2ww pathways, aiming for a report within 7 days of request from the end of February 2024. There is an overall deficit in capacity for computerised tomography (CT) and magnetic resonance imaging (MRI) scanning. Interventional CT capacity is a particular challenge for cancer pathways leading to delays in radiofrequency ablation procedures for renal and liver tumours. Meetings with Liver and Renal Teams confirm there are no interchangeable treatment options which give the same benefit with equivalent or less risk for these patient groups. Building this capacity, given that this Trust is the only provider in the North Integrated Care Partnership (ICP), would therefore be a key objective.

2.1.1 Harm Reviews

Harm reviews, for patients on cancer pathways who are not treated within 104 days, continue to be undertaken. Further work is needed to ensure that this process is fully embedded in departmental governance structures. Work is ongoing with all tumour groups to aim to implement a review of harm at multidisciplinary team level as this is likely to give the optimal expertise and consistency to the process as well as maximising the opportunities for learning. This will be a focus for the next 3 months.

Whilst the harm reviews undertaken to date do provide some assurance that patients are being clinically prioritised based on acuity and risk during their wait for treatment, it is clear that the best solution is to treat patients within target dates.

2.1.2 Cancer Strategy

The key operational objectives are to reduce the number of patients waiting over 62 days for treatment and to become compliant with the 14 day, 28 day and 62 day treatment targets, particularly the latter.

With a view to the medium term, work continues towards delivery of a Trust Cancer Strategy in early 2024. The main themes identified to date are:

- Personalising care for our patients.
- Working better together across the system.
- Recognising and addressing health inequalities.
- Innovation and sustainability of services.

The key enablers of change are judged to be: workforce fit for the future along with data and digital transformation. The aim is to produce a draft by end of February 2024

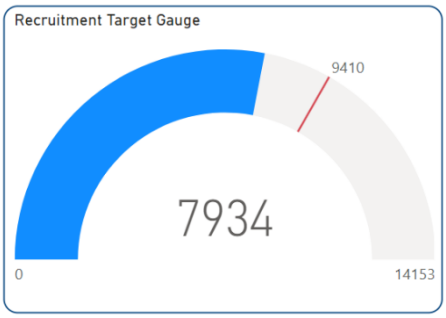
3. RESEARCH

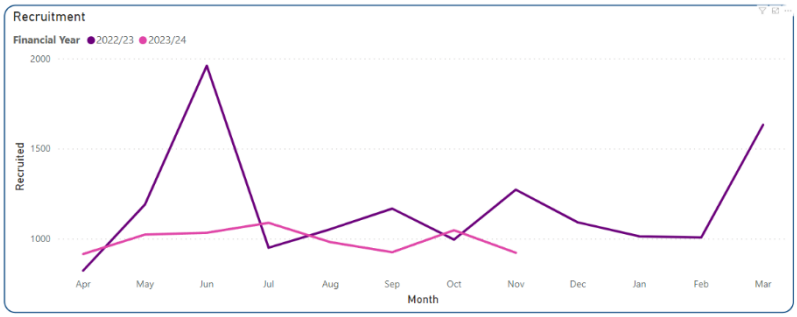
3.1 Activity

The data referenced below relates to the period to the end of November 2023.

Recruitment to research studies continues to be lower than the previous year and as previously reported this is due to a number of factors including:

- Impact of industrial action.
- Vaccine study in May - June 2022/2023 with very high recruitment figures.
- Variable study complexity.





3.2 Some notable highlights in the last quarter

- We are currently running our largest ever study (2,741 participants to date), called INGR1D2, which identifies infants at high risk of developing type 1 diabetes to study new treatments with the potential to prevent development of the condition.
- The SHAPES study, which looks at body shape in early pregnancy and how it relates to health, recruited it's 1,000th patient in November 2023.
- European First: The hepatology research team recruited Europe's first patient to a study which is looking at a drug to treat non-alcoholic steatohepatitis.
- Chris Harding, Consultant Urological Surgeon, was awarded £2m in National Institute for Health and Care Research (NIHR) funding for his unique research investigating treatments instilled into the bladder to prevent recurrent urinary tract infections.
- UK First: The dermatology research team recruited UK's first patient to the A-STAR BIO study investigating long-term effectiveness and safety of eczema treatments for adults and children.
- UK First: The Clinical Research Facility team recruited UK's first patient to the ODYSSEY trial. This trial is testing investigational vaccines designed to limit new outbreaks of bird and pig flu.

3.3 Commercial Research

The Research Team continues to be focussed on growing commercial activity and income in line with national priorities. Highlights include:

- Playing a leading role in the development of the National Contract Value Review (NCVR), a novel clinical trial costing tool, aimed to accelerate set-up times for national, multi-site studies. This was implemented in October 2023 and its impact is being monitored.
- In October 2023 IQVIA, a leading global contract research organisation visited our facilities. The Trust was recognised as one of IQVIA's super partner sites.

- A successful visit from Novartis was hosted in November 2023, which strengthened the working relationship with them as primary partners, particularly in cardiovascular and oncology research.

3.4 Upcoming plans for next quarter

- Commercial Partner Site visit: Sanofi – January 2024.
- Complete the restructure of research delivery teams to align with the Clinical Boards.
- Commence development of a full business case for a Sir Bobby Robson Institute for Oncology Research, supported by Newcastle Hospitals Charity and the Sir Bobby Robson Foundation.
- Launch Research Performance Reports for Clinical Boards.

4. INDUSTRIAL ACTION

Preparation and rota planning has been more challenging on this occasion. Elective throughput diminished significantly but the Trust remained clinically safe.

5. MENTAL HEALTH STRATEGY

This has now been finalised. The Mental Health Operational Framework has been reshaped. Regular Steering Group meetings are plan.

6. HONORARY CONSULTANT CONTRACT RESTORATION

6.1 Professor Sir John Burn

When Professor Sir John Burn took up the position of Trust Chairman he was required to step down from his Honorary Consultant Appointment. He was provided with a letter of clinical access to enable him to continue his research. Now his decision to withdraw his request for an extension to his term as Chair requires his Honorary Consultant Contract, Clinical Genetics to be restored. This was agreed following Medical Directors Chairs approval and the contract issued on 11 December 2023.

7. BOARD REFERENCE PACK (BRP) DOCUMENTS

Included within the BRP are the following documents to note:

i) Consultant Appointments
ii) Quarterly Guardian of Safe Working Report – Quarters 1 and 2

8. RECOMMENDATION

The Board is asked to note the contents of the report.

A R Welch FRCS
Medical Director/ Deputy Chief Executive Officer
15 January 2024

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Agenda item A11(b)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	25 January 2024						
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 Nurse Staffing and Clinical Outcome Group • Nursing and Midwifery Safer Staffing • Practice Education Update • Professional Nurse Advocate update						
Recommendation	The Board of Directors is asked to note and discuss the content of this report.						
Links to Strategic Objectives	• Putting patients at the heart of everything we do. Providing care of the highest standard focusing on safety and quality. • We will be an effective partner, developing and delivering integrated care and playing our part in local, national, and international programmes. • Being outstanding, now and in the future.						
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☒	☒	☒	☐	☒	☐	☐
Link to Board Assurance Framework [BAF]	Strategic Objective One Putting patients at the heart of everything we do. Providing care of the highest standard focusing 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:

Section one of the report contains this month's 'Spotlight' section which provides an overview of the Trust's Nurse Staffing and Clinical Outcomes Group.

National guidance documents such as 'Developing Workforce Safeguards' (NHS England (NHSE) 2018) and National Quality Board (2016) 'How to ensure the right people, with the right skills, are in the right place at the right time' clearly articulate the importance of triangulating safer staffing metrics with clinical outcomes and nurse sensitive indicators. This is to ensure Trusts are triangulating professional judgement with quality data to inform safer staffing decisions operationally, tactically, and strategically.

Over the last 5 years, the Executive Chief Nursing Team (ECNT) have been refining and improving safer staffing governance frameworks to ensure we robustly deliver on the aims and objectives outlined in national guidance. One aspect of this has been delivered through the development and embedding of the Nurse Staffing and Clinical Outcomes Operational Group. The aim of this group is to ensure robust oversight, decision making, escalation and assurance with the aim of maintaining safe and high-quality care whilst minimising risk to patients and staff.

The group meets monthly and utilises a Trust designed nurse staffing and clinical outcome dashboard for review alongside the core agenda. The dashboard reports on a number of staffing and outcome data sets (the report outlines these in detail). Each of the metrics is Red-Amber-Green (RAG) rated, generating separate scores for each metric, a separate staffing and outcome risk score and a combined total risk score. The dashboard is maintained by the nursing workforce team and updated monthly. At present, this is a largely manual process and work is on-going to automate the population of data where possible.

The five highest scoring wards in each section will have their metrics analysed to determine which, if any, level of support needs to be given. The wards with existing support in place will also be reviewed to understand if the actions put into place are having the desired impact. In addition, any group member can request review by the group based on professional judgement, or circumstances causing concern. This approach is important as whilst data driven review is essential, professional concern or 'gut feeling' often precedes changes in metrics and the aim of the group is to take a proactive rather than responsive approach.

The report includes a table outlining the escalation criteria used and the actions required.

When areas of concern are identified the group provides expert guidance to form action plans, supporting the wards and departments to manage and mitigate risk with the Heads of Nursing and Matrons implementing and monitoring the action plans. The group will

examine the progress against the action plans, alongside the dashboard trend data to determine the effectiveness of the current support. This information will guide decisions about whether the level of support needs to be escalated or de-escalated. Reporting of any high risk areas is into the Quality Committee and then Trust Board via the Executive Chief Nurse and Deputy Chief Nurse with monthly reporting into the ECNT.

Whilst the work of this group and the reporting and governance arrangements have been developed and finessed over the last few years, there are still improvements the group are focused on to continue to strengthen this work. A number of these are outlined in the report.

Sections 2 and 3:

Sections two and three highlight areas of risk and details actions and mitigation to assure safer staffing in line with agreed escalation criteria for nursing (section two) and midwifery (section three).

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

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

The following key points from this group are noted below:

- Several wards have required support at medium or high level since the last report to Board. Action plans are in place for three wards with additional clinical support, education and resources provided, overseen by the ECNT and relevant Clinical Boards. Two wards have stepped down from high to medium following consistent improvement in staffing and outcome metrics and following high-level support and action planning. An overview of this work has been reported into the Quality Committee.
- Where beds have been temporarily closed due to staffing concerns, whether due to vacancy, high sickness absence or skill mix concerns, a weekly review with the ECNT is in place and will continue until all commissioned bed capacity is safely opened.
- In addition to the high-level monitoring, oversight and assurance provided by the group there continues to be a robust leadership and management framework led by the Head of Nursing and Matron team.
- Red flags generated within the SafeCare module by the nursing staff in conjunction with professional judgement have provided valuable triangulation of data alongside DATIX reports. All these alerts are responded to promptly by members of the Senior Nursing Team directly with the ward staff, Heads of Nursing and Matrons.
- In the last quarter the number of DATIX submitted relating to staffing were:
    - October 19
    - November 12
    - December 2

Recruitment and Retention remain a priority workstream and the report provides an update on the current pipeline of Registered Nurses (RN) and Healthcare Support Workers (HCSWs). International Recruitment (IR) remains an important focus.

The following key points are contained within the report:

- The current RN vacancy rate is 1.90%, which is significantly improved from the 5.76% in January 2023. This is based on the financial ledger at Month 8 and relates to current substantive staff in post. It does not include those nurses currently in the recruitment process, where there is a pipeline of 113 (head count) Band 5 RN across adult (n=90) and paediatrics (n=23).
- Whilst recruitment has improved there remains a number of departments which are above the Trust average causing operational challenges. This is particularly noted in Paediatrics where a number of commissioned beds remain closed. An active workforce plan is in place overseen jointly by the Family Health Clinical Board and Corporate Nursing Team. This includes continued international recruitment, a new rotational development programme, focused additional education support for staff in post and a number of recruitment open days. Due to the deployment of international recruits the vacancy position will improve in the next 3 months but the staff will require several months of support and training and unlikely to positively impact on bed capacity imminently.
- The current total RN turnover is 8.37%. The national turnover rate has not been updated since August 2023 and therefore no recent benchmarking can be undertaken.
- The national HCSW programme aims to reduce the vacancy rate in the North East and Yorkshire to 3.7% by March 2024. The Trust vacancy rate at present is 6.6% with 138 (head count) candidates in the recruitment pipeline. The recent increase in vacancy rate is due to a combination of staff being successfully recruited into trainee nursing associate posts, an increase in establishment to cover the winter ward where a number of Healthcare Assistant vacancies remain and normal turnover. The vacancy rate is projected to decrease in March 2024 but is being closely monitored.
- To manage turnover, largescale Band 3 Healthcare Assistant recruitment continues with a rolling programme of interviews planned throughout 2024.
- A HCSW steering group continues to take place monthly to review and monitor performance. The current phase of the programme is focusing on retention, professional development, and pastoral support of HCSWs across the organisation. This includes the provision of high-quality induction, a career conversation for all HCSWs and a programme of training. The aim is to ensure the HCSW turnover is 8% or less, similar to that of the registered workforce.
- A target for international recruitment of RNs was set for 224 candidates for 2023/24. To date, 181 have been appointed with 47 in recruitment pipeline. This takes the Trust four beyond target but accounts for expected attrition.
- To manage and mitigate the expected RN turnover it is recognised that international recruitment will need to be one recruitment pipeline. A proposal is in development for consideration.

Section 3 provides an overview of the current midwifery staffing position. The following key points are noted:

- The Maternity Service workforce has strengthened following the recruitment of 25 midwives since October 2023. Pressure on the workforce continues due to a combination of long and short-term sickness absence of 6.5% and increased maternity leave; as well as the increased support and supernumerary time required by new recruits as they orientate and embed into the midwifery workforce.
- The current Registered Midwife vacancy rate is 0%. We are utilising the existing over recruitment agreement to maintaining this position whilst developing a workforce plan which outlines current and future need.
- Turnover rates are following a downward trajectory with a current rate of 9.1% with five midwives leaving the service during November and December 2023. The national turnover rate has not been updated since August 2023 and therefore no recent benchmarking can be undertaken.
- From 1 November 2023 to 31 December 2023, there have been zero occasions against a possible 430 episodes recorded, where the midwife has been unable to provide continuous one-to-one care and support to a woman in established labour; and two occurrences where the delivery suite coordinator has not remained supernumerary and has resulted in the coordinator being the named midwife for a woman. On these occasions, a review of the acuity and activity was undertaken, and together with professional judgement, the most appropriate utilisation of the available workforce resource has been made, thereby preserving, and maintaining safety.
- In November and December 2023, the number of red flags recorded on Delivery Suite was 6 and 11 respectively. This represents an overall decrease on the preceding two months where there were 19 and 11 red flags were recorded (Delivery Suite) and is broadly in line with a usual monthly average of below 10. The most common red flag reported is the delay between admission for, and commencement of, induction of labour. As induction of labour is a planned, elective procedure, the decision to commence the process is based on the judgement of the clinical team on duty following a review of the variable nature of clinical activity and acuity at the time.
- Newcastle Birthing Centre re-opened on 6 November as Maternity Services returned to OPEL level 1. Diversion of labouring women to Delivery Suite continues to be a consideration during times of increased operation pressure in line with local escalation protocols.

Section 4:

Section 4 provides a summary update of the work of the Practice Education Team.

The Practice Education Team oversee all aspects of Nursing, Midwifery and Allied Health Professional (AHP) undergraduate training, ensuring students at Newcastle Hospitals have access to the highest quality learning opportunities and experiences. An overview of their work is included in the report. The following key points are noted:

- The team work proactively to co-ordinate placements in conjunction with the education providers throughout the year to maximise capacity, which ensures that quality is maintained and there is a fair allocation of students in each area. This coordination is key to accommodate the learner activity which can peak at certain points in the year, when our wards and departments will support over 650 nursing students in adult and paediatric specialties with an additional number of AHP and

midwifery students, plus Trainee Nursing Associates on supernumerary placements.

- There is significant national focus on maximising placement capacity to meet the commitment laid out in the Long-Term Workforce Plan to increase the number of healthcare students in education. To maximise recruitment the Higher Education Institutions (HEIs) have undertaken significant work to review their attraction and admissions to increase applications to their programmes. Consequently, the Trust is required to provide a reciprocal increase capacity for which the Trust has been recognised for innovation in delivering placements and are currently in a strong position to support all of the placements required. However, due to the lack of filled places in HEI, not all capacity is currently being utilised which will be a risk for future years.
- Further risk still remains with HEI choosing to focus all cohort admissions in September rather than spreading throughout the year. This is being discussed and escalated through HEI partnership meetings but with limited progress so far.
- Since merging with NHS England, Health Education England (HEE) has continued non-recurrent funding available to support placement expansion and maintain quality. The funding has enabled the implementation of a short project over the winter months to where there may have been challenges due to clinical pressures and patient acuity. An overview of the projects is outlined within the report.
- Apprenticeship workstreams continue to develop year on year with staffing being provided with a 'new to care offer' along with opportunities for our existing clinical workforce, ensuring we put into practice our aim of "growing our own" workforce.
- In September 2023 we saw the qualification of our first cohort of Operating Department Practitioners and Occupational Therapists through apprenticeship routes. This was an opportunity for staff, in support worker roles, to develop their already established specialist skills in their field and take the next steps in their career journey, becoming registrants of the HCPC.
- 16 previous Nursing Associates and Assistant Practitioners, completed their Registered Nursing Degree Apprenticeship, joining the NMC register between September 2023 and January 2024. Recruitment of Trainee Nursing Associates has again been very successful, with 25 appointed in 2023 and a further 11 already recruited to commence in early 2024. To ensure this pipeline of ambitious staff a programme of training and career development opportunities are available for our support workers.

Section 5:

Section 5 provides the Trust Board with the regular update of the Trust's progress in implementing and embedding the Professional Nurse Advocate (PNA) role.

The PNA model was launched in 2021 by the Chief Nursing Officer, with the main aims of improving the health and wellbeing of the nursing workforce via delivery of the A-EQUIP model, which involves advocating for and empowering nurses via quality improvement and restorative clinical supervision. Each organisation is expected to meet a 1:20 ratio of PNA: nurse and are obliged to report on their PNA activity monthly, as mandated in current contract.

The following key points are noted within the report:

- As of December 2023, there were 47 qualified PNAs (just under 1:100 ratio) and a number of PNAs have completed their programme. This has increased by circa 20 over the last year but is still some way off the target of approximately 250 nurses. The inability to meet the target by 2025 is largely due to external factors, including the delay to confirmation of progression and a dependence on externally commissioned programme places being available.
- There has been a general increase in provision of restorative clinical supervision (RCS), career conversations and involvement in Quality Improvement (QI). This activity is reported externally via the Provider Workforce Report.
- With the support of the Trust Communications Team a PNA intranet page has been developed with the aim of raising the profile and understanding of the role and introducing the Trust PNA strategy.
- The development of the PNA intranet page has been a vital step in the socialisation of the role across the organisation, it is recognised the communication of the role and all the associated benefits has continued to be a challenge. The Executive Chief Nursing team plan a PNA launch event in early 2024 in an aim to meet the required ratio of 1:20 ratio of PNA to nurses. It is anticipated that launch and communications will further support a healthy pipeline of nurses to complete the PNA programme.
- The PNA programme is dependent on centrally commissioned places at various national HEIs, which are offered to organisations on a pro-rata basis. This restricts the number of nurses who can be offered a place on the programme which is also dependent on central funding which is not confirmed beyond March 2024. Discussions are taking place with local HEIs to identify how, via an accreditation agreement, the Trust could potentially take a lead in the programme delivery and in turn, develop a sustainable offer.

RECOMMENDATION

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

Report of Maurya Cushlow
Executive Chief Nurse
25 January 2024

EXECUTIVE CHIEF NURSE REPORT

1. SPOTLIGHT - NURSE STAFFING AND CLINICAL OUTCOMES OPERATIONAL GROUP

National guidance documents such as 'Developing Workforce Safeguards' (NHSE 2018) and National Quality Board (2016) 'How to ensure the right people, with the right skills, are in the right place at the right time' clearly articulates the importance of triangulating safe staffing metrics with clinical outcomes and nurse sensitive indicators. This is to ensure Trusts are triangulating professional judgement with quality data to inform safe staffing decisions operationally, tactically, and strategically.

Over the last 5 years, the Executive Chief Nursing team have been refining and improving safe staffing governance frameworks to ensure we robustly deliver on the aims and objectives outlined in national guidance. One aspect of this has been delivered through the development and embedding of the Nurse Staffing and Clinical Outcomes Operational Group.

1.1 Overview of the operational group

The group comprises of the Associate Director of Nursing team, Heads of Nursing and Matrons along with representation from safe staffing, practice development and education, clinical standards, quality improvement, clinical governance and infection prevention and control.

The aim of this group is to ensure robust oversight, decision making, escalation and assurance with the aim of maintaining safe and high-quality care whilst minimising risk to patients and staff. The group meets monthly and utilises a Trust designed nurse staffing and clinical outcome dashboard for review alongside the core agenda. The dashboard reports on a number of staffing and outcome data sets per ward and department as outlined below:

Nurse Staffing Data	Clinical Outcome Data	Patient Experience Data
Staffing Fill Rates	Clinical Assurance Toolkit compliance	Complaints
Care hours per patient day data (including recent model hospital benchmarking)	Pressure Ulcer prevalence including root cause analysis reviews	Friends and Family response total and percentage completion
Sickness absence %	Falls prevalence including root cause analysis reviews	
Vacancy Rate	Hospital acquired infections	
Turnover Rate		
Temporary Staffing use		
Safe Staffing Reporting (datix/red flags)		

Each of the metrics is RAG rated, generating separate scores for each metric, a separate staffing and outcome risk score and a combined total risk score. The dashboard is maintained by nursing workforce team and updated monthly. At present this is a largely manual process and work is on-going to automate the population of data where possible.

