MEETING OF THE BOARD OF DIRECTORS IN PUBLIC

Date: Wednesday 24th May 2023
Time: 9:30 am
Venue: Rooms 9&10, Education Centre/Teams

AGENDA

	TIME	ITEM	STATUS	PAPER
1.	9:30 am	**Welcome and Chair's Business**		
2.	9:33 am	**Declarations of Interest** To declare any pecuniary or non-pecuniary interests *Check – Attendees to declare any potential conflict of items listed on the agenda to the Company Secretary on receipt of agenda, prior to the meeting*	Declaration	Verbal
3.	9:34 am	**Apologies for Absence** *Quoracy check: (s3.3.31 SOs: No business shall be transacted at a meeting unless a minimum of **4** members of the Board (including at least **one** Non-Executive and **one** Executive Member of the Board are present)*	Agree	Verbal
4.	9:35 am	**Minutes of the meeting held on 29 March 2023** To be agreed as an accurate record	Agree	Enclosure 4
5.	9:40 am	**Matters Arising / Action Log**	Update	Enclosure 5
6.	9:45 am	**Patient & Staff Story** • Heart Failure Team	Assurance	Presentation
		ITEMS FOR DECISION		
7.	10.00 am	**Constitutional Amendment** To approve the amendment presented by The Company Secretary	Approval	Enclosure 7
8.	10:05 am	**Trust Strategic Aims and Objectives 2023/24:** To approve the aims and objectives presented by The Interim Director of Strategy, Planning and Partnerships	Approval	Enclosure 8
9.	10:15 am	**Enabling Strategies** To approve the EDI, Clinical and Finance strategies presented by the Chief Executive, Medical Director and Group Director of Finance and Digital	Approval	Enclosure 9
		ITEMS FOR ASSURANCE		
10.	10:35 am	**Assurance from Board Committees** i. Finance and Performance Committee – 25 April 2023 and 23 May 2023 (verbal) ii. Quality Governance Committee – 25 April 2023 iii. Digital Committee – 5 April 2023 iv. POD Committee – 9 May 2023	Assurance	Enclosure 10
11.	10:55 am	**Chief Executive's Update Report** i. **Thematic Review** To receive a briefing report from the Chief Executive	Assurance	Presentation
12.	11:15 am	**Governance Reports** i. **Organisational Risk Register** ii. **Risk Management Strategy** To receive the reports presented by the Chief Nurse	Assurance	Enclosure 12
13.	11:30 am	**Annual Planning Update** To receive the report, presented by the Group Director of Finance and Digital	Assurance	Enclosure 13

14.	11:40 am	**Integrated Oversight Report** To receive the report, presented by the Chief Operating Officer, Chief Nurse, Medical Director and Executive Director of People and Organisational Development	Assurance	Enclosure 14
15.	11:55 pm	**Nurse Staffing Monthly Exception Report & Bi-Annual Safe Staffing Review Report** To receive the report, presented by the Chief Nurse	Assurance	Enclosure 15
16.	12:05 pm	**Maternity Update** i. **Maternity Integrated Oversight Report** To receive the report, presented by the Chief Nurse	Assurance	Enclosure 16
17.	12:15 pm	**Learning from Deaths 6 Monthly Report** To receive the report, presented by the Medical Director	Assurance	Enclosure 17
18.	12:25 pm	**SIRO Report and Digital Update** To receive the report, presented by the Chief Information Officer		WITHDRAWN
		ITEMS FOR INFORMATION		
19.	12:35 pm	**Cycle of Business** To receive the cycle of business outlining forthcoming items for consideration by the Board, presented by the Company Secretary	Information	Enclosure 19
20.	12:40 pm	**Questions from Governors in Attendance** To receive any questions from governors in attendance		Verbal
21.	12:50 pm	**Date and Time of the next Meeting** The next scheduled meeting of the Board of Directors to be held in public will be Wednesday 26th July 2023 at 9:30am		Verbal
22.	12:50 pm	**Chair Declares the Meeting Closed**		Verbal
23.	12:50 pm	**Exclusion of the Press and Public** To resolve to exclude the press and public from the remainder of the meeting, due to the confidential nature of the business to be discussed		Verbal

Trust Board

Minutes of a meeting of the Board of Directors
held at 9.30 am on Wednesday 29th March 2023, in
Rooms 9&10, Education Centre, Queen Elizabeth Hospital and via MS Teams

Present:	
Mrs A Marshall	Chair
Mrs J Baxter	Chief Operating Officer
Mr A Beeby	Medical Director
Dr R Bonnington	Non-Executive Director
Mrs L Crichton-Jones	Executive Director of People & OD
Mrs T Davies	Chief Executive
Dr G Findley	Chief Nurse
Cllr M Gannon	Non-Executive Director
Mrs K Mackenzie	Group Director of Finance and Digital
Mr A Moffat	Non-Executive Director
Mrs H Parker	Non-Executive Director
Mrs M Pavlou	Non-Executive Director
Mrs A Stabler	Non-Executive Director
In Attendance:	
Mrs J Boyle	Company Secretary
Mrs L Heelbeck	Head of Midwifery (23/58 & 23/71)
Mr T Pratt	Associate Director QE Facilities (23/72)
Mr G Rowlands	Freedom to Speak Up Guardian (23/74)
Mr K Sohanpal	Equality, Diversity Inclusion & Engagement Manager (23/73)
Ms D Waites	Corporate Services Assistant
Governors and Members of the Public:	
Mr G Main	Public Governor – Western
Mr G Riddell	Public Governor – Western
Apologies:	
Mr M Robson	Vice Chair / Non-Executive Director
Mr A Robson	Managing Director QE Facilities

UNCONFIRMED

Agenda Item	Discussion and Action Points	Action By
23/53	**CHAIR'S BUSINESS:** The meeting being quorate, Mrs A Marshall, Chair, declared the meeting open at 9.30 am and confirmed that the meeting had been convened in accordance with the Trust's Constitution and Standing Orders. She welcomed those present including the Trust's Governors and Mrs T Davies to her first publicly-held Board meeting as Chief Executive.	
23/54	**DECLARATIONS OF INTEREST:** Mrs A Marshall requested that Board members present report any revisions to their declared interests or any additional declaration of interest in any of the items on the agenda.	

Agenda Item	Discussion and Action Points	Action By
23/55	**APOLOGIES FOR ABSENCE:** Apologies for absence were received from Mr M Robson and Mr A Robson.	
23/56	**MINUTES OF THE PREVIOUS MEETING:** The minutes of the meeting of the Board of Directors held on Wednesday 25th January 2023 were approved as a correct record following a minor amendment in relation to minute reference 23/14 Nurse Staffing Exception Report whereby the last sentence relating to Healthcare Assistants will be deleted.	
23/57	**MATTERS ARISING FROM THE MINUTES:** The Board action log was updated accordingly.	
23/58	**PATIENT STORY – MATERNITY VOICES** The Board welcomed Leanne Lynn and her baby boy, Tommy, to the meeting where she shared her pregnancy journey and involvement in the Maternity Voices Partnership programme which provides service users the opportunity to visit the department and share information and feedback to support the development of services. Mrs L Heelbeck, Head of Midwifery, explained that work is being developed around individualised care in response to the Care Quality Commission survey and Mrs A Stabler, Non-Executive Director, highlighted that teams are working with mothers to develop a leaflet around reasonable adjustments and plans are in place to provide single rooms as part of the estates development. Mrs Marshall thanked Ms Lynn for attending the Board to share her experiences.	
23/59	**CONSTITUTIONAL AMENDMENT:** Mrs J Boyle, Company Secretary, presented the report which seeks Board approval for a constitutional amendment to adjust the out-of-area constituency to be coterminous with the North East and North Cumbria Integrated Care System (NENC ICS). She explained that the proposed amendment fits with the role of the Board and Council of Governors to now consider the public at large across the entire ICS when decisions are made and enables the public within the ICS area to become members of the Trust, governors and also to apply for Non-Executive Director posts. In this regard it would therefore increase the opportunities to secure high calibre and diverse	