The five highest scoring wards in each section will have their metrics analysed to determine which, if any, level of support needs to be given. The wards with existing support in place will also be reviewed to understand if the actions put into place and having the desired impact. In addition, any group member can request review by the group based on professional judgement, or circumstances causing concern. This is approach is important as whilst data driven review is important, professional concern or 'gut feeling' often precedes changes in metrics and the groups aim is to take a proactive rather than responsive approach.

Wards will be escalated and de-escalated according to criteria described below.

Level of Support	Escalation Criteria	Actions Required
Low	Where there is an isolated staffing or outcomes concern, with identified rationale for metrics, with actions identified to improve and resolve.	• Review by Associate Director of Nursing at Head of Nursing/Matron at 1:1 with support from Senior Nursing Team if required. • Review at following months meeting
Medium	There are concerns in both staffing and outcomes or failing to show improvement through previous measures without immediate risk to patient safety.	• Agree and document action plan with identified lead for each. • Discuss with Head of Nursing/ Matron and Director of Operations. • Action plan to be updated monthly and progress reviewed at following months meeting. • Wards to be highlighted to Executive Chief Nurse Team and Executive Team if sustained risk.
High	Significant concern in areas of staffing and outcomes, which pose an immediate risk to patient safety.	• Urgent meeting with Matron and Director of Operations. • Initiation of deep dive information gathering, alongside review of bed/staffing capacity to determine if staff moves/bed closures are required. • Executive Chief Nurse Team to be briefed to sign off actions. • Agree action plan – specific actions to be taken and lead for each. • External validation of all metrics. • Escalation to all key stakeholders • Report to ECN monthly meeting and into Quality Committee.

When areas of concern are identified the group provides expert guidance to form action plans, supporting the wards and departments to manage and mitigate risk with the Heads of Nursing and Matrons implementing and monitoring the action plans. The group then examine the progress against the action plans, alongside the dashboard trend data to determine the effectiveness of the current support. This information will guide decisions

about whether the level of support needs to be escalated or de-escalated. Reporting of any high risk areas is into the Quality Committee via the Executive Chief Nurse and Deputy Chief Nurse with monthly reporting into the ECNT.

1.2 Future developments

Whilst the work of this group and the reporting and governance arrangements have been developed and finessed over the last few years, there are still improvements the group are focused on to continue to strengthen this work. Further work is required to ensure that all staff across the professional groups understand the work of this group. We want to ensure any staff member can ask for this group to review their ward or department irrelevant of the data and see this as a supportive wrap around function providing help to them when they need it.

The Executive Chief Nurse Team are also reviewing those wards which required high level support over the last year to understand if in retrospect, concerns could have been identified earlier and if the support provided led to de-escalation in a timely manner. Any learning identified will shape future dashboards and terms of reference.

2. NURSING AND MIDWIFERY STAFFING UPDATE

2.1 Nurse Staffing Escalation

The Trust's Nursing and Midwifery Safe Staffing guidelines clearly articulate a process for safe staffing escalation and provides a framework to ensure robust safe staffing governance. The Trust is currently operating at level 2 staffing escalation. This is due to the following triggers:

- Sickness absence sustained above 5% for the nursing and midwifery workforce and above 7% for additional clinical services.
- Winter-preparedness surge beds in operation.
- An increase in staffing datix and red flags particularly in paediatric wards.

The following actions remain in place and are overseen by the Executive Chief Nurse:

- Twice daily staffing review by Senior Nursing team reported into the on-call and site operational teams.
- Safecare (daily staffing deployment tool) utilised to deploy staff within and across Clinical Boards.
- Weekly staffing and bed capacity meetings with Matrons/Heads of Nursing of wards with bed closures and staffing challenges.

Since the introduction of Clinical Boards and improvement in vacancy position, nursing staff redeployment has reduced and been increasingly managed within Clinical Board, coordinated by the Heads of Nursing and Matron teams. During the last quarter, there have been fewer escalations to the Senior Nursing Team to redeploy staff across Clinical Boards. However, level 2 escalation will remain in place until the de-escalation criteria has been met.

2.2 Nurse Staffing and Clinical Outcomes

In line with Developing Workforce Safeguards (2018), the Nurse Staffing and Clinical Outcomes Operational Group continue to meet monthly as detailed in the Spotlight section.

Below is an overview of the number wards reviewed and level of escalation for the last quarter:

Month	Total	Clinical Board	High level support	Medium level support	Low level support
Oct-23		CB1: WOM x 1, CHI x 3	1	1	2
		CB2: T&O x 2, NEU X 1	1	1	1
		CB4: CAR x 2	1		1
		CB5: INT x 9, REN x 1	1	5	4
		CB6: URO x 1, SUR x 2		2	1
Total	**22**		**4**	**9**	**9**
Nov-23		CB1: WOM x 1, CHI x 3	1	2	1
		CB2: T&O x 3, NEU X 1	1	1	2
		CB4: CAR x 4	1	1	2
		CB5: INT x 7, REN x 1		4	4
		CB6: URO x 1, SUR x 2		2	1
Total	**23**		**3**	**10**	**10**
Dec-23		CB1: WOM x 2, CHI x 3	1	3	1
		CB2: T&O x 3, NEU X 1		2	2
		CB4: CAR x 3	1		2
		CB5: INT x 7, REN x 1		2	6
		CB6: URO x 1, SUR x 1		2	
Total	**22**		**2**	**9**	**11**

The following key points from this group are noted below:

- Several wards have required support at medium or high level since the last report to Board. Action plans are in place for three wards with additional clinical support, education and resources provided, overseen by the Executive Chief Nurse Team and Clinical Board. Two wards have stepped down to medium and low-level support following consistent improvement in staffing and outcome metrics and following high-level support and action planning. An overview of this work has been reported into the Quality Committee.
- Where beds have been closed due to staffing concerns, whether due to vacancy, high sickness absence or skill mix concerns, a weekly review with the Executive Chief Nurse Team is in place and will continue until all commissioned bed capacity is safely opened.
- In addition to the high-level monitoring, oversight and assurance provided by the group there continues to be a robust leadership and management framework led by the Head of Nursing and Matron team.

- Red flags generated within the SafeCare module by the nursing staff in conjunction with professional judgement have provided valuable triangulation of data alongside DATIX reports. All these alerts are responded to promptly by members of the Senior Nursing Team directly with the ward staff, Heads of Nursing and Matrons.
- In the last quarter the number of DATIX submitted were:
  - October 19
  - November 12
  - December 2

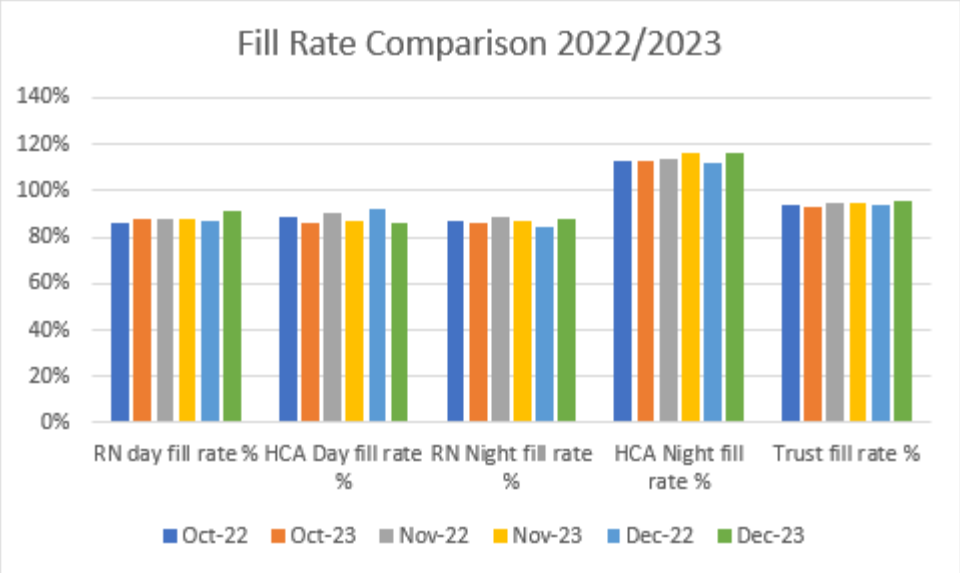
2.3 Trust Fill Rates and Care Hours Per Patient Day (CHPPD) Data

The Trust level fill rates and CHPPD are detailed below:

Month	CHPPD	RN day fill rate %	HCA Day fill rate %	RN Night fill rate %	HCA Night fill rate %	Trust fill rate %
October 2023	8.1	88%	86%	86%	113%	93.25%
November 2023	8.1	88%	87%	87%	116%	94.50%
December 2023	8.6	91%	86%	88%	116%	95.25%

Below is the comparison data for this year and the same period last year. The increased RN fill rate is due to reduced vacancy, although the workforce "awayness" for other reasons such as sickness and maternity leave has remained challenging. Several wards have temporarily closed beds to mitigate the risk to patient safety. It is worth noting during the same time period last year the fill rates were reflective of the temporary reduction of 32 adult beds to mitigate risk due to staffing. There are currently now only six beds closed due to staffing but with surge beds opened in other areas.

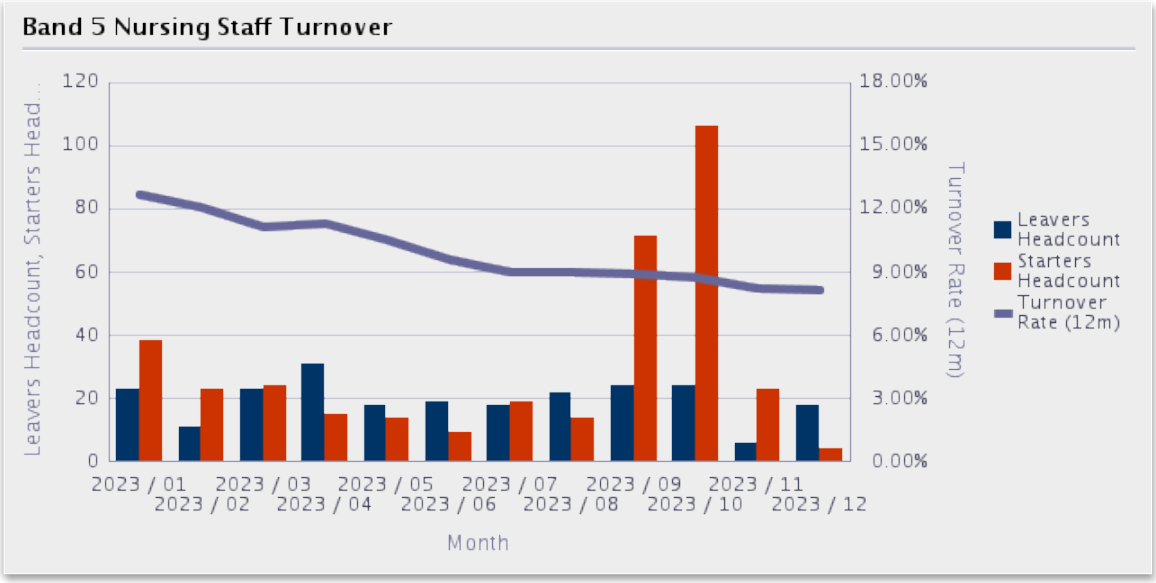
Below is the comparison data from this year and the same period last year.



- The Trust overall fill rate has remained consistent from 93.25% to 95.25%.
- The RN dayshift fill rate at 88%-91% is slightly higher when compared to the same period last year. RN nightshift fill rates are 86%-88% which again is slightly higher. Fill

rates are affected by sustained sickness absence above the 3% threshold which has been noted over this period to be around 5%.

- HCA dayshift fill rates have decreased compared with the same period last year, whereas the nightshift fill rates have increased. The increases coincide with reduced RN fill rates, where the HCA workforce has been deployed to mitigate shortfall in RN.
- The turnover chart below demonstrates RN leavers and starters. The extended supernumerary status for internationally recruited nurses while undergoing OSCE training and receipt of their professional registration means that the increase in starters v's leavers September to November will take time to translate into an increase in fill rates.



- The staffing and e-rostering teams have initiated a "Check Challenge and Coach" process in November 2023, alongside a rostering education programme which aims to maximise rostering potential and improve fill rates.
- Currently actual staffing numbers are entered manually and are subject to a monthly accuracy check. The staffing and electronic rostering team are exploring an automated solution which will further improve accuracy and may create some changes in the fill rates. This solution is expected to be in place by early 2024.

2.4 Recruitment and International Recruitment

2.4.1 Registered Nursing Recruitment

The current RN vacancy rate is 1.90%, which is significantly improved from the 5.76% in January 2023. This is based on the financial ledger at Month 8 and relates to current substantive staff in post. It does not include those nurses currently in the recruitment process, where there is a pipeline of 113 (head count) Band 5 RN across adult (n=90) and paediatrics (n=23). Whilst recruitment has improved there remains a number of departments which are above the Trust average causing operational challenges. This is particularly noted in Paediatrics where there were particular gaps noted over PICU, Ward 4 GNCH and Ward 1a GNCH. An active workforce plan is in place overseen jointly by the Family Health Clinical Board and Corporate Nursing Team. This includes additional international recruitment, a new rotational development programme, focused additional education support for staff in post and a number of recruitment open days. Due to the deployment of

international recruits the vacancy position will improve in the next 3 months but the staff will require several months of support and training and unlikely to positively impact on bed capacity imminently.

To compliment the successful generic recruitment, over the last 12 months we have utilised bespoke recruitment being targeted for those areas with a higher-than-average turnover, using high-quality communications and social media options to promote these vacancies. This approach has evaluated well with the clinical teams and has led to positive outcomes in terms of successful appointments. This process will remain in place, overseen and approved by the Executive Chief Nurse team.

The Nursing, Midwifery, Allied Health Professionals (NMAHP) recruitment and retention group has been refreshed with new Terms of Reference agreed. The purpose of this group is to provide oversight of quality improvement work through enhancing and optimising workforce strategy, implementing and overseeing key priorities and work streams in relation to NMAHP recruitment and retention and monitor outcomes.

2.5.2 HCSW Recruitment

The national HCSW programme aims to reduce the vacancy rate in North East and Yorkshire to 3.7% by March 2024. Our vacancy rate at present is 6.6% with 138 (head count) candidates in the recruitment pipeline. The recent increase in vacancy rate is due to a combination of staff being successfully recruited into trainee nursing associate posts, an increase in establishment to cover the winter ward where a number of Healthcare Assistant vacancies remain and normal turnover. The vacancy rate is projected to decrease in March 2024. Work streams agreed as part of the programme include quality in workforce reporting; benchmarking of centralised HCSW recruitment; improving the apprenticeship offer and attracting staff new to care. To manage turnover, largescale Band 3 HCA recruitment continues with a rolling programme of interviews planned throughout 2024.

A HCSW Steering Group continues to take place on a monthly basis to review and monitor performance. The current phase of the programme is focusing on retention, professional development, and pastoral support of HCSWs across the organisation. This includes the provision of high-quality induction, a career conversation for all HCSWs and a programme of training. Our aim is to ensure the HCSW turnover is 8% or less, similar to that of the registered workforce.

The HCSW retention work was showcased during a week of celebrations in November for Health Care and Maternity Support Workers Day to ensure our HCSWs felt valued and recognised. This work has been recognised by NHSE with the Associate Director of Nursing being invited to present this work at NHSE community of practice events.

2.5.3 International Recruitment

The international recruitment programme has successfully deployed 305 candidates from the Philippines and India in 2022/23. A recruitment target was set for 224 candidates for 2023/24. To date, 181 have been appointed with 47 in recruitment pipeline, this takes us four beyond our target but accounts for expected attrition. Once all 529 staff are deployed this cohort will represent around 10% of our total registered workforce and 16% of our Band 5 staff nurse workforce once all recruits pass their OSCE. Significant work is undertaken by

the International Recruitment Team, Human Resources and Business colleagues to ensure the quality of experience for new nurses and midwives is not compromised.

To manage and mitigate the expected registered nurse turnover it is recognised that international recruitment will need to be one of our recruitment pipelines in future years though less so than the last few years. A proposal is in development for consideration.

Newcastle Hospitals have been awarded the prestigious NHS Pastoral Care Quality Award which is in recognition of the quality work in international recruitment and our commitment to providing high-quality pastoral care to all our internationally educated nurses and midwives during their recruitment process and employment. The international recruitment team also collaborate with the Trust Race Equalities Network and contribute to national campaigns to strengthen the pastoral support of international recruits including the #StayandThrive campaign with several staff are completing the International Recruitment PNA qualification.

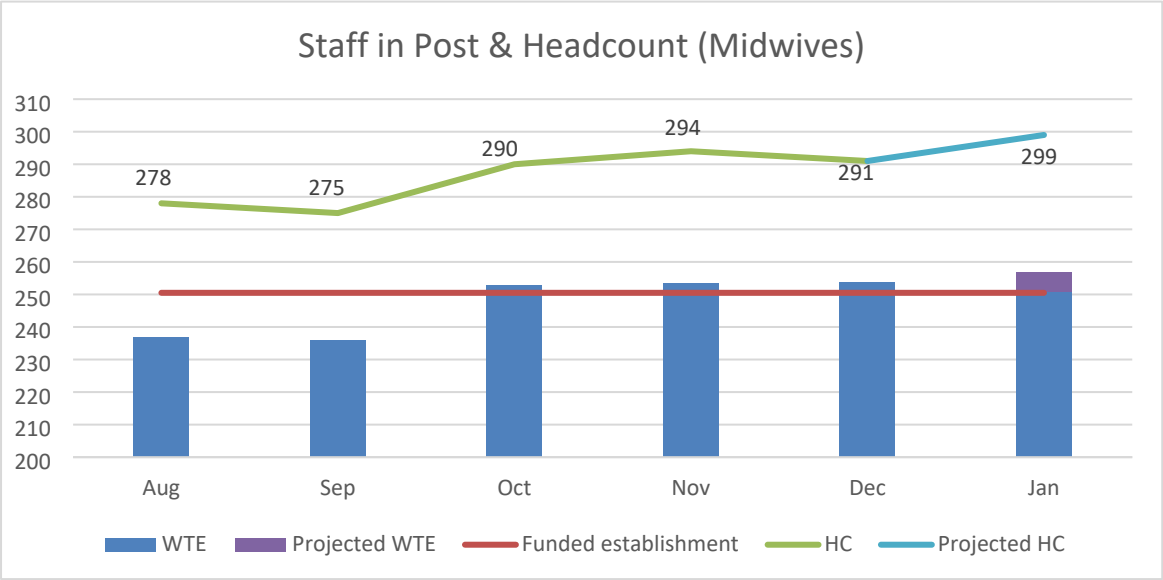
3. Midwifery Staffing

3.1 Current Staffing Position

The Maternity Service workforce has strengthened following the recruitment of 25 midwives since October 2023. Table 1 illustrates the current midwifery staffing position, including frontline clinical staff and those in specialist and management roles. This highlights the current whole time equivalent (wte) midwives against the funded establishment of 250.50wte and the projected impact of a further 4.4wte midwives due to commence in post from January 2024 to take recruited midwives to 4.75wte over funded establishment. The Trust has a permanently approved 20wte over-establishment which will continue throughout the year to mitigate against increased levels of sickness absence and maternity leave. This supports the challenge throughout the year as a result of one University output annually of midwives in September to ensure sustainability of the large midwifery workforce and management of risk in this critical specialty. All seven internationally recruited midwifery positions are now appointed.

The service is yet to realise the full impact of the strengthened workforce position due to an average of 3.3% long and 3.7% short-term sickness absence with 4.9% maternity leave in November and December; alongside many of the new recruits currently orientating and embedding into the workforce during supernumerary time in each clinical area.

Table 1: Midwives in Post (WTE and Headcount) against funded establishment – August 2023 to January 2024



Turnover rates are following a downward trajectory with a current rate of 9.1% compared to a rate of 13.1% in July 2023. Five midwives have left the service during November and December, for a variety of reasons including relocation, retirement (consistent with an ageing workforce) and a cited lack of opportunities. The service's newly published retention action plan identifies key actions and targeted interventions for staff at all stages of their career, from students, through early and mid-career, to late-career Midwives approaching retirement. Providing development and career progression opportunities for staff (including the introduction of Advanced Clinical Practitioner roles) is a key focus of retention work.

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

From 1 November 2023 to 31 December 2023, there have been zero occasions against a possible 430 episodes recorded, where the midwife has been unable to provide continuous one-to-one care and support to a woman in established labour; and two occurrences where the delivery suite coordinator has not remained supernumerary and has resulted in the coordinator being the named midwife for a woman. On these occasions, a review of the acuity and activity was undertaken, and together with professional judgement, the most appropriate utilisation of the available workforce resource has been made, thereby preserving, and maintaining safety.

In November and December 2023, the number of red flags recorded on Delivery Suite were 6 and 11 respectively. This represents an overall decrease on the preceding two months where there were 19 and 11 red flags recorded on Delivery Suite and is broadly in line with a usual monthly average of below 10. The most common red flag reported is the delay between admission for, and commencement of, induction of labour. As induction of labour is a planned, elective procedure, the decision to commence the process is based on the judgement of the clinical team on duty following a review of the variable nature of clinical activity and acuity at the time.

3.3 Risk and Mitigation

Newcastle Birthing Centre re-opened on 6 November as Maternity Services returned to OPEL level 1. Diversion of labouring women to Delivery Suite continues to be a consideration during times of increased operation pressure in line with local escalation protocols. A Quality Impact Assessment has been undertaken which indicates that this process supports the safety of women and babies.

Intermittent closure impacts on patient experience due to the uncertainty it creates, as well as partners being unable to stay overnight on the postnatal ward which is in contrast to their expected experience on the Birth Centre. Regular consultation and communication with service users via the Maternity and Neonatal Voices Partnership (MNVP) has been prioritised, in order to provide patients with the information that they need.

4. PRACTICE EDUCATION UPDATE

4.1 Placement Capacity

The Practice Education Team oversee all aspects of NMAHP undergraduate training, ensuring students at Newcastle Hospitals have access to the highest quality learning opportunities and experiences. The team works collaboratively with HEIs to develop and strengthen the portfolio of placements for our learners. The Trust works predominantly with three local HEIs but the team supports placements for students from across the United Kingdom who have sought out experience working at Newcastle Hospitals.

As befits an anchor organisation the Trust continues to be the biggest provider of undergraduate nursing placements in the region and one of the largest nationally. The team work proactively to co-ordinate placements in conjunction with the education providers throughout the year to maximise capacity, this ensures that quality is maintained and there is a fair allocation of students in each area. This organisation is key to accommodate the learner activity which can peak at certain points in the year, when our wards and departments support over 650 nursing students in adult and paediatric specialities with an additional number of AHP and midwifery students, along with Trainee Nursing Associates on supernumerary placements. There is a current risk to capacity as HEI are increasingly moving to September cohort entries which impacts on the cross year recruitment pipeline of new graduates for Trusts. This risk has been highlighted to HEI partners and is being discussed through partnership meetings. Due to programme attrition and lack of filled undergraduate places in HEI's, not all placement capacity is being fully utilised.

There is significant national focus on maximising placement capacity to meet the commitment laid out in the long-term Workforce Plan of increasing the number of healthcare students in education. To maximise recruitment the HEIs have undertaken significant work to review their attraction and admissions to increase applications to their programmes. To match this the Trust is required to provide a reciprocal increase capacity and for a number of years, the Trust has been recognised for innovation in delivering placements and we are currently in a strong position to support all of the placements required. Where capacity challenges have presented, in Midwifery for example, the Practice Education Team works to explore creative options, most recently designing a two week

spoke for midwifery students to undertake learning with the 0-19 service. This evaluated very positively by the students and was highly commended as an invaluable learning experience that they would not have otherwise had.

Latterly and in response to the changing workforce, the Practice Education Team has provided education and training to support the development of practice educators across the Trust to ensure a high-quality educator workforce to support those on programmes of learning. There has been a focus on those nominated leads in each department who oversee the learners and a welcome return to face-to-face education sessions and updates.

Since merging with NHSE, HEE has continued make non-recurrent funding available this year to support placement expansion and maintain quality. The funding has enabled the implementation of a short project over the winter months to support specific nursing placements with assessing and supporting their students, where there may have been challenges due to clinical pressures and patient acuity.

- Maternity - In the absence of a permanent Practice Education Facilitator specifically for Midwifery, the Practice Education Team have allocated an experienced team member to support with capacity building and educator development, ensuring continued high quality learning opportunities and experiences. Over the next year there are plans to increase student numbers and support alternative models of education, and programme entry routes.
- Operating Department Practitioner (ODP) – the Practice Education Team have been working alongside clinical colleagues in the new Day Treatment Centre to build capacity to support learners, ensuring a high-quality learning environment. Students are being introduced to the area taking a gradual approach, with close support from the Practice Education Team.
- AHP - With the increase in capacity of AHP placements made over previous years, funding was available to secure a permanent AHP Practice Education Facilitator. Over the next year there will be a particular focus on Occupational Therapy and Dietetics, building capacity and considering alternative models of education, where we have already seen success. The 'Extended Day Model', supporting Physiotherapy students on placement, has entered its third successful phase and was invited to be showcased in a Regional AHP Webinar.
- Paramedic Science – The Practice Education Team have been working closely with our partners at University of Sunderland to create placement capacity for students on the Paramedic Science programme. We now support the majority of Year 1, 2 and 3 students on their hospital based placement, which is an essential element of their training.

4.2 Apprenticeships

Apprenticeship workstreams continue to develop year on year with staffing being provided with a 'new to care offer' along with opportunities for our existing clinical workforce, ensuring we put into practice our aim of "growing our own" workforce. In September 2023, we saw the qualification of our first cohort of ODPs and Occupational Therapists through apprenticeship routes. This was an opportunity for staff, in support worker roles, to develop their already established specialist skills in their field and take the next steps in their career journey, becoming registrants of the HCPC.

A further group of staff, previously Nursing Associates and Assistant Practitioners, completed their Registered Nursing Degree Apprenticeship, joining the NMC register in September.

Recruitment of Trainee Nursing Associates has again been very successful, with 25 appointed in 2023 and a further 11 already recruited to commence in early 2024. To ensure this pipeline of ambitious staff a programme of training and career development opportunities are available for our support workers.

5. PROFESSIONAL NURSE ADVOCACY UPDATE FOR TRUST BOARD JANUARY 2024

5.1 Background

The PNA model was launched in 2021 by the Chief Nursing Officer, with the main aims of improving the health and wellbeing of the nursing workforce via delivery of the A-EQUIP model, which involves advocating for and empowering nurses via quality improvement and restorative clinical supervision. Each organisation is expected to meet a 1:20 ratio of PNA: nurse and are obliged to report on their PNA activity on a monthly basis, as mandated in current contract.

5.2 Current Trust Position

At December 2023, there were 47 qualified PNAs (just under 1:100 ratio) with a number of PNAs who have completed their programme and await confirmation of progression. This has increased by circa 20 over the last year but is still some way off the target of approximately 250 nurses. The challenge in increasing the number of PNAs lies largely in the fact that the Trust are dependent on the regional PNA team providing funded places at HEIs on a pro-rata basis. Whilst this means that Newcastle Hospitals will see a greater number of places in comparison to other smaller organisations the number of places still does not grow the number of PNAs at the rate that is required.

Confirmation from the regional team of PNAs having successfully completed their programme is also delayed as HEIs cannot provide confirmation until the results of each programme have gone through their Examination Board. There is currently a priority on providing places on the programme for Adult ICU and Neonatal nurses, with two ring-fenced places offered per unit at several points across the academic year. RVI 35 and the four eligible adult intensive care units have nursing staff currently on programme.

There has also been a general increase month on month in provision of restorative clinical supervision (RCS), career conversations and involvement in QI. This activity is reported externally via the Provider Workforce Report. With the support of the Trust Communications Team a PNA intranet page has been developed with the aim of raising the profile and understanding of the role and introducing the Trust PNA strategy.

Since July 2023, there has also been a prompt within the Datix system for any nurse raising an incident to indicate whether they would like support from a PNA. To date all nurses who have responded positively to the prompt have been offered PNA support.

5.3 Challenges

The development of the PNA intranet page has been a vital step in the socialisation of the role across the organisation but given conflicting challenges across the Trust it is recognised the communication of the role and all the associated benefits has continued to be a challenge. The Executive Chief Nursing team plan a PNA launch event in early 2024 in an aim to meet the required ratio of 1:20 ratio of PNA to nurses. It is anticipated that launch and communications will further support a healthy pipeline of nurses to complete the PNA programme.

Current completion of the PNA programme is dependent on centrally commissioned places at various national HEIs, which are offered to organisations on a pro-rata basis. Currently this restricts the number of nurses who can be offered a place on the programme and is dependent on central funding which is currently not confirmed beyond March 2024. However, discussions are taking place with local HEIs to identify how, via an accreditation agreement, the Trust could potentially take a lead in the programme delivery and in turn, develop a sustainable offer, support a greater number of nurses to access the programme and provide a consistent programme utilising skills and expertise from across the Trust.

5.4 Next Steps

There is a clear requirement to significantly increase the Trust PNA numbers. The Trust PNA Lead and PNAs across the organisation will continue to develop a sustainable PNA offer working with partners in and outside of the organisation, and to raise the profile of the role across all Clinical Boards.

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

6. RECOMMENDATION

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

Report of Maurya Cushlow
Executive Chief Nurse
25 January 2024

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	25 January 2024		
Title	Maternity Update Report		
Report of	Maurya Cushlow, Executive Chief Nurse		
Prepared by	Jane Anderson, Director of Midwifery Lucy Patterson, Head of Midwifery Jeanette Allan, Senior Risk Management Midwife		
Status of Report	Public	Private	Internal
	☒	☐	☐
Purpose of Report	For Decision	For Assurance	For Information
	☐	☒	☐
Summary	The purpose of this paper is to provide the Trust Board with an update against the national drivers and priorities for maternity services, including: • An update following the Care Quality Commission (CQC) inspection of the Maternity Service in January 2023, whose findings were published in May 2023. The maternity service was graded 'requires improvement' against the domains of 'well-led' and 'safe' as part of the national maternity inspection programme. The Trust met with the Integrated Care Board (ICB) on 5 December 2023 to agree an action plan for assurance as part of the System Oversight Framework (SOF). • An overview of the formal findings and actions resulting from the Ockenden Assurance visit on 10 November 2023, led by the LMNS with key stakeholder involvement. There remain four outstanding partially compliant actions from the Interim Report which the Trust continues to progress. Monitoring of Ockenden assurance will now be incorporated within the Trusts' advancement toward implementing the 'Three year delivery plan for Maternity and Neonatal Services'. As previously reported the 'Three year plan' was published by NHS England (2023) in response to findings from National maternity investigations including Ockenden. • Overview of a Joint Commissioner Assurance visit to the Neonatal Unit which took place in October. The visit focused on incident reporting, nursing workforce and a number of other key lines of enquiry including Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries (MBRRACE) data. • An update regarding correspondence received from HSIB (now MNSI) on the 14 August 2023 highlighting issues of concern relating to culture within the Maternity Service. The Trust met with HSIB on two occasions to explore their concerns. Focussed work is in development and a final letter of closure from HSIB was received on 1 December 2023.		
Recommendation	Trust Board are asked to: i) Receive and discuss the report; ii) Note the ongoing oversight and assurance from the ICB through the System Oversight Framework (SOF) in response to the final report of the CQC inspection in January 2023; iii) Note the formal findings of the CQC core inspection of Maternity in July 2023 due to be published in January 2024 will be presented in March 2024;		

<table>
<tr><td></td><td colspan="7">iv) Note the formal findings of the Ockenden assurance visit undertaken on 10 November 2023, led by the NENC LMNS, and that future reporting of Ockenden will be superseded by Trust implementation and monitoring against the ‘Three year plan’.
v) Note the findings of a Joint Commissioner Assurance visit to the Neonatal Unit, together with the Trust’s response;
vi) Note the correspondence received from the Healthcare Safety Investigation Branch (HSIB now MNSI) and Trust response including actions and final HSIB letter of closure; and
vii) Note the associated risks involved.</td></tr>
<tr><td>Links to Strategic Objectives</td><td colspan="7">Putting patients at the heart of everything we do. Providing care of the highest standards focussing on safety and quality.</td></tr>
<tr><td rowspan="2">Impact
(please mark as appropriate)</td><td>Quality</td><td>Legal</td><td>Finance</td><td>Human Resources</td><td>Equality & Diversity</td><td>Reputation</td><td>Sustainability</td></tr>
<tr><td>☒</td><td>☐</td><td>☒</td><td>☒</td><td>☐</td><td>☒</td><td>☐</td></tr>
<tr><td>Link to the Board Assurance Framework [BAF]</td><td colspan="7">No direct link.

Risks are detailed within the main body of the report.</td></tr>
<tr><td>Reports previously considered by Trust Board</td><td colspan="7">Previous reports have been presented to the Trust Board on Ockenden, The Kirkup Report, and The Maternity Incentive Scheme (CNST).</td></tr>
</table>

MATERNITY SERVICES UPDATE

EXECUTIVE SUMMARY

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

Section 2 provides an update on the actions arising from the CQC maternity inspection undertaken in January 2023 as part of the national maternity inspection programme, the results of which were published on the 12 May 2023. The two key domains of 'safe' and 'well-led' were inspected resulting in an overall rating for the Maternity service as 'requires improvement'. A rating of 'good' was declared for well-led and 'requires improvement' for safe.

As previously reported to Trust Board the Maternity Service is subject to a formal System Oversight Framework (SOF) monitored by and reported to the ICB. The Director of Nursing and Midwifery for the ICB met with key members of the Maternity Service's Senior Leadership Team on 5 December to agree the support offer and review the action plan. A number of suggestions were made to further strengthen the actions implemented by the service, and to ensure that evidence provided is robust in clearly demonstrating improvement. An updated action plan has been developed (Appendix 1), approved by the Chief Nurse, and will be processed through the Family Health Clinical Board's governance framework.

Section 3 provides an update on the formal feedback received following the Ockenden assurance visit undertaken on 10 November 2023. The review followed last year's 'Insight Visit', with representation from NHS England (NHSE), the Integrated Care Board (ICB), the Local Maternity and Neonatal System (LMNS), the Maternity and Neonatal Voices Partnership (MNVP), together with peer reviewers from South Tees Hospitals NHS Foundation Trust.

The visiting team gave brief, high-level verbal feedback to the Trust at the end of the day, focussing on areas of good practice and areas which may benefit from ICB/LMNS support. Overall, a positive visit was experienced by the review team. The team noted that staff were happy and welcomed the visitors and that the women who were spoken with during the day were very complimentary about the care that they had received.

The final written report was received on 19 December 2023. Positive areas of note included the work undertaken with regard to preterm optimisation and, in particular, the successful improvement of breastfeeding initiation rates. The 'What Matters to You' cultural improvement work undertaken by the service in collaboration with IHI was recognised as a positive quality improvement project, together with student midwifery recruitment to the existing workforce. The specialist midwifery team were highlighted as being passionate and it was evident that the impact on outcomes for women was promising.

Whilst there were no formal recommendations, the following areas were identified as areas which could benefit from further support by the LMNS/ICB:

- The assurance team acknowledged the Trust's midwifery and medical workforce strategies; however, it was suggested that multi-disciplinary workforce planning could be further supported by the LMNS/ICB.

- The ongoing implementation of triage is an area of focus across the NENC and was identified as being an area which could be further supported. Since the visit, the Birmingham Symptom-specific Obstetric Triage System (BSOTS) went live on 18th December 2023 and is currently embedding into practice with a planned audit programme for compliance.

- Some staff were not wearing a yellow name badge. This feedback has been actioned with the requisition of name badges for all staff who self-identified as without one; delivery is awaited.

- Computer screens in some areas were left unattended breaching information governance regulations. The Maternity Leadership Team have increased presence and vigilance when visible within the department and challenge any identified information governance breaches. A global communication has been shared with all in the department.

The Trust continues to progress improvements through BadgerNet data capture to strengthen evidence and assurance on the four remaining partially compliant recommendations from the interim Ockenden report. The Trust Board are asked to note future updates will no longer detail separate Ockenden reporting; assurance will be subsumed within the Trusts monitoring of compliance against implementing the 'NHS Three Year Plan for Maternity and Neonatal Services'. Trust Board members will recall, details of the 'Three year plan' were presented in May 2023 following publication in March 2023, with initial Trust benchmark status presented in July 2023. The 'Three year plan' was developed in response to national reports (Ockenden and Kirkup) with the intention that Trusts focus on one clear plan comprising four high-level themes divided into twelve objectives, a progress update will be provided in future papers.

Section 4 provides the Trust Board with information in relation to a Joint Commissioner Assurance visit to the Neonatal Unit which took place in October 2023. The visit was supported by the Neonatal clinical team who were able to share data relating to a recent MBRRACE report.

The visit also focused on incident reporting, nursing workforce and a number of other lines of enquiry. Following the visit, the ICB asked for clarification on a number of areas. This included clarity regarding:

- Serious Incident Reporting,
- Neonatal Nursing Workforce

- Storage of Clean Linen
- Requirement of Emergency Call Bells

The Trust's response is detailed within this paper.

Section 5 provides an update regarding the final letter of closure following concerns raised by the Healthcare Safety Investigation Branch (HSIB); renamed Maternity and Newborn Safety Investigations (MNSI), regarding the Maternity Service. The Maternity Senior Leadership Team met with members of MNSI on 27 September and 14 November 2023. The Executive Chief Nurse met separately with MNSI to gain assurance that no immediate actions were necessary. The feedback from MNSI indicated that the maternity culture affected some staff's ability to escalate clinical concerns. Action taken forward from this external feedback will be aligned to the work of the national Perinatal Culture and Leadership programme and is to be focussed upon an improving patient safety programme to be scheduled over 2024. Further detail and timescales regarding this work will be supplied in future updates to Trust Board.

MATERNITY SERVICES UPDATE

1. INTRODUCTION

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

The Trust Board are provided with an update relating to actions highlighted by the CQC findings from their January 2023 inspection. An action plan was implemented by the service immediately following receipt of the draft report in March 2023, to enable the monitoring and reporting of key actions against the findings. The Trust are now working within an ICB System Oversight Framework (SOF). The Director of Nursing and Midwifery for the ICB met with key members of the Maternity Service's Senior Leadership Team on 5 December 2023 to agree the monitoring and support offer and to review the action plan (Appendix 1).

An update is provided in relation to formal feedback received following the Ockenden assurance visit undertaken on 10 November 2023.

Of note, future Maternity updates will no longer detail separate Ockenden reporting; assurance will be subsumed within the Trust's monitoring of compliance against implementing the 'NHS Three Year Plan for Maternity and Neonatal Services'. As previously reported to the Trust Board, the 'Three Year Plan' published in March 2023, was developed in response to national reports (Ockenden and Kirkup) with the intention that Trusts focus on one clear plan comprising four high-level themes, divided into twelve objectives.

The Trust Board is provided with an update regarding the final letter of closure following concerns raised by the Healthcare Safety Investigation Branch (HSIB), renamed Maternity and Newborn Safety Investigations (MNSI), regarding the Maternity Service.

2. CARE QUALITY COMMISSION (CQC) MATERNITY INSPECTION UPDATE

As previously reported to the Trust Board, the Maternity services received a short notice CQC inspection on 10 and 11 January 2023 as part of the national maternity inspection programme. The two key domains of 'safe' and 'well-led' were inspected and findings published on 12 May 2023 with an overall rating for the Maternity service as 'requires improvement'.

An action plan was implemented by the service immediately after receipt of the draft report in March 2023, to enable the monitoring and reporting of key actions against the findings. As previously reported to the Trust Board, due to the overall rating of 'Requires Improvement', the Maternity Service is subject to a formal System Oversight Framework (SOF). The ICB have responsibility to monitor and support the Trust throughout this process. The Director of Nursing and Midwifery for the ICB met with members of the Maternity Service's Senior Leadership Team on 5 December to agree the support offer and review the action plan.

At this meeting the ICB acknowledged the work undertaken by the service to strengthen compliance, monitoring, and assurance, in areas recommended by the CQC, and provided guidance regarding the auditing model required by the ICB in order to demonstrate consistent compliance with Trust agreed tolerance targets. Further suggestions were made to enable the mutual agreement of the exit criteria in relation to the SOF. As a result, the Action Plan for Maternity Services has been updated ensuring alignment with the wider Trust Action Plan. This has been returned to the ICB for review and at the time of writing the report is pending agreement (included within Appendix 1).

The Trust Board are also reminded that the Maternity service received additional CQC enquiry during and following a further unannounced core inspection between 25-27 of July 2023. A further meeting will be arranged to review the action plan and the Trust's position against the SOF in view of any further recommendations by the CQC. It was acknowledged these should be reviewed in totality when agreeing exit criteria from the Framework and to ensure alignment with the work underway more widely across the Trust.

3. OCKENDEN

The Trust's position and compliance against Ockenden has previously been reported in successive papers to Trust Board. As previously reported there remain four partially compliant recommendations from the Interim Report which the Trust continues to progress.

A BadgerNet solution has been identified for the allocation of women experiencing complex pregnancies to a named consultant lead and the recording of a formal risk assessment undertaken at every antenatal contact by activating mandatory fields within the electronic patient record. Further discussion is currently underway with members of the medical team to ensure that this change to practice is embedded.

Members of the Trust Board will recall that the achievement of fetal wellbeing training and competency assessment has been challenging following the introduction of the revised Core Competency Framework and the associated additional training requirements. Compliance with this target has been recognised as a current and ongoing risk and features on the departmental risk register.

Ensuring every woman has easy access to accurate, evidence-based information to support informed choice and informed consent is an area that has been developed with the introduction of BadgerNet. Work is ongoing in collaboration with the Patient Experience Team and colleagues across the region to facilitate information in a variety of languages and ensure women are supported to be informed regarding their choices and make true informed consent.

Formal feedback has been received from the Ockenden Assurance Visit held on 10 November 2023 when the Trust welcomed visitors representing NHS England (NHSE), the Integrated Care Board (ICB), the Local Maternity and Neonatal System (LMNS), the Maternity and Neonatal Voices Partnership (MNVP), as well as peer reviewers from South Tees Hospitals NHS Foundation Trust. The primary aim of the visit was to review evidence

and receive assurance relating to Trust compliance with all 7 Immediate and Essential Actions (IEAs) from the Interim Ockenden report (2020).

The visiting team gave brief, high-level verbal feedback to the Trust at the end of the day, focussing on areas of good practice and areas which may benefit from ICB/LMNS support. Overall, a positive visit was experienced by the review team. The team noted that staff were happy and welcomed the visitors and that the women who were spoken with during the day were very complimentary about the care that they had received. The final written report was received on 19 December 2023.

Positive areas of note included the work undertaken with regard to preterm optimisation and, in particular, the successful improvement of breastfeeding initiation rates. The 'What Matters to You' cultural improvement work undertaken by the service in collaboration with IHI was recognised as a positive quality improvement project, together with student midwifery recruitment to the existing workforce. The specialist midwifery team were highlighted as being passionate and it was evident that the impact on outcomes for women was promising.