UNCONFIRMED

Agenda Item	Discussion and Action Points	Action By
	candidates as part of any forthcoming Non-Executive Director recruitment. The recommendation has been approved by the Council of Governors at its recent meeting on 15 February 2023 and will also be presented at the Annual Members Meeting however will be amended in advance of the meeting in September 2023. Mrs A Stabler, Non-Executive Director, queried whether other trusts were also making the adjustments in line with the ICS area and Mrs Boyle confirmed that a number of other organisations have implemented a "rest of England" constituency. After consideration, it was: **RESOLVED:** to approve the amendment to Annex 1 (d) to make the out-of-area constituency coterminous with the NENC ICS area.	JB
23/60	**ANNUAL DECLARATIONS OF INTEREST:** Mrs J Boyle, Company Secretary, presented the Annual Declaration of Board Members Interests, Gifts and Hospitality in accordance with section 20 of Schedule 1 of the Health & Social Care (Community Health and Standards) Act 2003 whereby NHS Foundation Trusts are required to maintain a register of Directors' and Governors' interests. This requirement is also enshrined in section 10 of the Trust's Constitution. Mrs Boyle reported that the register for Gateshead Health NHS Foundation Trust is held at Trust Headquarters and is available to the public through the Company Secretary and highlighted that interests have been declared in accordance with the Trust's Managing Conflicts of Interest Policy. This is also aligned to the model policy issued by NHS England. All Board Members must make an annual declaration and are required to make subsequent in-year declarations to record any changes in interests. Mrs Boyle highlighted that this also includes the declaration of interest for Mrs Trudie Davies, Chief Executive, as a new Board member. Mrs Marshall noted that the declaration of Board members of QE Facilities should also be included and this will be added for Mrs Maggie Pavlou. Following consideration, it was: **RESOLVED:** i) to approve and record in the Board minutes the declared interests subject to the above amendment ii) to note that the next annual review of the declaration of Board members' interests will take place in March 2024.	DW

UNCONFIRMED

Agenda Item	Discussion and Action Points	Action By
23/61	**TRUST STRATEGIC AIMS AND OBJECTIVES:** Mrs J Boyle, Company Secretary, provided assurance to the Board over the closing position of the strategic objectives for 2022/23 and presented the draft strategic objectives for 2023/24, which suggests an approach to develop the final objectives for ratification at Trust Board in May 2023. She reminded the Board that an update on the delivery of the corporate objectives was presented in January 2023 and the report summarises the progress made towards the delivery of the actions which in turn support the delivery of the strategic objectives. The Board noted that they have been reviewed by the relevant Board committee and assurance is provided that any strategic objectives which have not been fully delivered will be carried forward into 2023/24. In respect of this, Mrs J Baxter, Chief Operating Officer, highlighted that a benefits realisations report is due to be presented to the next Finance and Performance Committee in relation to Strategic Objective SA3.1 around the delivery of the New Operating Model. Mrs Boyle informed the Board that the Executive Team members have reviewed the 11 strategic objectives and propose that they remain relevant for 2023/24 and align to the Corporate and enabling strategies therefore the draft action plans are presented in Appendix 2 of this report, Agenda Item 9. It is therefore proposed that a Board session is held in April 2023 to allow the final draft of the strategic objectives to be developed and ensure the actions and outcome measures fully align across all objectives and Board committees. The final objectives will then be brought back for ratification at the Board meeting in May 2023. Following discussion, it was: **RESOLVED:** i) to review the accompanying action plans and the summary contained within this report, approving the year-end closing position for the strategic objectives and being assured that remaining actions will continue to be progressed. ii) to agree the approach to hold a Board session in April to review the strategic objectives for 2023/24.	JB
23/62	**ENABLING STRATEGIES:** Mrs J Boyle, Company Secretary, presented the enabling strategies for Communications, Quality and People for final ratification following the Board strategy session which was held with Senior Management colleagues on 9th February 2023. She drew attention to the report which highlights the key updates which have been made to each strategy and explained that the remaining strategies including Equality, Diversity and Inclusion; Clinical; Estates;	