Whilst there were no formal recommendations arising from the visit, the following areas were identified as areas which had potential to be supported by the LMNS/ICB:

- The assurance team acknowledged the Trust's midwifery and medical workforce strategies; however, it was suggested that multi-disciplinary workforce planning could be further supported by the LMNS/ICB.

- The ongoing implementation of triage, which is an area of focus across the NENC, was identified as being an area which could be further supported. Since the visit, the Birmingham Symptom-specific Obstetric Triage System (BSOTS) went live on 18th December 2023 and is currently embedding into practice with a planned audit programme for compliance.

- Some staff were noted not to be wearing a yellow name badge. This feedback has been actioned with the requisition of name badges for all staff who self-identified as without one; delivery is awaited.

- Computer screens in some areas were left unattended breaching information governance regulations. The Maternity Leadership Team have increased presence and vigilance when visible within the department and challenge any identified information governance breaches. A global communication has been shared with all in the department.

Subsequent to the visit the Executive Chief Nurse from the ICB raised a specific issue in relation to the reporting and interpretation of grading of two specific incidents in the neo-natal unit. This was discussed in a separate meeting with the ECN and Director of Quality & Effectiveness and further detail and clarity provided which has highlighted further the importance of internal feedback to staff when they submit a concern.

The Trust Board are asked to note future updates will no longer detail separate Ockenden reporting; assurance will be subsumed within the Trusts monitoring of compliance against implementing the 'NHS Three Year Plan for Maternity and Neonatal Services'. Trust Board members will recall, details of the 'Three year plan' were presented in May 2023 following publication in March 2023, with initial Trust benchmark status presented in July 2023. The 'Three year plan' was developed in response to national reports (Ockenden and Kirkup) with the intention that Trusts focus on one clear plan comprising four high-level themes divided into twelve objectives, a progress update will be provided in future reports.

4. JOINT COMMISSIONER ASSURANCE VISIT TO THE NEONATAL UNIT

In October 2023 a Joint Commissioner Assurance visit to the Neonatal Unit took place. The visit was supported by the Neonatal clinical team who were able to share data relating to a recent MBRRACE report. The visit also focused on incident reporting, nursing workforce and a number of other lines of enquiry. The visit was followed by feedback from the Integrated Care Board who largely reported positive findings, specifically relating to parental experience and care.

Following the visit, the ICB asked for clarification on a number of areas. This included clarity regarding:

- Serious Incident Reporting,
- Neonatal Nursing Workforce
- Storage of Clean Linen
- Requirement of Emergency Call Bells

In response to these enquiries a robust response was provided by the Clinical Board. The highlights are detailed as follows:

Serious Incident Reporting

The ICB recommended a process for the reporting of incidents. The Clinical Board response included that the Neonatal Service report all incidents via the Trust Datix system, that all incidents are triaged by the Lead Nurse for risk and discussed within the wider neonatal team and that the identification of potential Serious Incidents would be escalated to the CGARD Team. The response also highlighted how incident lessons are shared within the Neonatal Service via unit and departmental meetings, that lessons learned from Serious Incidents are shared as per Trust process and that upon receipt of completed SI reports the Trust CGARD team would share copies of the reports to an agreed contact within the ODN, Spec Comm and Nursing Quality Team.

Neonatal Nursing Workforce

The second recommendation from the visit involved confirmation of a robust recruitment plan and plan to staff the four additional cots due to open in January 2024. A response was provided that outlined a clear Neonatal workforce plan. This referenced recent Dinning/ Neonatal Staffing Review, which indicates that the current nursing establishment is largely fit for purpose, whilst acknowledging that with cot expansion future Dinning reviews may look very different.

The workforce plan for Neonates, including recruitment to required band 5,6 and 7 posts includes:

- Recruitment for cot expansion band 5's and band 7's – this will create band 6 posts.
- Bespoke Neonatal Open Day planned for 21 January 2024 – previous yearly bespoke Neonatal open days showcasing development opportunities/ celebrating our successes have proved very popular and yielding.
- Robust induction package for all new staff commencing in post to NICU.
- Continue to benefit from recruitment on adult and paediatric centralised recruitment and recruitment of Internationally Educated Nurses.
- Clear pathways for development at all bands -Succession Planning Band 5/Band 6 & Band 6/Band 7 Development programmes.
- Development opportunities into specialist roles.
- Increase of staff undertaking PNA course with a further 4 staff commencing in January – March 2024.
- Transitional Care consultation commencing December 2023 with 4 existing staff. Human Resources, Unison and RCN will support process.
- Continued Education & Training, including access to QIS programme and network teaching programmes.

The Trust response also outlined the monitoring and review process. It is worth noting that by end of March 2024 the Neonatal workforce position will be fully established, with any subsequent recruitment via the current over-recruit RCG. The four cots will open as planned at the end of January 2024.

<u>Clean Linen Storage</u>

The third recommendation was made following observation during the visit that clean linen was left in a linen skip on the floor. This was rectified immediately at the time of the visit and the linen was moved to an alternative area. The Clinical Board response highlighted that as part of the Senior Sisters and Matrons weekly clinical standards audit schedule, monitoring the effectiveness of this system will be undertaken to ensure the change has been appropriately embedded.

<u>Requirement of Emergency Call Bells</u>

During the visit the Joint Commissioning Team picked up an immediate action, recommending that the Trust should immediately explore the implementation of an emergency call bell system. The Clinical Board response highlighted that a risk assessment had taken place and mitigation was in place, including the presence of a Dect phone for

emergency use in each clinical area. Quotations for a system had simultaneously been sought and very recently investment has been agreed to progress the implementation of a call bell system.

The Clinical Board response was submitted to the ICB in December 2023 and actions continue to be monitored and reviewed via the neonatal Clinical Governance process.

5. HEALTH CARE SAFETY INVESTIGATION BRANCH (HSIB)

The Trust Board will recall that correspondence from HSIB (now MNSI) which highlighted concerns with regard to the culture within the maternity service was received into the organisation in August 2023.

The Maternity Senior Leadership Team met with members of MNSI on 27 September and 14 November 2023. The Executive Chief Nurse met separately with MNSI for further assurance that no immediate actions were necessary in relation to the concerns which had been raised. The feedback from MNSI focussed on the re-emergence of themes relating to teamwork and communication, clinical escalation, and the impact the culture within the Maternity Service has on the ability of staff to escalate clinical concerns. This was specifically related to the perceived inequity of approach and behaviours experienced by some staff with protected characteristics which has negatively impacted confidence, psychological safety and wellbeing when seeking clinical support or escalating clinical concerns in real time.

Actions taken forward from this external feedback focus on a programme of cultural change which will align to the work of the national Perinatal Cultural and Leadership Programme which the quadrumvirate are attending. Commencing in quarter 4, it is anticipated that through a programme of quality improvement, engaging with staff with a focus on quality and safety, improvements will be seen in relation to those areas identified.

A final letter of closure in relation to the concerns raised has been received by the Trust from MNSI.

6. CONCLUSION

The final report of the January 2023 CQC Maternity Service's inspection was received in May 2023; the Trust continue to progress the actions identified. The Trust have now met with the ICB to agree the support offer, action plan, and exit criteria. The Trust have returned a factual accuracy response following receipt of the draft report from the re-inspection made of the Maternity service during the CQCs unannounced inspection in July 2023; the final report is due be received in January 2024 the detail of which will be presented to the Trust Board in March.

The final report from the Ockenden Assurance visit held on 10 November 2023 has now been received by the Trust. The feedback overall was very positive with no formal recommendations.

There remain four partially compliant recommendations from the Interim Ockenden Report which the Trust continues to progress. The outstanding recommendations for completion are:

- The allocation of women experiencing complex pregnancies to a named consultant lead.
- The recording of a formal risk assessment undertaken at every antenatal contact.
- Achievement of fetal wellbeing training and competency assessment.
- Ensuring every woman has easy access to accurate, evidence-based information to support informed choice and informed consent.

A solution has been identified within the electronic patient record to meet the first two recommendations and is in the process of implementation and embedding with members of the medical team. Achievement of fetal wellbeing training and competency assessment has been recognised as a current and ongoing risk and features on the departmental risk register. Work to ensure every woman has easy access to accurate, evidence-based information to support informed choice and informed consent is ongoing within Maternity Services in collaboration with the Patient Experience Team and regional colleagues. Future maternity updates will focus on reporting against the 'Three Year Plan'.

In October 2023 a Joint Commissioner Assurance visit to the Neonatal Unit took place. The visit was supported by the Neonatal clinical team who were able to share data relating to a recent MBRACE report. The visit also focused on incident reporting, nursing workforce and a number of other lines of enquiry. The visit was followed by feedback from the Integrated Care Board who largely reported positive findings, specifically relating to parental experience and care. A response has been made by the Trust detailed within this paper.

The Trust has received a final letter of closure following meetings held to discuss the concerns highlighted in correspondence by MNSI relating to the Maternity Service's culture and the ability of staff to escalate clinical concerns. Actions taken forward from this feedback will be aligned with the work required of the national Perinatal Culture and Leadership programme and through staff engagement focus on safety and quality within the maternity service.

7. RECOMMENDATIONS

The Trust Board is asked to:

i) Receive and discuss the report;

ii) Note the ongoing oversight and assurance from the Integrated Care Board through the Systems Oversight Framework (SOF) in response to the final report of the CQC inspection in January 2023;
iii) Note the formal findings of the CQC core inspection of Maternity in July 2023 are expected imminently and will be reported in future papers;
iv) Note the formal findings of the Ockenden assurance visit undertaken on 10 November 2023, led by the NENC LMNS; and that future reporting of Ockenden will be superseded by Trust implementation and monitoring against the 'Three year plan';
v) Note the findings of a Joint Commissioner Assurance visit to the Neonatal Unit, together with the Trust's response;
vi) Note the correspondence received from the Healthcare Safety Investigation Branch (HSIB now MNSI) and Trust response including cultural change programme, and final HSIB letter of closure; and
vii) Note the associated risks involved.

Report of Maurya Cushlow
Executive Chief Nurse
25 January 2024

APPENDIX 1

APPENDIX 1 ID	Source	Quality Improvement Theme	Actions for Improvement (which will deliver the outcome measures)	Outcome measures (which will be evidenced via those items listed in the Assurance column) Shown in purple text where assurance not yet in place	Progress Update	Status	Lead	Timescale for completion	Link to available assurance
1	National Maternity Inspection	Clinical Standards	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	A formal standardised process has been developed, implemented and embedded for both daily checks and use of standard emergency equipment. Compliance will be measured weekly by the Midwifery Matrons and this will be formally reported through established maternity governance pathways. Non-compliance with Trust wide parameters, defined by the CAT tool, for 2 consecutive weeks or more per month will be formally escalated to the Clinical Board at the monthly Nursing and Midwifery Professional Meeting with the Director of Operations and Clinical Board Chair and a remedial action plan developed until within CAT tool target parameter.	The Trust implemented immediate actions to meet with this requirement following CQC inspection in January 2023. Clinical Standards Checklists for each area/ward were standardised and embedded across every department in line with Trust wide templates which have been operational since June 2023. Compliance Data for Adult Resus checks is 84% and Neonatal Resus checks is 79%. Compliance rates have been escalated to the Executive Trust Nurse and to further strengthen the assurance process in maternity services, an additional interim local operational SOP has been introduced in January	Compliant with mechanism for ongoing monitoring and reporting to ensure practice is embedded.	Head of Midwifery Midwifery Matrons Action owner: Ward Managers and Team Leads	Enhanced weekly monitoring to be implemented until the end of March 2024; practice expected to be embedded and compliance maintained with step down to CAT Tool only for monthly monitoring from April 2024.	Clinical Standards Checklists Interim Local SOP for enhanced assurance Weekly Leaders Assurance Checklist Weekly DoM Meeting Minutes

					2024 for enhanced assurance of daily compliance. Increased oversight is established with a supporting framework for compliance tolerance targets and responsive actions led by the responsible Midwifery Matron. Weekly oversight of Trust wide compliance tolerance targets and responsive actions are monitored via the Director of Midwifery Meeting with data then feeding into the monthly Nursing and Midwifery Professional Meeting with the Director of Operations and Clinical Board Chair.				

2	National Maternity Inspection	Well Led	The trust must ensure all staff receive such appraisal as is necessary to carry out their duties. Regulation 18 (1) (2) (a)	Compliance for midwifery and support staff will be monitored weekly by the Midwifery Matrons at the Director of Midwifery Meeting against the Trust target of 95% compliance. There is monthly oversight by the Associate Director of Operations at the Directorate Management Meeting and compliance is formally reported to the Clinical Board at the monthly Nursing and Midwifery Professional Meeting with the Director of Operations and Clinical Board Chair. Medical staff appraisals are monitored by the Associate Director of Operations and Clinical Director on a monthly basis and features as a standing agenda item for the Consultant's monthly meeting.	The Trust immediately undertook targeted work to improve appraisal rates towards the Trust target of 95%. The appraisal process for Midwifery and Support Staff was reviewed in Q3 2023 and the 'Maternity Family Tree' for Midwifery and Support Staff launched in January 2024 alongside expectation and process guidance for both appraisers and appraisees. The current appraisal rate as at 11th January 2024 is as follows: Medical Staff 55%, Midwives 71%, Support Staff 77% and have been escalated to the Executive Chief Nurse. Actions are in place for a 10% increase in each staff group by 1st February 2024 with a further 10% increase by 1st March 2024.	Partial Compliance with mechanism for ongoing monitoring with a trajectory for compliance to be achieved and sustained.	Director of Midwifery Associate Director of Operations Clinical Director Head of Midwifery Senior Midwife for Workforce Action owner: Midwifery Matrons Ward Managers and Team Leads	Trust Target of 95% compliance met and sustained by 31st March 2024.	Midwifery and Support Staff Appraisal Process and 'Maternity Family Tree' DMT Meeting Minutes Monthly HR Dashboard Monthly Consultants Meeting Minutes

3	National Maternity Inspection	Medicine Management	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)	A strengthened process for medicine management has been developed, implemented and embedded across the Trust. Compliance with medication storage and fridge temperature monitoring will be measured weekly by the Midwifery Matrons and this will be formally reported through established maternity governance pathways. Non-compliance with Trust wide fridge monitoring parameters, defined by the CAT tool, for 2 consecutive weeks or more per month will be formally escalated to the Clinical Board at the monthly Nursing and Midwifery Professional Meeting with the Director of Operations and Clinical Board Chair and a remedial action plan developed until within CAT tool target parameter.	The Trust implemented immediate actions to meet with this requirement following CQC inspection in January 2023. The storage of medication and IV Fluids was reviewed in each area in collaboration with the Estates Department and necessary action taken to ensure all are stored in locked cupboards behind a locked door in each area/ward. Fridge and Freezer temperature monitoring templates for each area/ward were standardised and embedded across every department in line with Trust wide templates which have been operational since June 2023. Compliance across the department for fridge temperatures in December is partially compliant. This has been escalated to the Executive Chief Nurse, to further strengthen the assurance process in maternity services, an	Compliant with mechanism for ongoing monitoring and reporting to ensure embedded practice.	Head of Midwifery Midwifery Matrons Action owner: Ward Managers and Team Leads	Enhanced weekly monitoring to be implemented until the end of March 2024; practice expected to be embedded and compliance maintained with step down to CAT Tool only for monthly monitoring in April 2024.	Fridge and Freezer Monitoring Checklist Interim Local SOP for enhanced assurance Weekly DoM Meeting Minutes

					additional interim local operational SOP has been introduced in January 2024 for enhanced assurance of daily compliance. Increased oversight is established with a supporting framework for compliance tolerance targets and responsive actions led by the responsible Midwifery Matron. Weekly oversight of Trust wide compliance tolerance targets and responsive actions are monitored via the Director of Midwifery Meeting with data then feeding into the monthly Nursing and Midwifery Professional Meeting with the Director of Operations and Clinical Board Chair.				

4	National Maternity Inspection	Patient Safety	The Trust should ensure that all staff complete the required mandatory training including the appropriate level of safeguarding adults and children training. (Regulation 12)	The Trustwide process for monthly monitoring of Trustwide mandatory training compliance against a Trust target of 95% occurs at the monthly Directorate Management Meeting for Midwifery and Support Staff with an additional local arrangement for a monthly HR Manager meeting between Matrons and Ward Managers/Team Leads to monitor compliance and set Line Manager specific targets. Medical Staff mandatory training is monitored by the Associate Director or Operations and Clinical Director on a monthly basis and feature as a standing agenda item on the monthly Consultant Meeting. Monthly monitoring of maternity specific training compliance against bespoke national targets is undertaken at a monthly maternity training meeting and trajectory for achieving and sustaining agreed. This is reported bi-monthly to Quality Committee and Trust Board.	The current Trustwide mandatory training rate as at 11th January 2024 is as follows: Medical Staff 77%, Midwives 85%, Support Staff 91% with targeted actions for all to be at Trust compliance target by 31st March 2024. The impact of the Core Competency Framework v2 for Newcastle is currently under review to understand the additional financial resource required.	Partially Compliant	Directorate Management Team Action Owner: Director of Midwifery Associate Director of Operations Clinical Director Head of Midwifery Midwifery Matrons Ward Managers and Team Leads Lead Midwives Safeguarding Quality & Effectiveness Midwife Senior Midwife Practice Development Lead Midwife	Trust wide mandatory training target of 95% compliance met and sustained by 31st March 2024. Maternity specific training compliance will follow the requirements of MIS.	DMT Meeting Minutes Monthly HR Dashboard Monthly Maternity Training Meeting Minutes Monthly Consultants Meeting Minutes Quality Committee Paper Trust Board Paper

5	National Maternity Inspection	Clinical Standards	The Trust should ensure all areas are clean and staff use control measures to prevent the spread of infection. (Regulation 12)	A strengthened process for the monitoring of clinical standards has been developed, implemented and embedded across the Trust. Compliance will be measured monthly by the Midwifery Matrons using the CAT tool and this will be formally reported through established Trustwide governance pathways. Non-compliance with Trust wide parameters, for 2 consecutive months will be formally escalated to the Clinical Board at the monthly Nursing and Midwifery Professional Meeting with the Director of Operations and Clinical Board Chair and a remedial action plan developed until within CAT tool target parameter.	The Trust have implemented immediate actions to meet with this requirement. Clinical Standards Checklists for each area/ward were standardised and embedded across the department in line with Trust wide templates and have been operational since June 2023. Clinical Standards are monitored and reported through the Trust-wide monthly Clinical Assurance Tool (CAT). To further strengthen the assurance process in maternity services, environment cleaning standards are triangulated on a monthly basis with Domestic Services Supervisor. As part of the Interim Operational SOP for enhanced assurance a departmental programme for peer review of clinical areas has been introduced bimonthly in addition to the quarterly peer review by an external Matron as part of the Trust peer review process.	Compliant, with mechanism for ongoing monitoring and reporting to ensure embedded practice.	Director of Midwifery Head of Midwifery Midwifery Matrons Associate Director of Nursing for Clinical Standards Hotel Services Manager Action owner: Ward Managers and Team Leads	Monthly monitoring ongoing to maintain compliance.	Clinical Standards Checklists Interim Local SOP for enhanced assurance Weekly Leaders Assurance Checklist Weekly DoM Meeting Minutes CAT Tool Results Monthly Meeting Minutes Monthly Maternity Cleaning Standards Meeting

6	National Maternity Inspection	Well Led	The Trust should ensure sufficient midwifery staff are deployed to keep women, birthing people and babies safe. (Regulation 18)	Over the last 12 months there has been a 3% reduction in Midwifery Turnover with a stretch target of a further 3% reduction in 2024 to <6%. The Midwifery vacancy rate is currently 0 with 4.69wte over recruit into our agreed 20wte with the aim to recruit fully into the 20wte over recruit through rolling recruitment. A monthly staffing vs outcome meeting will be introduced in January 2024 in collaboration with the Trust Senior Nurse Staffing Team to review fill rates against clinical outcomes with Maternity Services recruitment position and Birthrate Plus Red Flags monitored and included in monthly ECN slide deck presented to Executive Directors.	The Trust have responded to this via the introduction of a quarterly rolling midwifery recruitment programme and the introduction of the Midwifery Workforce Improvement Strategy in October 2023. The midwifery workforce staffing to acuity assurance process has been strengthened with the introduction of the NENC daily SitRep in December 2023. Daily Matron oversight and collective review chaired by the Head of Midwifery twice weekly continues for additional assurance regarding workforce planning and mitigation of risk. Maternity Services are currently undertaking a repeat BirthRate+ workforce review with a recommendation expected in Q4.	Compliant with a mechanism in place for monitoring and reporting.	Director of Midwifery Head of Midwifery Action owners: Head of Midwifery Senior Midwife for Workforce Patient Flow Manager Midwifery Matrons	Currently meeting with the 2020 Birthrate+ recommendation; work will be ongoing aligned to refreshed review.	NENC Daily SitRep and SOP Daily Monitoring and Mitigation Action Log Staffing vs Outcome Meeting Minutes Workforce Improvement Strategy ECN Slides

7	National Maternity Inspection	Estates	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)	A multidisciplinary review of the Intrapartum environment was undertaken in Winter 2022 to identify areas requiring improvement that are restricted by the estate and are consequently listed on the departmental Risk Register. In 2024 there will be a focus on Intrapartum Services for the Service User 15 Steps Programme within Maternity Services.	Estates and environmental work across the service is a priority, however, the old estate has limitations which requires significant change to bring resolution. Bespoke work is currently being explored to refurbish the bereavement facilities on Delivery Suite to improve the provision of privacy and dignity for families. Architect drawings have been completed outlining the proposal for an extended bereavement suite. The estates department are in the process of costing this improvement.	Partially Compliant	Director of Midwifery Associate Director of Operations Clinical Director Head of Midwifery Action Owner: Directorate Management Team Director of Estates	The timescale for completion is expected to be 2024.	Architectural Drawings for the Halcyon Suite Risk Register Service User 15 steps output
8	National Maternity Inspection	Patient Safety	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	E-Obs and MEWS compliance will be monitored monthly in line with existing Trustwide processes against the Trust target of 90%. There is monthly oversight by the Midwifery Leadership Team at the Staffing vs Outcome Meeting and compliance is formally reported to the Clinical Board at the monthly Nursing and Midwifery Professional Meeting with the Director of Operations and	The Trust introduced an electronic Modified Early Warning Score (MEWS) system e-obs in July 2023. This has enabled a continuous process of review in relation to completion of MEWS, and greater quality assurance through audit. The current compliance rate as at 11th January 2024 is 35% with a trajectory for a 10%	Partially Compliant	Directorate Governance Team and Quality & Clinical Effectiveness Midwife Action Owner: Risk Management Midwives Ward	Trust Target of 90% compliance met and sustained by April 2024.	SOP for paper MEWs chart used in outpatients Monthly audit of eobs as well as paper based MEWs chart used in outpatients Quality and Safety Clinical Board Minutes Staffing vs

			birthing people.	Clinical Board Chair where remedial action plans for each area will be agreed.	increase for February 2024 following staff education. Compliance will significantly improve with the introduction of the interface between eobs and Badgernet due to the removal of data duplication and therefore improved audit accuracy.		Managers and Team Leads Shift Coordinators		Outcome Meeting Minutes
9	National Maternity Inspection	Patient Safety	The Trust should continue to monitor the security of the unit to be reviewed in line with national guidance.	A monthly audit programme will commence in January 2024 to monitor compliance with the Baby Abduction Policy and findings will be shared widely with the workforce. The frequency of Baby Abduction Drills will be increased in 2024 with a drill undertaken quarterly and report shared with the Quality and Safety Group within the Clinical Board.	Estates improvements from the learning from 2022 annual Baby Abduction Drill undertaken and tested in 2023 Baby Abduction Drill. Increased Programme of Baby Abduction Drills for 2024 to include Neonatal Unit.	Partially Compliant	Director of Midwifery Associate Director of Operations Clinical Director Head of Midwifery Action Owner: Head of Security PN Matron	To undertake review of 3 month audit findings in March 2024 pending action plan.	2022 Baby Abduction Report and Action Plan 2023 Baby Abduction Report and Action Plan Monthly Audit Infographics General Meeting Minutes
10	National Maternity Inspection	Patient Safety	The Trust should continue work to introduce a robust formal triage and escalation process	Monthly compliance audit programme presented at staffing vs outcome meeting for monitoring and oversight purposes. Triage Red Flags monitored and included in monthly ECN slide deck which is presented to Executive Directors.	The Trust implemented a bespoke electronic Maternity Triage system (BSOTS) in December 2023. Monthly audit programme implemented with monthly quality improvement process for review.	Partially Compliant	Clinical Director Director of Midwifery Action Owner: Head of Obstetrics	To undertake review of 3 month audit following implementation findings in March 2024 pending action plan.	BSOTS SOP and Guideline Monthly Audit Staffing vs Outcome Meeting Minutes ECN Slide Deck

			within the maternity assessment unit.				Antenatal Matron Team Lead MAU		

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	25 January 2024						
Title	Maternity Incentive Scheme (MIS) Year 5 (CNST)						
Report of	Angela O'Brien, Director of Quality and Effectiveness						
Prepared by	Rhona Collis, Quality and Clinical Effectiveness Midwife/ Jane Anderson, Director of Midwifery						
Status of Report	Public		Private		Internal		
	☒		☐		☐		
Purpose of Report	For Decision		For Assurance		For Information		
	☐		☒		☐		
Summary	The NHS Resolution Clinical Negligence Scheme for Trusts (CNST) Maternity incentive scheme invites Trusts, in this Year 5 scheme, to provide evidence of their compliance using self-assessment against ten maternity safety actions. The scheme intends to reward those Trusts who have implemented all elements of the 10 Maternity Safety Actions. This is the fourth update report regarding the 10 safety actions in the Year 5 scheme which were first published on the 31 May 2023. The technical guidance was revised in July 2023.						
Recommendation	The Trust Board are asked to note the contents of this report and approve the self- assessment to date to enable the Trust to provide assurance that the required progress with the standards outlined are being met.						
Links to Strategic Objectives	Putting patients first and providing care of the highest standard focusing on safety and quality. Enhancing our reputation as one of the country's top, first class teaching hospitals, promoting a culture of excellence in all that we do.						
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☒	☐	☒	☐	☐	☒	☐
Link to Board Assurance Framework [BAF]	SO1.4 [high-quality safe care] SO2.4 [statutory and mandatory training] Failure to comply with the ten safety action standards could impact negatively on maternity safety, result in financial loss to the Trust from the incentive scheme and from potential claims.						
Reports previously considered by	This is the fourth report for Year 5 of this Maternity Incentive Scheme.						

MATERNITY INCENTIVE SCHEME (MIS) YEAR 5 (CNST): MATERNITY SAFETY ACTION COMPLIANCE

EXECUTIVE SUMMARY

The NHS Resolution Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme invites Trusts, in this Year 5 scheme, to provide evidence of their compliance using self-assessment against ten maternity safety actions. The scheme intends to financially reward those Trusts who have implemented all elements of the 10 Maternity Safety Actions. In addition, completion of all 10 Safety Actions upholds the reputation of the Trust in relation to the quality of care provision within the Maternity Service.

The Year 5 CNST safety actions were published on the 31 May 2023. There have been several amendments made and an updated version of the safety actions was published in July 2023.

For Year 5 Safety Actions 1,2,3,4,5,7 and 10 the relevant time period is between 30 May and 7 December 2023. For Safety Actions 6 and 9 it is prior to the submission date of the 1 February 2024. For safety action 8 (Multi-professional training) the time period is from 6 December 2022 to 5 December 2023. This report will be the fourth report to the Trust Board since the publication of Year 5 on the 31 May 2023.

The Trust is on target to achieve full compliance with 8 out of 10 safety actions in year 5. Due to the additional training requirements this year and ongoing staffing challenges the required training compliance of 80% in all staff groups cannot be achieved before the 5 December 2023. The Trust should continue to submit the declaration form acknowledging compliance with 8 safety actions. The Trust may still be eligible for a small amount of funding to support ongoing progress and an action plan should be submitted with the Board declaration form.

MATERNITY INCENTIVE SCHEME YEAR 5 (CNST): MATERNITY SAFETY ACTION COMPLIANCE

1. BACKGROUND TO CLINICAL NEGLIGENCE SCHEME FOR TRUSTS (CNST) MATERNITY INCENTIVE SCHEME – YEAR 5

Maternity safety is an important issue for Trusts nationally as obstetric claims represent the scheme's biggest area of spend (£6,033.4 million in 2021/22). Of the clinical negligence claims notified to NHS Resolution in 2021/22, obstetric claims represented 12% of the volume and 62% of the value.

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

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

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

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

The Trust Board declared full compliance with all 10 maternity safety actions for Year 1, Year 2, Year 3, and Year 4 of this scheme. Confirmation of the Trust's achievement in fully complying with all 10 standards, was confirmed by NHS resolution and the Trust was rewarded, for Year 1, Year 2, Year 3, and Year 4, with £961k, £781k, £877k and £707k respectively in recognition of this achievement. In addition, the Trust also received £463k for year 4 – which was a share of the surplus funds in respect of Trusts that did not achieve ten out of ten actions. In year 4, 52% Trusts achieved full compliance with all ten safety actions.

This paper provides an update on the progress of all the 10 Safety Actions and the requirements to achieve full compliance by the 1 February 2024.

2. SAFETY ACTION UPDATE

This paper will provide a full report on each safety action.

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

a) All eligible perinatal deaths should be notified to MBRRACE-UK within seven working days and the surveillance information should be completed within one calender month of the death.

There have been 33 perinatal deaths between 30 May and 7 December. All have been notified within seven working days and the surveillance information completed within one calendar month of the death.

b) For 95% of all deaths of babies in the Trust eligible for PMRT review, parents should have their perspectives of care and any questions they have sought.

All the deaths since 30 May include the parent's perspectives of care as part of the PMRT review.

c) For deaths of babies who were born and died in your Trust multi-disciplinary reviews using PMRT should be carried out from 30 May 2023. 95% of reviews should be started within two months of the death, and a minimum of 60% of multi-disciplinary reviews should be completed to the draft report stage within four months of the death and published within six months.

Within the reporting period 30 May to 7 December 2023, 20 of the perinatal deaths were eligible for review using the PMRT.

PMRT	Started within two months (95%)	Draft report within 4 months (60%)	Report published within 6 months
Total of 20	100%	78% (11/14)	75%

d) Quarterly reports should be submitted to the Trust Executive Board from the 30 May 2023.

The quarterly PMRT report for Q2 is included in this report as per the requirements of this safety action and can be found in the Private Board Reference Pack (BRP) [APPENDIX 1].

The Trust is confident that full compliance with the 4 elements of this safety action have been achieved.

2.2 SAFETY ACTION 2: ARE YOU SUBMITTING DATA TO THE MATERNITY SERVICES DATA SET (MSDS) TO THE REQUIRED STANDARD?

1) *Trust Boards to assure themselves that at least 10 out of 11 Clinical Quality Improvement Metrics (CQIM's) have passed the associated data quality criteria in the "Clinical Negligence Scheme for Trust: Scorecard" for data submission relating to activity in July 2023. Final data for July 2023 will be published during October 2023.*

2) July 2023 data contained valid ethnicity category (Mother) for at least 90% of

women booked in the month.

3) *Trust boards to confirm to NHS Resolution that they have passed the associated data quality criteria in the "Clinical Negligence Scheme for Trust: Scorecard" for data submission relating to activity in July 2023 for the following metrics:*

Midwifery Continuity of Carer (MCoC)

Note: If maternity services have suspended all MCoC pathways, criteria ii is not applicable.

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

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

The Trust has suspended all MCoC pathways.

4) Trusts to make an MSDS submission before the Provisional Processing Deadline for July 2023 data by the end of August 2023.

The Trust has received confirmation that all the above data requirements have successfully passed for the July 2023 reporting period.

5) Trusts to have at least two people registered to submit MSDS data to the SDCS Cloud who must still be working in the Trust.

The Trust has more than two people registered to submit MSDS data.

The Trust is confident that full compliance with all 5 elements of this safety action.

2.3 SAFETY ACTION 3: CAN YOU DEMONSTRATE THAT YOU HAVE TRANSITIONAL CARE SERVICES IN PLACE TO MINMISE SEPARATION OF MOTHERS AND THEIR BABIES?

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

The pathways of care were updated in August 2023 to reflect minor changes to the existing pathway which had been in place for year 3 and year 4.

b) *A robust process is in place which demonstrates a joint maternity and neonatal approach to auditing all admissions to the NNU of babies equal to or greater than 37 weeks. The focus of the review is to identify whether separation could have been avoided. An action plan to address findings is shared with the quadrumvirate (clinical directors for*

neonatology and obstetrics, Director or Head of Midwifery and operational lead) as well as the Trust Board, LMNS and ICB.

The action plan for Q1 and Q2 22/23 'Term admissions to the Neonatal Unit' were included with the November report. They have previously been shared with the quadrumvirate, Trust Board, LMNS and ICB. A Q3 report will be available for the March Trust Board.

c) Drawing on insights from the data recording undertaken in Year 4 scheme, which included babies between 34+0 and 36+6, Trusts should have or be working towards implementing a transitional care pathway in alignment with the BAPM Transitional Care Framework for Practice for both late pre-term and term babies. There should be a clear, agreed timescale for implementing this pathway.

The Trust is working towards full implementation of a transitional care pathway in alignment with the BAPM Transitional Care Framework for Practice. Currently there is just one area of non-compliance, whereby the Trust has opted to care for pre-term babies on low flow oxygen on the neonatal unit rather than Transitional care. This is reflected in the staffing ratio proposed for the new stand-alone 24hr Transitional Care ward which is scheduled to open in March 2024.

The Trust is confident that full compliance with all 3 elements of this safety action have been achieved.

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

a) Obstetric medical workforce

1) NHS Trusts/organisations should ensure that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas:

a. currently work in their unit on the tier 2 or 3 rota

b. have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP)

c. hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums.

Short term locums in Obstetrics and Gynaecology on tier 2 or 3 have been appointed to cover periods of sickness and industrial action within the past year. All locums have been from within our current cohort, or in 1 case during October from the previous year's cohort (an ST6 on Tier 3). All hold eligibility through the RCOG certificate. All Obstetric Consultant locum cover has been provided by the current Consultant cohort.

2) Trusts/organisations should implement the RCOG guidance on engagement of

long-term locums and provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings.

The Trust does not currently (as at January 2024) have any staff employed as long term locums within Obstetrics. There are, however, new significant vacancies at Consultant level which are out to advert. In the short term the frequency for Consultants will increase from 1 in 12 to 1 in 9 to address the shortfall for the acute service. We anticipate use of consultant colleagues for elective daytime work until Consultant Obstetrician numbers can recover. In addition to the 25% shortfall, a business case is in draft to increase by 3 further Consultant Obstetrician posts.

3) Trusts/organisations should implement RCOG guidance on compensatory rest where consultants and senior Speciality and Specialist (SAS) doctors are working as non- resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day. Services should provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings.

The Trust provides 98 hr consultant resident presence for the acute service to do so with current vacancy factor (25%) requires a rota of 1 in 9 24 hr shifts for consultants; this is followed by a day of compensatory rest. The junior doctors work a 1 in 8 rota with fully compliant compensatory rest periods before and after their shifts.

4) *Trusts/organisations should monitor their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance.*

Attendance by the Consultant at the clinical situations listed by the RCOG has been monitored and discussed at the Obstetric Governance group in August and October. Overall attendance was 100% so no additional action plans are required.

b) Anaesthetic medical workforce

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

An audit of 6 months of the anaesthetic rota has been completed which showed full compliance of the requirement to have a duty anaesthetist immediately available for the obstetric unit 24hours a day.

c) Neonatal medical workforce

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

If the requirements had not been met in year 3 and or year 4 or 5 of MIS, Trust Board should evidence progress against the action plan developed previously and include new relevant actions to address deficiencies.

If the requirements had been met previously but are not met in year 5, Trust Board should develop an action plan in year 5 of MIS to address deficiencies. Any action plans should be shared with the LMNS and Neonatal Operational Delivery Network (ODN).

The neonatal service meets the BAPM recommendations at all 3 tiers of medical cover for the size of service provided.

d) Neonatal nursing workforce

The neonatal unit meets the BAPM neonatal nursing standards.

If the requirements had not been met in year 3 and or year 4 and 5 of MIS, Trust Board should evidence progress against the action plan previously developed and include new relevant actions to address deficiencies.

If the requirements had been met previously without the need of developing an action plan to address deficiencies, however they are not met in year 5, Trust Board should develop an action plan in year 5 of MIS to address deficiencies.

Any action plans should be shared with the LMNS and Neonatal Operational Delivery Network (ODN).

The Trust completed a neonatal nursing workforce calculation in early May 2023 and have just repeated the process (16 November 2023), in order to meet the CNST requirements (time period 30 May – 7 December 2023). The Trust does not currently meet the BAPM neonatal nursing standards so an action plan has been written and shared with the LMNS and Neonatal Operational Delivery Network.

The Trust is confident that full compliance with all four elements of this safety action have been achieved.

2.5 SAFETY ACTION 5: CAN YOU DEMONSTRATE AN EFFECTIVE SYSTEM OF MIDWIFERY WORKFORCE PLANNING TO THE REQUIRED STANDARD?

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

The Trust completed Birthrate Plus in December 2020 and are currently in the process of repeating this with a completion date expected in January 2024. This will provide the Trust with an up-to-date midwifery staffing calculation based on current care provision.

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

Currently the midwifery staffing budget is 0.34wte above the funded establishment. This was reported in the Chief Nurse's six monthly Nursing and Midwifery Staffing report to the Trust Board on 30 November 2023.

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

From the 30 May 2023 to 31 December 2023 there have been 10 episodes whereby the delivery suite or birthing centre coordinator has not remained supernumerary. The technical guidance states the Trust can report compliance if this is a one off event or not a recurrent event. There were two occasions reported in June, none in July and August, four in September, two in October, none in November and two in December. There were staffing pressures throughout September which is reflected in the 4 red flags for that month. The Trust will continue to monitor this closely.

d) All women in active labour receive one-to-one midwifery care.

From the 30 May 2023 to 31 December 2023 there have been 4 episodes whereby 1:1 care in active labour could not be provided. An action plan has been written and was included in the Board Reference Pack in November 2023.

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

A midwifery staffing oversight report was presented to the Trust Board on 25 May 2023 and 21 November 2023.

The Trust is confident that full compliance with all five elements of this safety action have been achieved.

2.6 SAFETY ACTION 6: CAN YOU DEMONSTRATE THAT YOU ARE ON TRACK WITH COMPLIANCE FOR ALL ELEMENTS OF THE SAVING BABIES LIVES CARE BUNDLE VERSION THREE?

1) Provide assurance to the Trust Board and ICB that you are on track to fully implements all 6 elements of SBLv3 by March 2024.

The Trust completed a self-assessment using the implementation tool and submitted evidence for the ICB to review on the 11 December 2023. The Trust had fully implemented 58 of the 71 (82%) interventions that are part of the Saving Babies Lives care bundle. Progress with implementing the outstanding 13 interventions was being closely monitored and the Trust was working towards being on track to fully implement all of these by March 2024. The feedback from the ICB was that additional evidence was required to be submitted in order to achieve the required compliance. Final feedback will be provided to the Trust on

the 19 January 2024.

2) *Hold quarterly quality improvement discussions with the ICB, using the new national implementation tool once available.*

The Trust met with the ICB on the 1 August and the 5 December 2023 to review the implementation tool and discuss progress. However, the tool had only just been published in July 2023 so the meeting on the 1 August was not an informative meeting or a review of progress. The meeting on the 5 December was productive but the Trust would have benefited from an earlier meeting with the ICB for constructive feedback.

The Trust must demonstrate implementation of 70% of interventions across all six elements overall, and implementation of at least 50% of interventions in each individual element. These percentages are calculated within the new national implementation tool, which has just been made available to all Trusts.

The Trust undertook a self-assessment compliance and achieved an overall 79%, with all 6 elements achieving >50%. However, this did not include compliance with all the audits required - this was based on guideline compliance alone. Once the audits have become available it is evident that achieving the required target has been challenging due to the staff training compliance falling short of the required 90% annual training. Additional evidence has been submitted to the ICB for review and the feedback from this will be available on the 18 January 2024. It is likely that the Trust will achieve compliance of >50% for 4 elements but not the two that require staff training to be >90%.

The Trust will be unable to declare full compliance with all elements of this safety action.

2.7 SAFETY ACTION 7: LISTEN TO WOMEN, PARENTS AND FAMILIES USING MATERNITY AND NEONATAL SERVICES AND CO-PRODUCE SERVICES WITH USERS (MNVP)?

1) *Ensure a funded, user-led Maternity and Neonatal Voices Partnership (MNVP) is in place which is in line with the Delivery Plan and MNVP Guidance. Parents with neonatal experience may give feedback via the MNVP and Parent Advisory Group.*

The Newcastle Maternity and Neonatal Voices Partnership is funded in line with the Delivery plan. The MNVP is well established and actively seeks the views of service users and feeds this back to the maternity and neonatal services.

2) *Ensuring an action plan is coproduced with the MNVP following annual CQC Maternity Survey data publication, including analysis of free text data, and progress monitored regularly by safety champions and LMNS Board.*

An action plan was coproduced with the MNVP and progress has been reported bi- monthly to the local maternity safety champions and quarterly to the LMNS Board.

3) *Ensuring neonatal and maternity service user feedback is collated and acted upon within the neonatal and maternity service, with evidence of reviews and themes and*

subsequent actions monitored by local safety champions.

Neonatal and maternity service user feedback is collated via the Patient Experience and Engagement Group and the Service User Feedback Forum meetings. The actions are monitored by the local safety champions and key findings discussed at the bi- monthly Obstetric Governance Group.

The Trust is confident that full compliance with all three elements of this safety action have been achieved.

2.8 SAFETY ACTION 8: CAN YOU EVDIENCE THE FOLLOWING 3 ELEMENTS OF LOCAL TRAINING PLANS AND 'IN-HOUSE' MULTI-PROFESSIONAL TRAINING?

1) *A local training plan is in place for implementation of Version 2 of the Core Competency Framework.*

2) The plan has been agreed with the quadrumvirate before sign-off by the Trust Board and the LMNS/ ICB.

A local training plan was adopted aligned to the regional ICB plan and agreed with the quadrumvirate in August 2023. This was also discussed at the Board level Maternity Patient Safety Champions meeting on 9 August 2023.

3) The plan is developed based on the "how to" Guide developed by NHS England.

Achieving full compliance with the training requirements continues to be the most significant challenge for Year 5. The training requirements have increased with the expectation that, as a minimum, staff will each receive 3 days training per year in 2023/24. Currently midwifery staff receive 2 days training and the Service found achieving these requirements in Year 4 a significant challenge. On the 23 October the Trust received notification from the Maternity Incentive Scheme that the training requirements had been reduced from 90% to 80% due to the current pressures on Maternity Services.