UNCONFIRMED

Agenda Item	Discussion and Action Points	Action By
	and Finance are currently being updated and will be presented to the May Board for ratification. Following consideration, it was: **RESOLVED:** to accept the changes to the strategies presented and approve with agreement that these can be launched.	JB
23/63	**BOARD ASSURANCE FRAMEWORK 2022/23 AND 2023/24** Mrs J Boyle, Company Secretary, presented the report which provides the Board with the Board Assurance Framework (BAF) 2022/23 for review at the year-end, following scrutiny by each of the mapped Board committees. It also provides a proposed plan for the development and review of the BAF for 2023/24. Mrs Boyle reported that the closing position of the BAF demonstrates that there has been active utilisation and update of the BAF throughout the year and highlights that 3 target scores have been met. She informed the Board that for the remaining 8 areas, the target scores have not been reached however the BAF demonstrates active work around the strengthening of controls and assurances in most areas. It is proposed that the strategic objectives for 2023/24 remain broadly consistent with 2022/23, with the actions and outcome measures being reviewed and revised to support delivery. This will include the removal of any closed risks and will be further discussed as part of the Board strategy and development session in April 2023. Mrs Marshall highlighted that the current risk score for Strategic Objective 3.1 has been increased to 16 however will be addressed via the benefits realisation report being developed in relation to the New Operating Model. Mrs A Stabler, Non-Executive Director, queried whether Strategic Objective 5.1 which relates to utilising skills and expertise beyond Gateshead, should be increased however Mrs Marshall indicated that this should be addressed within the commercial strategy however can be discussed further at the next Board strategy and development session. Mrs Stabler also felt that it would be beneficial to review governance processes. After further discussion, it was: **RESOLVED:** i) to review and approve the closing position of the BAF for 2022/23, noting that it has been under continuous review and update at the relevant Board committees. ii) to approve the planned approach for the BAF development and review for 2023/24.	JB

UNCONFIRMED

Agenda Item	Discussion and Action Points	Action By
23/64	**ASSURANCE FROM BOARD COMMITTEES** **Finance and Performance Committee (F&P):** Mrs A Marshall, presented the report on behalf of the Chair of the F&P Committee, and provided a verbal update on the meeting yesterday (28 March 2023) and reported that there were no items to escalate. The meeting focussed on the following areas: • A review of the Integrated Oversight Report took place and work is being undertaken to provide a more concise and exception-based report to Board. • New Operating Model benefits realisation report to be presented at next meeting. • Priority areas have been identified by the Executive Team in relation to length of stay and productivity and the impact on other issues relating to flow, etc. • A deterioration was noted in relation to the 62 day cancer waits and ambulance waits. • The echocardiology action plan was discussed which highlights increased productivity and the Board acknowledged the hard work which has been undertaken by the team. • The monthly finance report was received and will be discussed later in the meeting • Discussion took place around the Annual plan and forecasted deficit • Cost Reduction Programme accountability framework to come back next to Committee next month for discussion. • Supply Procurement Committee report was received which demonstrates good assurance of processes. • An Audit One report was received on the audit of the A&E 4 hour wait time and the 62-day cancer wait time performance and substantial assurance noted. **Quality Governance Committee (QGC):** Mrs A Stabler, Chair of QGC, provided a brief verbal overview to accompany the narrative report following the February 2023 meeting and highlighted that there were no items for escalation. She drew attention to the following key points: • The Committee received the Mental Health Act Policy and some issues have been raised in relation to prone restraint. A task and finish group has been established and discussions have taken place at the QE Facilities Board and an approach has been agreed in relation to additional training. **Digital Committee** Mr A Moffat, Chair of the Digital Committee, provided a brief verbal overview to accompany the narrative report following the February 2023 meeting and reported that there were no items for escalation. He highlighted the following key points:	

UNCONFIRMED

Agenda Item	Discussion and Action Points	Action By
	• The Committee approved the clinical systems strategy and a full business case will be presented at the next meeting. • Discussion took place on the progression made against Key Performance Indicators, in particular compliance in relation to Information Asset Owners and the Information Risk Management Programme and these will be escalated to the newly formed Compliance Group • A recent limited assurance Change Management report highlights two actions as high priority and one as medium therefore work is ongoing to address these. **People and Organisational Development (POD) Committee** Dr R Bonnington, Chair of the POD Committee, provided a brief verbal overview to accompany the narrative report following the March 2023 meeting and reported that there were no items for escalation. Discussion took place around the proposed rescheduling of Committee meetings and advice was provided around the time of finance and performance data however it was felt that this required further consideration. Mrs A Stabler, Non-Executive Director, raised a query in relation to the Clinical Excellence Awards and the allocation process and Mr A Beeby, Medical Director, explained that this was in line with national direction however should be returning to the pre-Covid process to ensure fairness. **Audit Committee** Mr A Moffat, Chair of the Audit Committee, provided a brief verbal overview to accompany the narrative report following the March 2023 meeting and reported that there were no items for escalation. He highlighted the following key points: • The Committee received the Internal Audit Progress Report and acknowledged that there were 8 recommendations currently overdue however it was noted that a considerable amount of work has been undertaken to ensure revised target dates are not exceeded. • There have been two additional internal audit work programmes agreed in relation to the review of QE Facilities procurement and the governance of capital and pay expenditure. Further discussion around these will take place in Part 2 of the Board. Mrs Marshall thanked the Committee Chairs for their reports. After consideration, it was: **RESOLVED**: to receive the reports for assurance	Exec
23/65	**CHIEF EXECUTIVE'S UPDATE REPORT**	

UNCONFIRMED

Agenda Item	Discussion and Action Points	Action By
	Mrs T Davies, Chief Executive, gave an update to the Board on current issues which have aligned to the Trust's Strategic Aims. She drew attention to the following updates: • Strategic Aim 1 exceptions re. Blaydon Urgent Treatment Centre which is currently operating on reduced opening hours due to staffing pressures. Mrs Davies highlighted that the Trust is working on a plan to address the challenges and prevent future closures. • Length of stay greater than 21 days – highlighted as an issue within the Integrated Oversight Report and the Trust is working with partners to improve productivity. • Strategic Aim 5 relates to developing and expanding services within and beyond Gateshead. Mrs Davies highlighted that Jacqui Rock, Chief Commercial Officer at NHS England, recently visited the Trust's Pathology Centre and provided positive feedback. • Mrs Davies informed the Board that Caroline Tweedie, Specialist Breast Care Nurse, won the Innovation Champion Award at this year's Bright Ideas in Health Awards and the Board congratulated her on her achievement. **RESOLVED:** to receive the report for assurance.	
23/66	**GOVERNANCE REPORTS** **Organisational Risk Register (ORR)** Dr G Findley, Chief Nurse, presented the updated ORR to the Board, noting that it is now received at the weekly Executive Team Meeting and monthly Executive Risk Management Group (ERMG) now chaired by Mrs T Davies, Chief Executive. This report covers the period 15th January 2023 to 15th March 2023. She highlighted that two risks have been added to the ORR following agreement at ERMG. These relate to health record systems and maintaining business continuity of services and recovery plans. One risk has been added in relation to out of date policies however Mrs Findley acknowledged the extensive work being undertaken to bring this under control. One risk has been reduced and five risks have been removed from the ORR. Following a query in relation to risk ratings and achievement of actions, Dr Findley highlighted that detailed discussions take place at the ERMG to ensure mitigations are in place. The meeting will now take place on a monthly basis. **RESOLVED:** to receive the report for assurance. **Well-led Peer Review Action Plan:** Mrs J Boyle, Company Secretary, provided the Board with an update on progress against the remaining actions on the action plan and reported	