In collaboration with the LMNS, the Trust agreed to introduce a third training day with a focus on Fetal Wellbeing. However, discussion with the LMNS advised that in view of a third day requiring additional resource, the Trust may not achieve full compliance with this additional requirement. The position with regard to training was presented to the Board Level Maternity Patient Safety Champions in August outlining the challenges faced with implementing this within such a short timescale. The training was scheduled to commence from the 4 September 2023, however, due to clinical workforce pressures, it has not been possible to continuously offer this additional day to all members of the team. The provision of clinical care remains a priority to preserve safety across the maternity service.

Training compliance for the existing schedule of a 2-day offer – Clinical Skills Emergency Drills and the Public Health in Practice day – was on target to achieve compliance provided that all the training sessions were delivered as planned over the 3 months between the 4 September and 5 December 2023. However, an additional change in requirement of the Core Competency Framework was the expectation that medical staff also receiving training

in 3 elements of the Public Health in Practice day. Currently they do not attend that day and the Trust is still working through the challenges of implementing this training requirement.

Table 1, 2 and 3 illustrate the position with regard to the current schedule of training for the 12 month period 1st December 2022 – 1st December 2023.

Table 1. Clinical Skills Day

Staff Group	Percentage trained
Midwives including Midwifery Managers, Matrons, Community Midwives, Midwifery Led Unit Midwives and Bank Midwives	84%
HCA/MSW/NN	74%
Theatre Staff	100%
Obstetric Consultants	77%
Anaesthetists	100%
Obstetric Trainees	94%
Anaesthetic trainees	75%
Total	**86%**

The Trust was unable to meet the training requirements of 80% for 3 of the individual staff groups.

Table 2. Maternity Safety and Public Health in Practice Day

Staff Group	Percentage trained
Midwives including Midwifery Managers, Matrons, Community Midwives, Midwifery Led Unit Midwives and Bank Midwives	80%
HCA/MSW/NN	70%
Theatre Staff	89%
Obstetric Medical staff	0%
Total	**80%**

The Trust was unable to meet the training requirements of 80% for 2 of the individual staff groups. The Core Competency Framework V2, published in June 2023, stipulate that medical staff undertake certain elements of the new training requirements and the Trust has not yet been able to embed this training into their work plan.

Table 3. Neonatal Life Support training compliance

Staff Group	Percentage trained
Neonatal Consultants	100%
Neonatal Trainees	100%
Neonatal Nurses	80%
Advanced Neonatal Nurse Practitioners	100%
Midwives	85%
Total	**93%**

The Trust has met the training requirements for Neonatal Life Support compliance.

Table 4. Fetal Wellbeing Training Day (commenced Sept 23 in line with Integrated Care Board ICB recommendations)

Staff Group	Percentage trained
Midwives including Midwifery Managers, Matrons, Community Midwives, Midwifery Led Unit Midwives and Bank Midwives	35%
Obstetric Consultants	10%
Obstetric trainees	56%
Total	**34%**

The Trust was informed at the November Trust Board that, given the additional resources required, together with existing staff pressures, achieving the required compliance was unlikely. Attendance at the Clinical Skills day and Public Health in Practice day is encouraging, however, remains below the reduced target of 80% in all staff groups. The challenges described are broadly in line with all providers across maternity services, hence the 10% reduction rate made by NHSR from 90% to 80%.

The Trust will be unable to declare full compliance with safety action 8.

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

a) *All six requirements of Principle 1 of the Perinatal Surveillance Model must be fully embedded.*

The Trust is fully compliant with all six requirements of the Perinatal Surveillance Model. The non-executive director works closely with the Board safety champion to address quality issues. Accompanied by a Matron or senior midwife, a monthly walkabout has taken place within the maternity unit and a report of the findings, summarised and shared with staff in November 2023.

A monthly review of maternity and neonatal quality is reported to the Trust Board via the Integrated Board Report.

The Trust has submitted quarterly Perinatal Quality Surveillance reports to the LMNS in accordance with the requirements of safety action 9.

b) Evidence that discussions regarding safety intelligence; concerns raised by staff and service users; progress and actions relating to a local improvement plan utilising the Patient Safety Incident Response Framework are reflected in minutes of Board, LMNS/ICS/Local and Regional Learning System meetings.

The Trust's claims scorecard, alongside incident and complaint data was shared with the Maternity Patient Safety Champions on the 14 July and the 29 November 2023. The ICB has confirmed that the Trust local priorities – using the PSIRF methodology to inform the Quality Improvement workstreams has been agreed and fulfils this requirement.

c) Evidence that the Maternity and Neonatal Board Safety Champions (BSC) are supporting the perinatal quadrumvirate in their work to better understand and craft local cultures.

The quadrumvirate attended Wave 5 of the NHS England Perinatal Culture and Leadership Programme in November 2023. This has become an agenda item at the Maternity Board Level Safety Champions meeting bi-monthly and evidence of the support they can provide to the quadrumvirate is minuted.

The Trust is confident that full compliance with all three elements of this safety action have been achieved.

2.10 SAFETY ACTION 10: HAVE YOU REPORTED 100% OF QUALIFYING CASES TO HSIB AND TO NHS RESOLUTION'S EARLY NOTIFICATION SCHEME?

A) *Reporting of all qualifying cases to HSIB from 6 December 2022 to 7 December 2023*

B) Reporting of all qualifying EN cases to NHS Resolution's Early Notification Scheme from 6 December 2022 to 7 December 2023

C) For all qualifying cases which have occurred, the Board are assured that:

i. the family received information on the role of HSIB and NHS Resolution's EN Scheme; and

ii. there has been compliance, where required with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of duty of candour.

There have been 13 qualifying cases (100%) reported to HSIB in the above time period.

None of the cases require reporting to the Early Notification Scheme.

All 13 families received information on the role of HSIB and the NHS Resolution's scheme and a formal letter regarding duty of candour.

The Trust is confident that full compliance with all three elements of this safety action have been achieved.

3. CONCLUSION

The Trust is confident in achieving full compliance with 8 out of 10 of the safety actions. The stretch ambition to achieve full compliance with safety action 8 – Multi- professional training – has been consistently reported to the Trust Board as an area of concern throughout year 5. Despite rigorous monitoring of the attendance and the proposed trajectories, achieving the required 80% compliance has not been achievable in the six months' time frame of year 5. Training compliance also applies to safety action 6 – Saving Babies Lives - which has also prevented the Trust from achieving full compliance with this safety action.

As advised by NHSR, the Trust should continue to submit the declaration form acknowledging compliance with 8 safety actions. Whereby all 10 Safety Actions are not met, the Trust may still be eligible for a small amount of funding to support ongoing progress and an action plan should be submitted with the Board declaration form.

The declaration form must be signed by the Trust's Chief Executive Officer and the Accountable Officer for the Integrated Care System by the 1st February 2024.

4. RECOMMENDATIONS

To (i) note the content of this report, (ii) comment accordingly and (iii) approve.

Report of Angela O'Brien
Director of Quality & Effectiveness
16 January 2024

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	25 January 2024						
Title	Learning from Deaths (July 2023 – September 2023)						
Report of	Angela O'Brien, Director of Quality and Effectiveness						
Prepared by	Pauline McKinney, Integrated Governance Manager – Quality						
Status of Report	Public		Private		Internal		
	☒		☐		☒		
Purpose of Report	For Decision		For Assurance		For Information		
	☐		☒		☐		
Summary	This paper aims to provide assurance to the Trust Board that the processes for Learning from Deaths across the organisation are in line with best practice as defined in the National Quality Boards (NQB) National Guidance on Learning from Deaths (LFD) March 2017, and guidance on working with bereaved families and Carers (July 2018). This paper also summarises the processes that are in place to provide assurance to the Trust Board that all deaths are reviewed including those with potentially modifiable factors. All deaths that require a more in-depth review (level 2) are recorded into the mortality review database to ensure lessons are learned and shared.						
Recommendation	The Public Trust Board is asked to receive this paper for information and discuss the learning identified from mortality reviews.						
Links to Strategic Objectives	Putting patients first and providing care of the highest standard focusing on safety and quality • Put patients and carers first and plan services around them						
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☒	☐	☐	☐	☒	☒	☐
Link to the Board Assurance Framework [BAF]	No direct link to the BAF. Provision of assurance that patient outcomes are reviewed, and lessons learned to include deaths of people with learning disabilities.						
Reports previously considered by	This is a recurrent report and was previously presented to Quality Committee on 26th September 2023.						

LEARNING FROM DEATHS

EXECUTIVE SUMMARY

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

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

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

LEARNING FROM DEATHS

1. BACKGROUND

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

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

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

The guidance released in July 2018 by the Department of Health and Social Care published the government's response to consultation on the "Introduction of Medical Examiners and Reforms to Death Certification in England and Wales". This guidance outlined the intention that the Medical Examiner system would be enshrined in statute and Medical Examiners would be based in all acute Trusts by 2021 with a view to start scrutinising community deaths by 2023.

2. MORTALITY REVIEW DATABASE – DATA SUMMARY

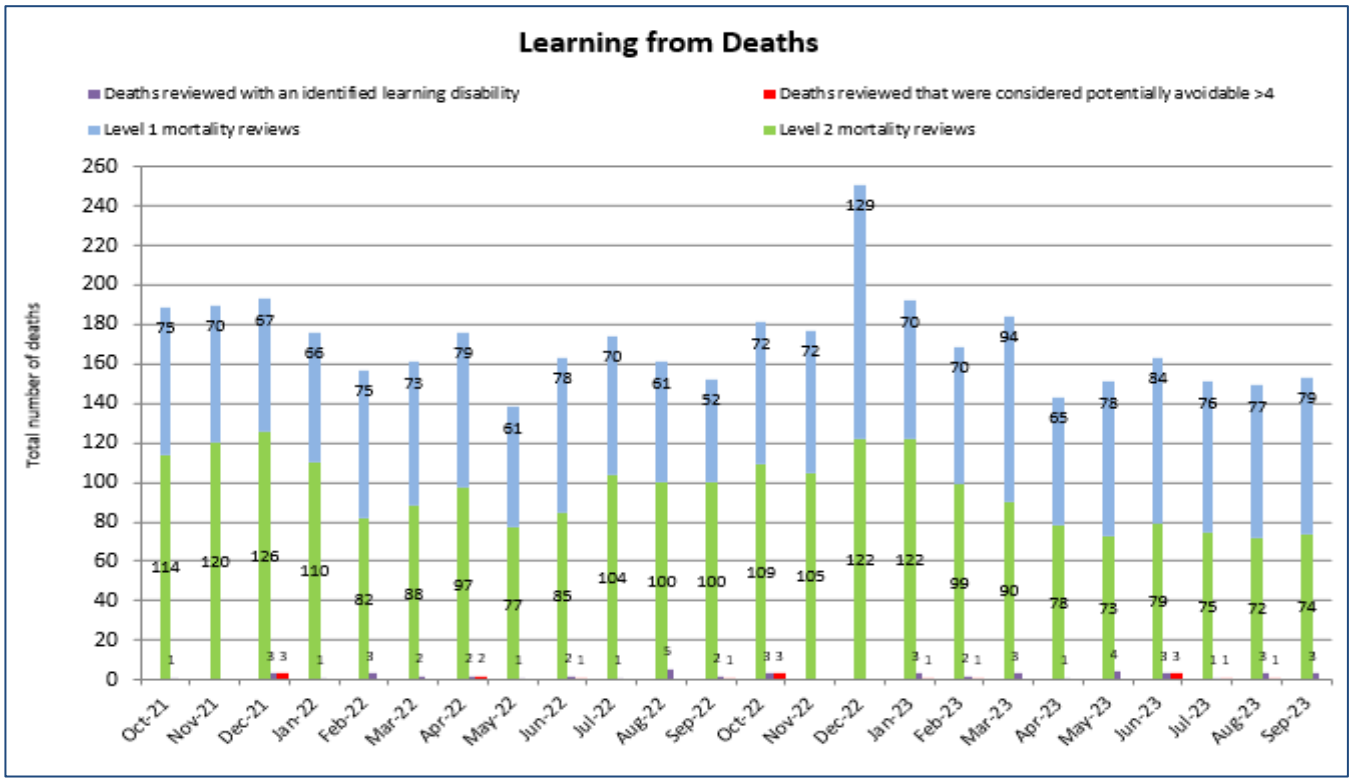
Current Morbidity and Mortality (M&M) meetings provide a robust forum for multidisciplinary discussion of inpatient deaths. The mortality review database was launched in June 2017 and has improved the ease at which lessons identified within M&M meetings can be shared between Directorates. The database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

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

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

2.1 Inpatient Deaths

In the 12-month period (October 22 – September 23), 1,924 patients died within Newcastle Hospitals, with 1,098 (57%) of those patients receiving a level 2 mortality review. There is a possibility that these mortality review figures will continue to rise due to further M&M meetings being held over the forthcoming months. These figures will continue to be monitored and modified accordingly. The graph below shows the total number of deaths over a 24-month period (October 21 – September 23) as well as level 2 mortality reviews. There was a rise in inpatient deaths in December 2022. This was noted nationally as well as locally, with initial data showing influenza to be the cause of death.



2.2 Patients identified with a Learning Disability

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

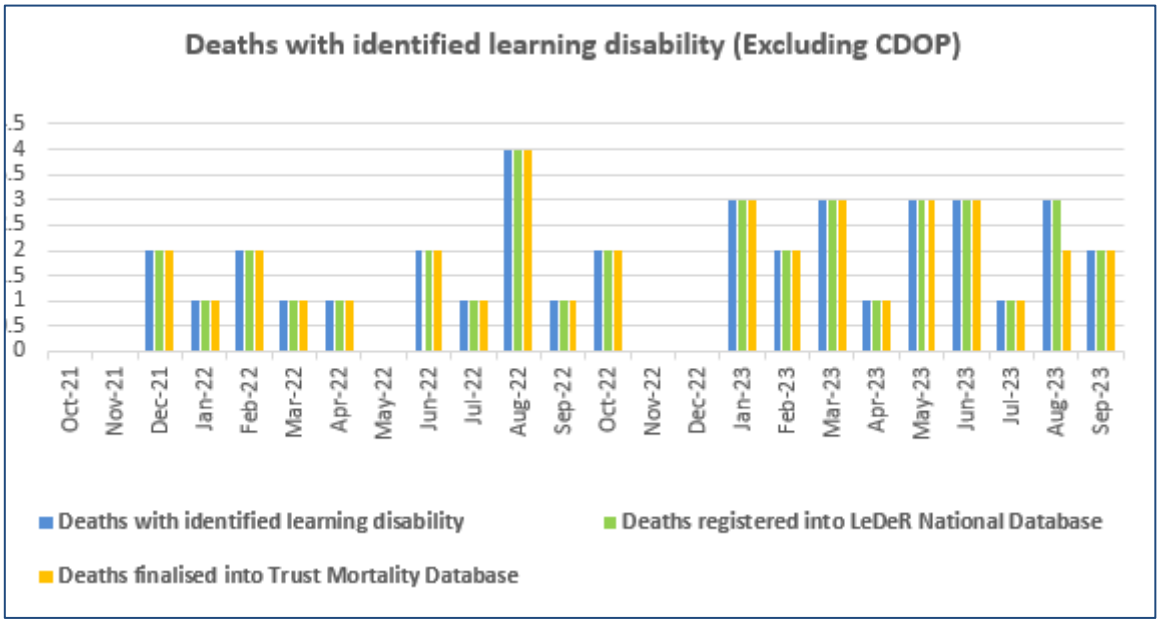
In the 12 month period (October 22 – September 23), 26 patients who died within Newcastle Hospitals were identified as having a learning disability. Within the Trust, whenever a patient with a learning disability dies, their death is reviewed by the clinical team along with the Learning Disability (LD) Team. There is a further in-depth case review at the Learning Disability Mortality Review Panel and the outcome of the case review is entered onto the Trust Mortality Review Database as well as into the LeDeR National Database. An update is provided from the Associate Director of Nursing at each quarterly Mortality Surveillance Group meeting and lessons learned are shared using various

methods, which includes presenting at the Clinical Risk Group and via Patient Safety Bulletins.

It was agreed by the National LeDeR programme that any patient <18 years, are no longer required to be registered into the National LeDeR database, this is due to duplication within the Child Death Overview Panel (CDOP) investigation.

The recent backlog of LeDeR case reviews requiring completion and recording into the Trust mortality review database has been supported by specialist LD nurses. The LD nurses have recently started to expand their role and undertake case reviews, presenting the findings to the Learning Disability Group. This support has shown to be imperative with the backlog of data waiting to be reviewed almost up to date.

The graph below shows the data for the past 24 months (July 21 – June 23) and includes those patients who have been registered into the national LeDeR database and Trust mortality review database.



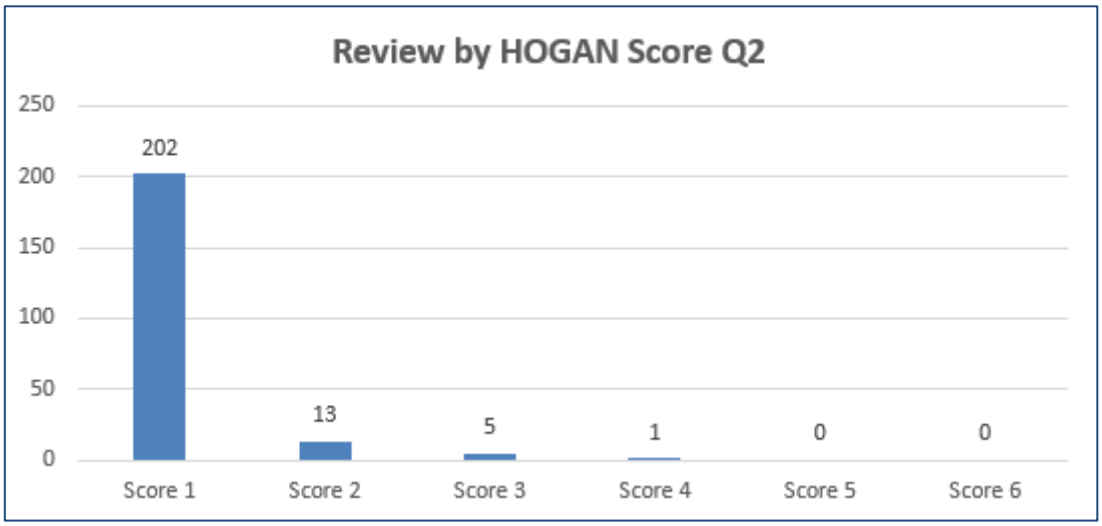
2.3 Outcome of Case Reviews – Hogan Score

Throughout Q2 (July 23 – September 23), 453 patients died, of which 221 have received a full case note review (Level 2), which was undertaken by a multidisciplinary team, and findings recorded into the Trust-wide mortality review database. This number will continue to rise as more M&M meetings go ahead over the forthcoming months.

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

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

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



The graph shows one patient was recorded as HOGAN 4 in Q2. The patient who was graded a HOGAN 4 received an indepth discussion at serious incident triage panel, the panel agreed the incident required reporting as a serious incident and an investigation is currently underway.

3. KEY LEARNING POINTS

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

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

The learning points identified following M&M reviews in Q2 are detailed below, together with what action has been taken. Clinicians from each Directorate are also encouraged to

share relevant learning from local mortality reviews with any other Clinical Board throughout the Trust.

Learning points identified from case reviews undertaken in Q2.

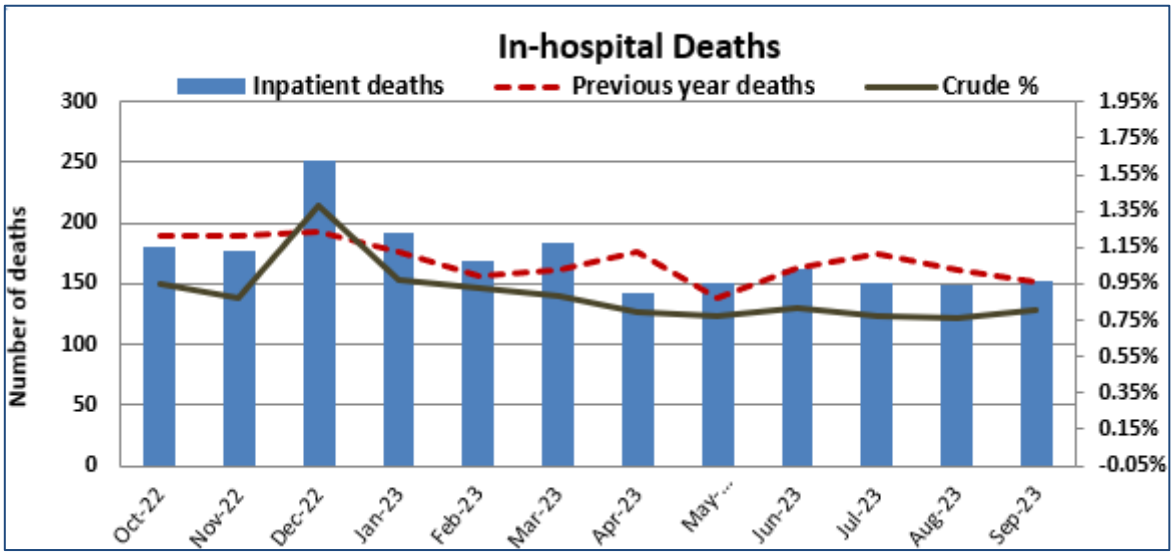
Directorate	Speciality	Summary	Learning Point	Outcome
Internal Medicine	Older People Medicine	Results of blood cultures returned showing bacterium, the results were viewed after active treatment was stopped and palliative care initiated.	Joint decision between clinician and family to stop treatment. Agreed results would not have changed treatment pathway. However, results should be viewed prior to making decision.	Discussed at Governance Meeting as a reminder to view all results prior to making end of life decision.
Internal Medicine	Older Peoples Medicine	Patient on long term catheter use, developed associated urinary tract sepsis due to delayed catheter change.	Education around catheter care guidelines to be highlighted to nursing staff at governance meetings.	Catheter Care was an agenda item at the ward governance meeting.
Internal Medicine	Liver/Hepatology	Emergency endoscopy and therapy required due to a possible GI bleed. Procedure went ahead with no MDT discussion.	Emergency MDT to go ahead for invasive procedures such as GI bleeding and the need for emergency endoscopy's.	Highlighted at the Directorate Clinical Governance Meeting.
Internal Medicine	Liver/Hepatology	Gastric balloon inflation went ahead without x-ray confirmation to ensure correct placement of sengstaken tubing.	X-ray confirmation of Sengstaken to always go ahead prior to the gastric balloon inflation as per internal guideline.	Following internal guidance was reiterated at the Directorate Governance Meeting. A teaching session at a future speciality consultant meetings is planned to reiterate the guidance further.
Learning Disability	Learning Disability	Prolonged in-patient stay due to poor communication between clinical wards.	Patient was under two specialities whilst an inpatient. Discharge planning between the specialities was delayed due to communication issues.	Issue highlighted to both Clinical leads via the learning disability team. Agreement made to contact the learning disability team for advice on discharge arrangements.

4. CRUDE MORTALITY

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

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

The graph below shows the crude mortality rates for period October 22 – September 23, which clearly shows a decrease in deaths in relation to the same period the previous year. The in-hospital deaths show an increase in December 2022. This rise was recorded nationally and was predominately related to influenza as the cause of death.



5. SHMI AND HSMR MORTALITY RATES

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

SHMI and HSMR data is scrutinised on publication to determine any areas that may raise concern. All groups within the data are individually monitored and all findings are presented to the Trust Mortality Surveillance Group on a quarterly basis. Any group that flags as a concern is raised with the relevant Clinical Board to ensure an in-depth analysis is undertaken and findings recorded into the mortality review database. All learning from this analysis is shared with Clinical Boards and presented to the Mortality Surveillance Group.

The latest SHMI publication for July 22 – June 23 shows the Trust to be at 1.01, which is within the national "expected levels".

A new commissioning dataset which uploads Trust data into Secondary Uses Service (SUS)*, was introduced into the Trust in April 2023. However, it recently came to light that only the patient's primary diagnosis was being uploaded. As SHMI and HSMR data are heavily dependent on secondary diagnosis to correctly risk adjust, this has hugely affected recent data publications, showing the Trust to have inaccurate negative data in regard to SHMI/HSMR and VLAD data. This fault has now been rectified and the Trust should see accurate data being published within the forthcoming months.

**SUS is a secure data warehouse for healthcare data in England that supports various reporting and analyses for the NHS.*

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

6. NEQOS

The Northeast Quality Observatory Service (NEQOS) is published quarterly and presents analysis showing the SHMI mortality indices including; a high level for Trusts identifying variation from the norm (outliers); trends through time; and using more granular analysis in order to describe contributing factors.

The latest NEQOS publication is up to June 2023. Overall, the table below shows the Trust to be consistently below the national average for SHMI and one of the lowest regionally.

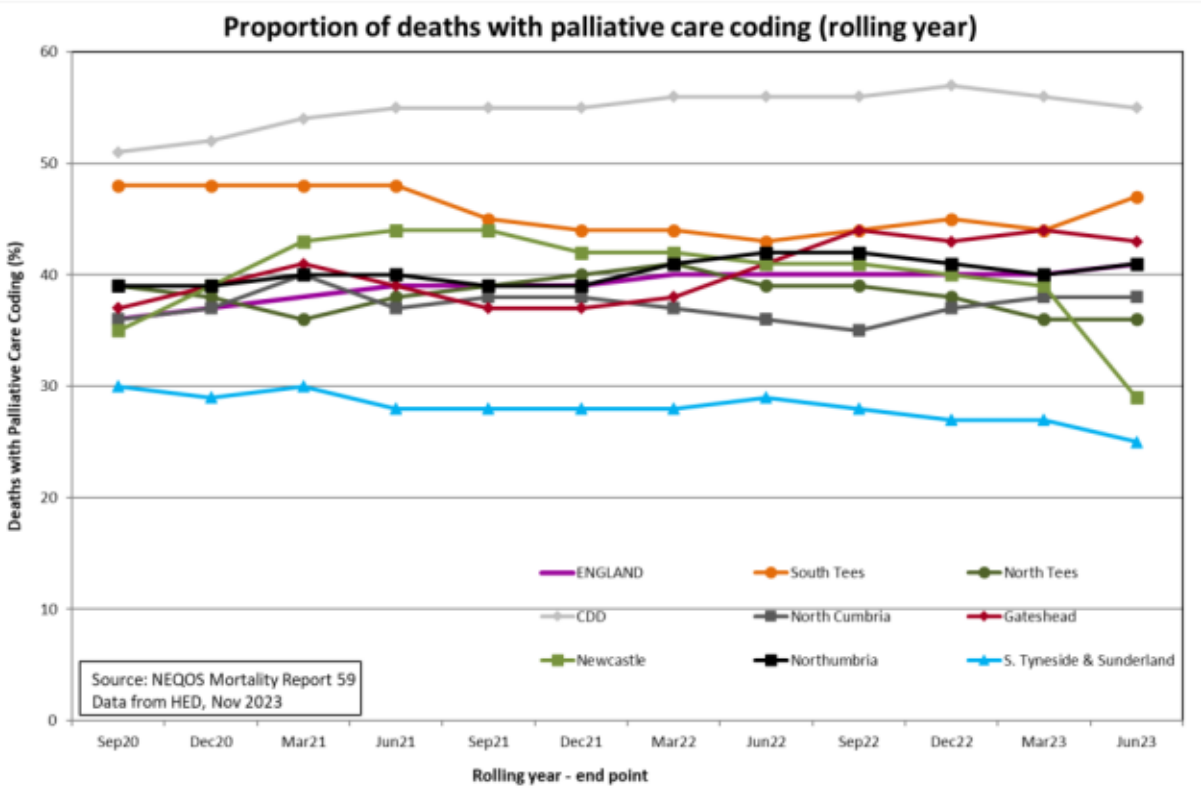
SHMI, total discharges, observed and expected deaths for July 22 – June 2023.

Provider	Discharges	Observed	Expected	SHMI	Category
County Durham and Darlington NHS FT	75475	3010	2520	119	Higher than expected
North Tees and Hartlepool NHS FT	56305	1850	1960	94	as expected
South Tees Hospitals NHS FT	79675	2580	2350	110	as expected
Gateshead Health NHS FT	34580	1310	1460	90	as expected
South Tyneside and Sunderland NHS FT	78020	3180	2815	113	Higher than expected
The Newcastle Upon Tyne Hospitals NHS FT	105365	2605	2580	101	as expected
Northumbria Healthcare NHS FT	96265	2800	3100	90	as expected
North Cumbria Integrated Care NHS FT	40660	1660	1645	101	as expected

7. PALLIATIVE CARE CODING

The graph below is published within the NEQOS quarterly report and is currently presented up to June 2023. The graph below shows deaths with a palliative care coding which includes those who have died within 30 days of discharge. Palliative care coding was historically low within Newcastle upon Tyne Hospitals in comparison to regional Trusts. The dramatic

decline in palliative care coding is part of the upload issue, mentioned above. This data will be corrected in the forthcoming months.



8. OUTCOME OF INVESTIGATIONS LINKED TO SERIOUS INCIDENTS

All unexpected patient deaths, or deaths with possible modifiable factors, are routinely escalated for review as potential serious incidents (SI) via the Trust incident reporting system (Datix). Deaths of this nature are subject to a detailed review, facilitated by a Clinical Director and often include members of the clinical team directly involved in the patients care. For deaths identified and reported externally as an SI, a comprehensive investigation is undertaken, which includes an analysis of the care provided to identify any learning and determines whether any modifiable factors contributed to the patient's death. Key learning points are identified, and action plans generated. A summary of investigation outcomes linked to SIs in Q1 are shown below:

- During July 2023 – September 2023 (Q2) there were 59 SIs reported to Commissioners via the Strategic Executive Information System (STEIS).
- Of these 59, there were nine patient deaths which identified potential modifiable factors which contributed to the death. Investigations are currently ongoing for six cases.

The incidents that have resulted or contributed to a patient's death, that have completed their investigation since the previous report submitted on 16th September 2023, are listed below and the learning is as follows:

2023/13838 and 2023/11013 – Fall
• Ward sisters able to access electronic dashboard so they can monitor compliance with falls risk assessments and falls policy compliance in order to target local training needs as required. • Falls prevention training is now included in Trust induction and Healthcare Academy teaching programme.

2023/12999 – Surgical Complication
• The CVC insertion policy has been updated to ensure more robust safety checks are in place for confirming the correct placement of a central line. • The Directorate Governance Lead circulated the updated policy to all units.

2023/4604 – Medical Device
• Surgeons are encouraged to consider alternative introducer devices during heart operations. • Cardiothoracic perfusionists to remind surgeons of the risks associated with sharp-tipped introducers during safety brief if needed.

2022/19132 – Medication Incident
• Review of anticoagulation and VTE prophylaxis training for foundation doctors is ongoing with new training now being delivered into induction. • VTE status is now part of the ward handover checklist. • Medicines management group to expand nursing staff education in the management of VTE including tinzaparin dose scheduling.

2023/3040 – Missed Treatment
• Senior working patterns in vascular surgery team are reviewed to facilitate the separation of consultant ward round and emergency clinic responsibilities. • Education provided to junior doctors to take urgent bloods rather than wait for phlebotomy service. • Learning and changes from this incident were presented at the Trust Clinical Risk Group.

2023/2448 – Lost to Follow-Up
• Trust IT development team to review functionality of email to e-record for viewing of letters on a non NUTH computer. • Review of process providing hard copy referral letters is currently ongoing with Newcastle Improvement Team.

2023/14673 – Surgical Complication
• The Trust agreed to permanently withdraw the use of this particular medical device in light of this incident.

2023/11765 – Unexpected Death
• Clinical leads for all critical care units in the trust have agreed on a suitable device or type of Vas-Cath to prevent the entraining of air once inserted such that disconnecting from use does not add the risk of air embolism. • Learning from this incident was shared at Clinical Governance Meetings of all Critical Care Units Trustwide. • A review went ahead of all existing training delivered to nurses in Critical Care Units to ensure consistent application of education and competencies.

9. MEDICAL EXAMINER

The Medical Examiners (ME) role went live in January 2021 as part of an initial test period, scrutinising patients' medical notes and discussing the care pathway with the ward clinician for all patients who died within two specified wards at the Freeman Hospital (FH). As the test period was considered a success, the project moved to the next stage in March 2021, which involved scrutinising all deaths at FH and finally including all deaths at Royal Victoria Infirmary (RVI) in August 2021.

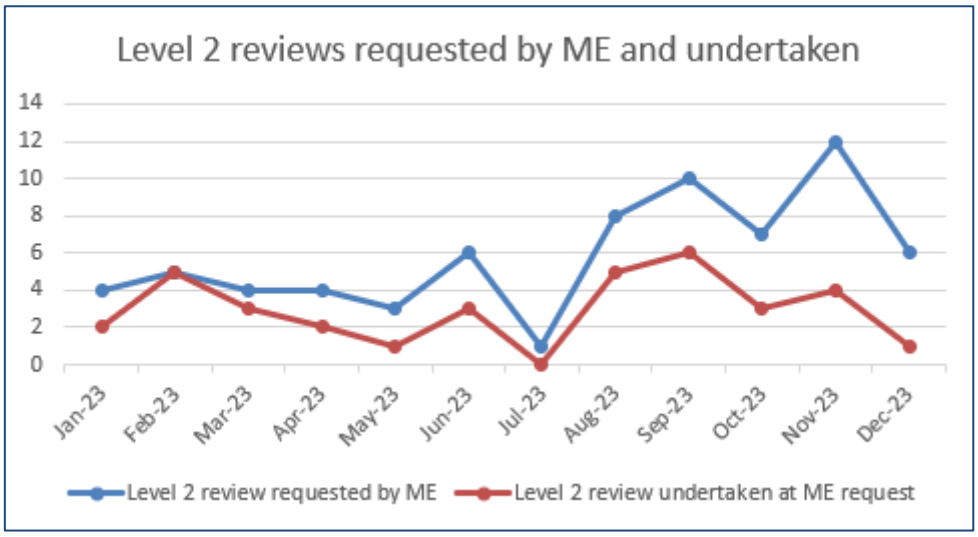
Since January 2023, Medical Examiners have started scrutinising all inpatient deaths other than those referred to the coroner's office.

The Medical Examiner process had planned to incorporate all community deaths by April 2023 in line with National Guidance. However, NHS England have deferred this date until April 2024.

Medical Examiners are currently scrutinising some community deaths, however not all GPs and hospices are fully incorporated into the process. This will become mandatory by April 2024. The Trust Medical Examiner office is offering training to all GPs and hospices in order for them to understand the scrutiny process.

A new process has commenced in July 2023, whereby the Medical Examiners inform the Trust mortality leads if a level 2 review is to be undertaken in line with the Trust mortality policy. This will provide additional assurance that all patients who are required to have a level 2 review, receive a review. This process will continue to be monitored by clinical governance & risk department with data presented at the mortality surveillance group. This data is also shared with Clinical Boards and presented at their Quality Oversight Group.

The graph below shows patients referred for a level 2 review by a Medical Examiner and how many were undertaken.



10. RECOMMENDATIONS

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

Report of Angela O'Brien
Director of Quality & Effectiveness
25th January 2024

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	25 January 2024						
Title	Healthcare Associated Infections (HCAI) Director of Infection Prevention and Control Report						
Report of	Maurya Cushlow, Executive Chief Nurse						
Prepared by	Dr Julie Samuel, Director of Infection Prevention & Control (DIPC), Consultant Microbiologist Mr Ian Joy, Deputy Chief Nurse Mrs Gillian Lishman, IPC Quality and Assurance Lead						
Status of Report	Public	Private	Internal				
	☒	☐	☐				
Purpose of Report	For Decision	For Assurance	For Information				
	☐	☒	☐				
Summary	This paper is the bi-monthly report on Infection Prevention & Control (IPC). It complements the regular Integrated Board Report and summarises the current position for the Trust to the end of December 2023. Trend data in Appendix 1 (HCAI Report and Scorecard December 2023) is included in the Public Board Reference Pack (BRP), which details the performance against targets where applicable.						
Recommendation	The Board of Directors is asked to (i) receive the report, note and approve the content and (ii) comment accordingly.						
Links to Strategic Objectives	Achieving local excellence and global reach through compassionate and innovative healthcare, education and research. Patients - Putting patients at the heart of everything we do and providing care of the highest standards focussing on safety and quality. Partnerships - We will be an effective partner, developing and delivering integrated care and playing our part in local, regional, national and international programmes. 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)	<u>Strategic Objective: 1</u> Putting patients at the heart of everything we do. Providing care of the highest standard focussing on safety and quality. Strategic Risk Description: i) SO1.4 [NHS core standards]. ii) SO1.10 [Infections]						
Reports previously considered by	This is a bimonthly update to the Board on Healthcare Associated Infections (HCAI).						

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

HEALTHCARE ASSOCIATED INFECTIONS (HCAI) DIRECTOR OF INFECTION PREVENTION & CONTROL (DIPC) REPORT

EXECUTIVE SUMMARY

This paper provides bimonthly assurance to the Trust Board regarding Healthcare Associated Infections (HCAIs). The following key points are noted in the report:

- One neonatal MRSA bacteraemia was attributed to the Trust in December 2023 which takes the Trust total to three against a target of zero. Details of the investigation are provided within the report.

- Post Infection Reviews of healthcare associated blood stream infections (BSI) continue to collate key themes around acquisition. Intravascular devices and catheter associated UTI remain the main preventable causes of infection followed by complex surgical infections contributing to community and hospital associated gram-negative blood stream infection (GNBSI). Infection Prevention and Control staff (IPC), specialist teams and Clinical Boards are working together to implement improvement action plans with oversight from the IPC Operational and Quality Oversight groups.

- Key areas for improvement include IPC cascade training through Harm Free Care Leads and ensuring IPC actions are implemented through the Clinical Boards governance structures.

- The Antimicrobial Steering Group (AMSG) continue to provide governance and oversight relating to antimicrobial prescribing. A request for additional resource for senior clinical team support and data management had been previously submitted but requires further review and is being looked into by the AMSG chair and Clinical Board. This investment would ensure a robust governance process around compliance with audits, CQUIN and delivering national contracts.

- The process of implementing Patient Safety Incident Response Framework (PSIRF) principles and ICNet integration into IPC operations is underway.

RECOMMENDATIONS

The Board of Directors is asked to (i) receive the report and approve the content and (ii) comment accordingly.

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

HEALTHCARE ASSOCIATED INFECTIONS (HCAI) DIRECTOR OF INFECTION PREVENTION & CONTROL (DIPC) REPORT

1. KEY POINTS FOR NOVEMBER/DECEMBER 2023

This paper provides a bi-monthly overview to the Trust Board regarding the Healthcare Associated Infections (HCAI). This includes:

- Current performance against national HCAI reduction trajectories. This includes benchmarking with performance across Shelford Trusts.
- Overview of Trust actions and work streams to support HCAI monitoring and reduction strategies.
- Overview of the work undertaken to support antimicrobial stewardship.
- Trust assurance frameworks.
- A linear trend line (red) has been added to graphs in tables 1, 2, 5, 6, 9, 10 and 11 instead of the 24-month average to ensure representation of trend over a longer period when measuring infections with low numbers.

1.1 *Clostridioides difficile* Infections (CDI)

At the end of December 2023, a total of 111 cases were attributed to the Trust (86 cases Hospital Onset Healthcare Associated (HOHA); 25 cases Community Onset Healthcare Associated (COHA)) – see Table 1. This places the Trust under the national threshold (≤97) by 13 cases as shown in Table 2, and demonstrates an improved position compared to the same period last year. Month on month trend graphs are included in the Integrated Board Report.

Table 1: Number of CDI attributed to NUTH from January 2022 to December 2023.

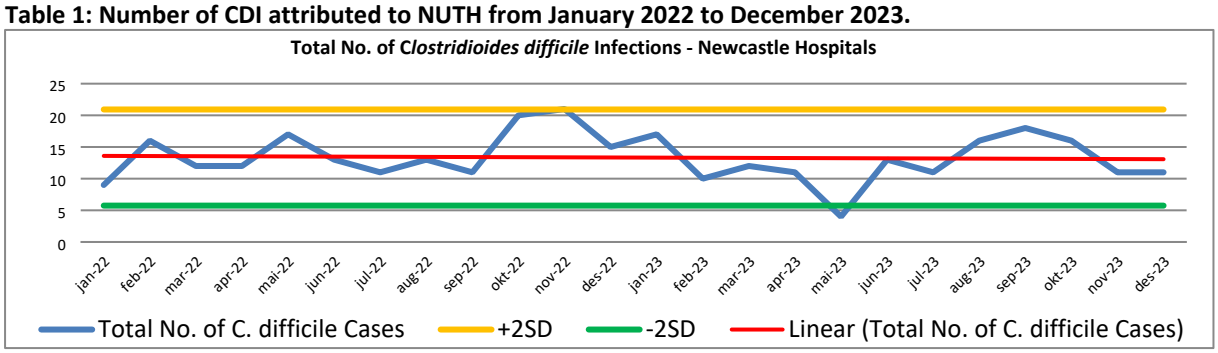
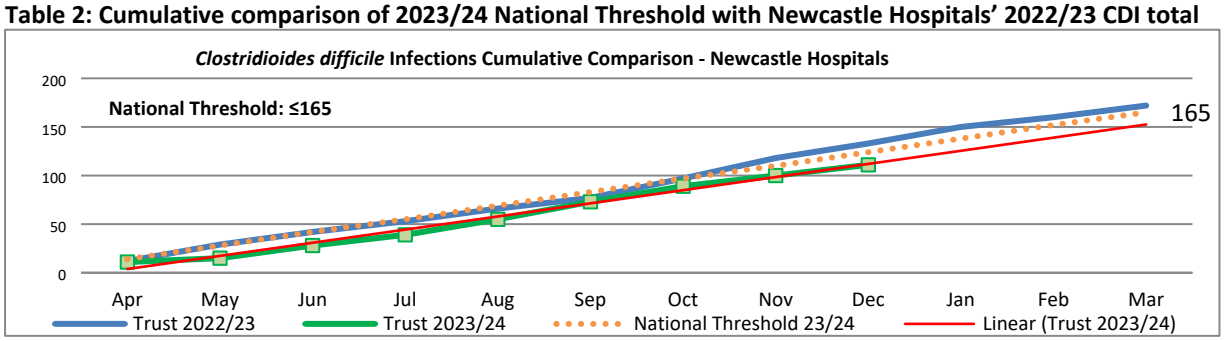


Table 2: Cumulative comparison of 2023/24 National Threshold with Newcastle Hospitals' 2022/23 CDI total



Tables 3 and 4 show the Trust's CDI infections compared with the Shelford Group for time periods between April 2022 and November 2023. Whilst there has been a reduction in CDI infections internally, the benchmark against the Shelford Group remains unchanged.

Table 3: CDI comparison data for Shelford group April – November 2023

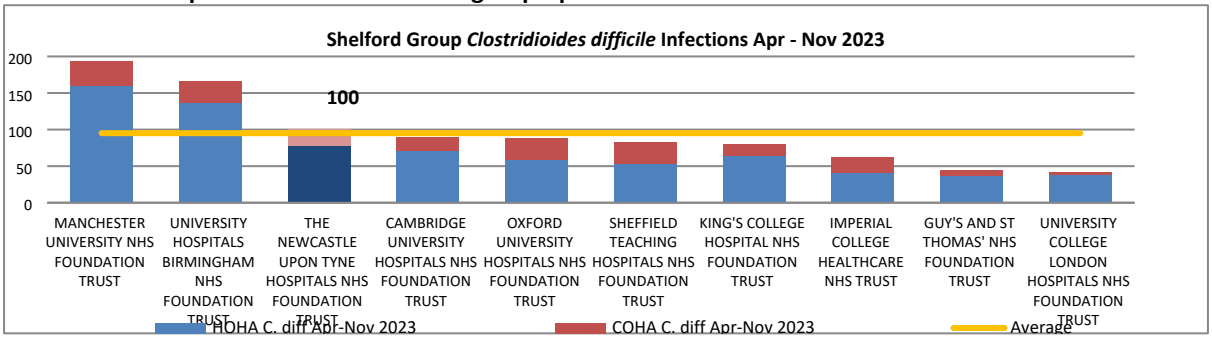
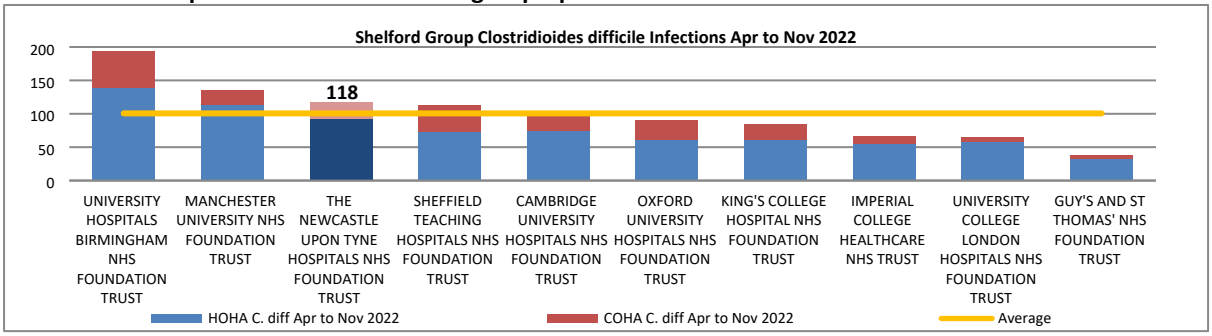


Table 4: CDI comparison data for Shelford group April – November 2022



Post infection reviews for CDI have identified various themes around documentation, isolation, sampling delays and antimicrobial prescribing practices. Lessons learnt from these reviews are incorporated into Clinical Board improvement action plans and reviewed at Quality Oversight groups with support from IPC/ AMS and Clinical teams.

1.2 MRSA / MSSA Blood stream infection (BSI)

The Trust had a further HOHA case of MRSA bacteraemia in December 2023 bringing the total to three cases. The main potential contributory factor for this case was unknown MRSA colonisation in family members which may have transmitted to the patient but was not identified on admission. Key learning outcomes from the post infection review were improve pathways around MRSA screening and decolonisation and improve compliance with antiseptic skin washes. Clinical Boards are working with IPC to ensure that action plans are completed, and learning disseminated appropriately to prevent further occurrences.

At the end of December, a total of 76 MSSA bacteraemia cases were attributed to the Trust (61 HOHA cases; 15 COHA cases). This places the Trust over our local trajectory by 8 cases (≤68 - no national threshold for MSSA), as outlined in table 5. Monthly trend graphs are included in the Integrated Board Report and performance against trajectories (table 6) and Shelford benchmarking (table 7) are included below for reference.

Table 5: Total MSSA Bacteraemia at Newcastle Hospitals January 2022- December 2023

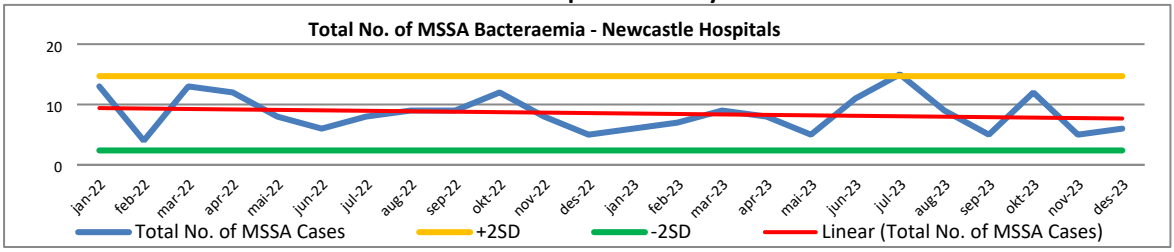


Table 6: MSSA cumulative comparison April 2022- end of March 2023 and April – October 2023

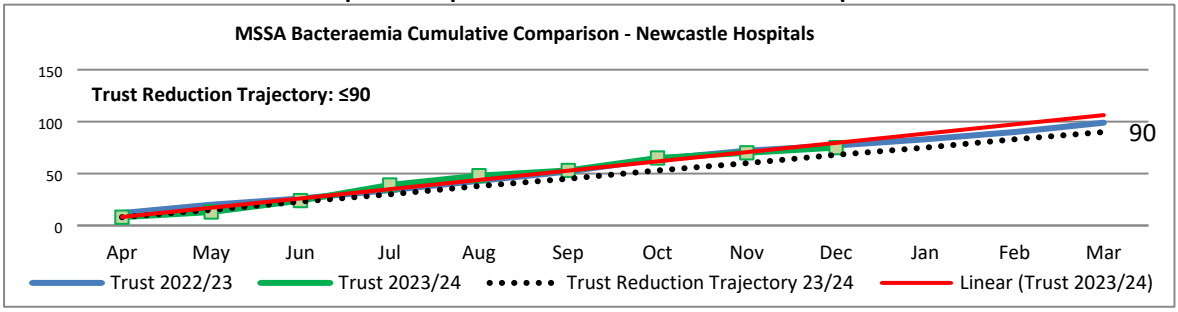
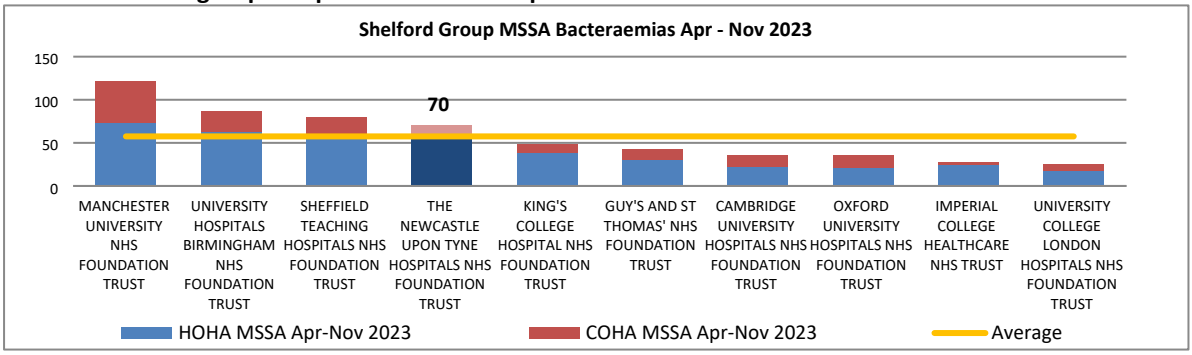


Table 7: Shelford group comparison for MSSA April – November 2023



Hospital associated BSIs continue to be reviewed by IPC teams to identify associated themes. Of the 11 MSSA BSI identified in November and December 2023, 7 were invasive device related. Of those, opportunities to improve both documentation and device management was identified in over half of the cases.

Targeted initiatives to improve device management including documentation are directed to clinical areas with high rates of infection with support from IV specialist teams. Practice is observed and audited, additional focused training is implemented and good practice recommendations are made to help with further training and continuous review. A line dashboard has been developed and is in testing phase. The dashboard will provide clear oversight on documentation compliance to clinical areas enabling a more proactive approach for education and support.

1.3 Gram Negative Blood stream infection BSI GNBSI (*E. coli,* Klebsiella, Pseudomonas aeruginosa)

Table 8 compares GNBI rates against national thresholds and as illustrated, numbers exceed current national trajectory. Tables 9, 10 and 11 illustrate in graph format performance against trajectory.

Table 8: The table(s) below outlines the Trust figures up to the end of December 2023

	E. coli	Klebsiella	Pseudomonas aeruginosa
Cumulative No. cases to end of December 2023	**193 cases**	**92 cases**	**37 cases**
National Threshold for December 2023	**≤142 Over by 51**	**≤98 Under by 6**	**≤37 Over by 9**

Table 9: Total *E. coli* bacteraemia April 2022- end of March 2023 and April – December 2023

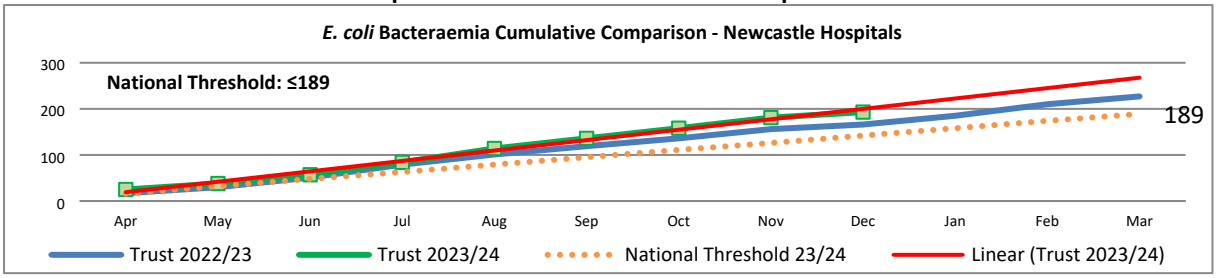


Table 10: Total Klebsiella bacteraemia April 2022- end of March 2023 and April – December 2023

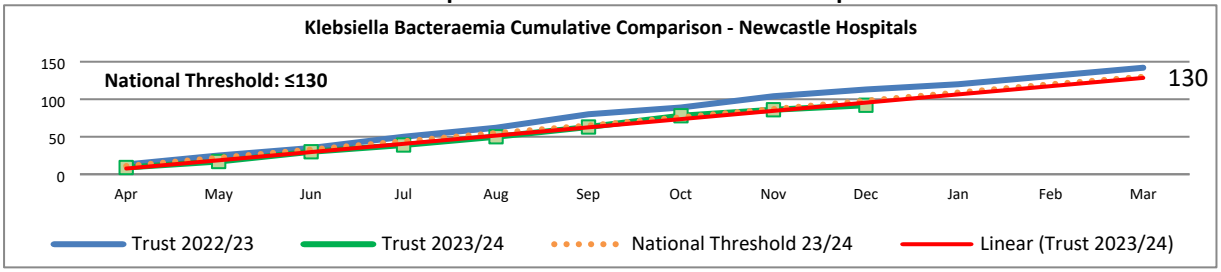
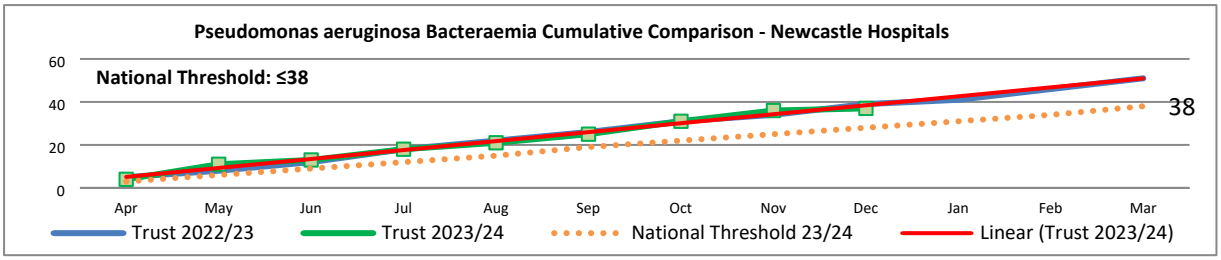


Table 11: Total Pseudomonas aeruginosa bacteraemia April 2022- end of March 2023 and April – December 2023



Urosepsis and complex hepatobiliary / surgical infections continue to be the primary sources for acquisition of GNBSI bacteraemia. IPC and continence specialists work collaboratively with clinical areas to improve continence care, bladder health and safe management of urinary catheters where further improvements can be made. Improvement actions are monitored by clinical boards with oversight and support provided by the Trust GNBSI group to improve practice and patient safety.

1.4 Incidence of Respiratory Viruses Including COVID-19

The number of COVID-19 HCAI cases reported in November 2023 (42 cases) and December

2023 (50 cases) was significantly less than in September and October 2023. The number of outbreaks declared over the same time also showed a decline from 10 to 8.

A seasonal increase in community Flu A correlated with the increase seen in the Trust resulting in an outbreak being declared at the end of December 2023. IPC and site operational teams continue to work together to ensure appropriate patient placement, but availability of cubicle capacity remains challenging. Issues are escalated in real time to minimise patient harm and maintain operational flow.

1.5 Incidence of viral diarrhoeas illnesses including Norovirus

There were 3 periods of increased incidence (PII) of diarrhoea and /or vomiting declared in November and December 2023 including a Norovirus outbreak resulting in some lost bed days. IPC and Clinical teams work together to ensure outbreaks are managed appropriately.

1.6 Surgical Site Infections (SSI) - Spinal Surgery

Quarter 3 (July-Sept 2023) saw 3 SSIs (0.9%) recorded at the RVI. This represents a significant decrease from that recorded for the 2nd quarter of 2023 (2.2%) and now falls below the national rate of 1.0%. Themes from reviews performed this quarter were patient non-compliance/adherence to guidance post discharge and delays seeking help from primary care providers. 2 out of the 3 patients who developed SSIs were domiciled outside the Newcastle Hospitals Trust area. Work is ongoing within the neurosurgical department nursing team in conjunction with the surveillance team and IPC to formulate a plan to improve compliance/understanding of the process that patients and primary care and referring hospitals should follow.

1.7 Patient Safety Incident Response Framework (PSIRF)

The phased implementation of PSIRF is on target for the end of January 2024.

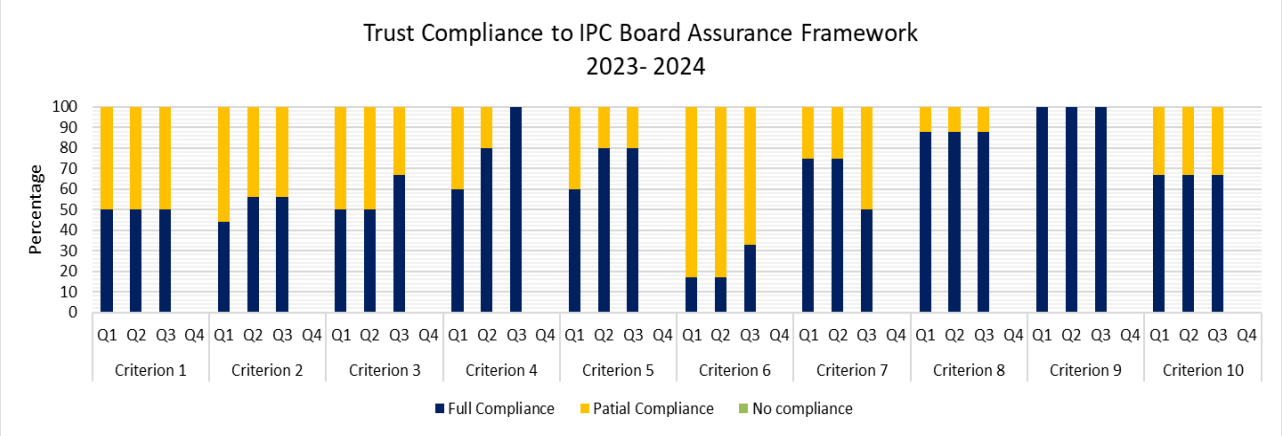
1.8 ICNet

Phase 1 of the ICNet software diagnostic tool went live on 11 December 2023. Currently, the IPCN team are running parallel surveillance systems to validate ICNet followed by full integration into IPC processes by March 2024.

1.9 IPC Board Assurance Framework (BAF)

Table 12 shows the Trust compliance to the IPC BAF by quarter. The Trust is fully compliant in 2 criterion and partially compliant in all others. There are no areas of non-compliance.

Table 12 – Trust Compliance to IPC BAF 2023/24

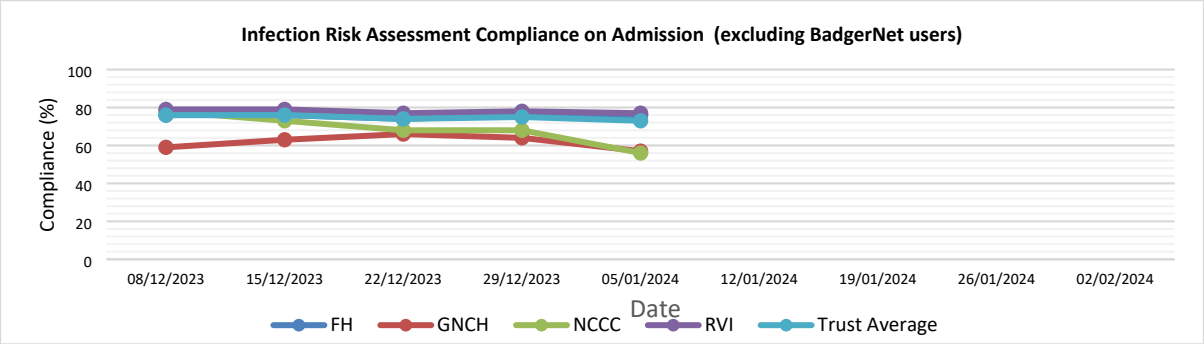


Each criterion, detailed in Table 12 is divided into subsections with key lines of enquiry. Partial compliance is determined by any single non-compliance point within a line of enquiry. There is a significant amount of cross over in criterion meaning that a gap in assurance can impact multiple areas of the BAF. Full details can be found in the full IPC BAF document and action log included in the Private BRP.

Key points of note for Quarter 3

- National Guidance for Carbapenemase-Producing Enterobacterales (CPE) a multi drug resistant gram-negative organism with significant risk of hospital transmission requires organisations to screen patients who have been in hospital in the last 12 months on readmission. The Trust has increased testing to improve compliance and reduce risk but is not able to achieve full compliance due to current lab capacity (Criterion 1, 5, 7, 8). The gap identified in CPE admission screening and the increasing concern over antimicrobial resistant organisms has led to a reassessment of our compliance level in relation to completing clinical risk assessments for this patient group. Criterion 7 has been adjusted to reflect this change. A review of laboratory testing capacity to improve compliance is underway.
- A multi-disciplinary task and finish group has been established to identify and implement improved cleanliness standards (Criterion 2).
- Phase 1 of ICNet, a software system for infection prevention surveillance, monitoring, will enable the IPCT to proactively support clinical areas to undertake local dynamic patient risk assessments to prevent/reduce and control infection transmission. Evidence of this is monitored through a reporting hub dashboard that has been extended to include a full infection risk assessment (Table 13). Once embedded, these systems will generate improved compliance across several criteria (Criteria 1,4,5,7,9).

Table 13 - Trust compliance to admission risk assessment documentation for IPC



- Due to outdated national training resources, a briefing paper is in the process of being drafted to propose that IPC mandatory training will be moved to an in-house model. This will ensure that the information reflects current practice (Criterion 1, 6)
- Criterion 3 largely relates to Antimicrobial Stewardship and as such is addressed in section 1.10 of this report.

1.10 Antimicrobial Stewardship (AMS)

The AMSG are progressing with projects and support IPC teams with interventional audits in areas with high CDI rates. Compliance with Take 5 audits which are undertaken to help identify any areas for proactive improvement, remains a concern and will be a standing item in Quality oversight groups to help drive key messages and improve compliance across Clinical Boards. The main Factor for poor compliance is competing workforce pressures and prioritisation of this work. This is being addressed by the AMSG chair with Clinical Board Chairs and Quality and Safety Leads.

The AMSG continue to provide governance around antimicrobial prescribing, but this requires continuous oversight from the AMS senior clinicians to provide strategic leadership. An investment proposal for senior clinical support has been submitted and is pending approval.

1.11 Staff Winter Vaccination Programme

The Trust Staff Vaccination programme is drawing to a close, however both COVID and flu vaccines are available from Occupational Health, Peer Vaccinators or a ‘pop-up’ clinic can be organised if requested from a Clinical Board.

As of 6 January 2024, 11,835 staff have received a flu vaccination (66%) and 9,359 staff received COVID vaccination (53%.). These levels are lower than last year however this lower uptake is reflective of the national picture. Of Trusts with a headcount of more than 10,000 the Trust has the greatest uptake in both COVID and flu vaccinations (data correct up to end of November 2023) which is a testament to the hard work undertaken by all of the staff within the programme. Work is still ongoing with workforce colleagues to cleanse the data and hopefully this will be seen with an increase in percentage uptake. The Newcastle Charities have also supported the programme in donating money per COVID vaccine delivered and this donation is being channelled into supporting staff who are experiencing financial hardships, and this should be acknowledged.

1.12 Water Ventilation and Decontamination

Trust Safety groups continue to oversee and provide assurance through the IPC Committee with actions implemented by the Operational groups.

2. RECOMMENDATIONS

The Board of Directors is asked to (i) receive the report and approve the content and (ii) comment accordingly.

Report of Maurya Cushlow
Executive Chief Nurse
25 January 2024

Dr Julie Samuel
Director of Infection Prevention & Control (DIPC)

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