UNCONFIRMED

Agenda Item	Discussion and Action Points	Action By
	that there are an increased number of completed actions with only 2 out of 43 actions remain outstanding. These relate to updating the Scheme of Delegation and Standing Financial Instructions and ensuring appropriate accountability and responsibility for data quality. Mrs Boyle highlighted that it is therefore proposed that the remaining actions are monitored as part of the work of the Audit and Digital Committees, both of which have a clear escalation route to Board and Mr A Moffat, Chair of the Committees confirmed that he was comfortable with this approach. It was therefore: **RESOLVED:** to receive the report for assurance.	
23/67	**ANNUAL NHS STAFF SURVEY RESULTS:** Mrs L Crichton-Jones, Executive Director of People and Organisational Development, provided the Board with an overview of the 2022 Annual Staff Survey results. She reported that the actions from the survey will be aligned to the Trust's People Plan which is overseen by the People and Organisational Development (POD) Committee and will also align with the Trust's Strategic Objectives. The POD team will ensure local results are cascaded through local management channels and Mrs Crichton-Jones thanked staff for completing the survey and the work being undertaken to progress key areas of focus for 2023. The Board noted the key themes from the results and Mrs Crichton-Jones drew attention to the new areas of focus which includes raising concerns and taking action and highlighted that work is ongoing to implement Freedom to Speak Up champions. An interactive dashboard has also been introduced for this year's results which allows managers to interact with their data and a guide has been produced around this which has also been recognised by NHS England as a good practice model. The Board acknowledged the good results and Mrs T Davies, Chief Executive, thanked everyone for their contribution. She felt that it was important for all levels, including the Board, to consider the impact of effective leadership and engagement and Mrs Crichton-Jones reported that the action plan will come back to review progress. Following a query from Mr A Moffat, Non-Executive Director, in relation to departmental processes, Mrs Crichton-Jones explained that the Organisational Development leads are working with the Business Units around the action plan and will be reviewed by the Business Unit Oversight meetings and Senior Management Team. After further discussion, it was:	LCJ

UNCONFIRMED

Agenda Item	Discussion and Action Points	Action By
	RESOLVED: to consider the results of the survey for 2022 and note the progress to date and plans surrounding key areas of focus for 2023.	
23/68	**FINANCE UPDATE:** Mrs K Mackenzie, Group Director of Finance and Digital, provided the Board with a summary of performance as at 28th February 2023 (Month 11) for the Group (inclusive of Trust and QE Facilities, excluding Charitable Funds). She reported that for this period, the Trust has reported an adverse variance of £95k from the Trust's revised financial target of breakeven and highlighted that this relates to cost including additional beds and high cost drugs. Key negotiations are taking place in relation to additional funding however commissioners have accepted a breakeven position therefore the Trust is not required to deliver the original planned £1.6m surplus. The Board thanked the team for their hard work in relation to difficult discussions and Mrs Mackenzie highlighted that the finance team are now fully established therefore further focus will take place in relation to transformation, financial sustainability and productivity analysis. Following consideration, it was: **RESOLVED:** to receive the report and note assurance as a direct consequence of the reported year to date position.	
23/69	**INTEGRATED OVERSIGHT REPORT:** Mrs J Baxter, Chief Operating Officer, Dr G Findley, Chief Nurse, Mr A Beeby, Medical Director, and Mrs L Crichton-Jones, Executive Director of People and Organisational Development, introduced the Integrated Oversight Report (IOR) for January and February 2023. The paper has been discussed and received in-depth scrutiny by the various Board Committees. Mrs Baxter reminded the Board that the report is currently being reviewed to focus on key items. She therefore drew attention to the following updates in relation to Effective and Responsive performance targets: • The Trust was top performing Trust in the region for 30-60 minute ambulance handovers and 4th for 60 plus minute delays. • The Trust has a zero tolerance in relation to trolley waits however this was unable to be prevented during the month due to significant pressures within the department	

UNCONFIRMED

Agenda Item	Discussion and Action Points	Action By
	• There is a continued focus on clinical prioritisation for cancer performance and increasing capacity to reduce patient backlogs and waiting times Dr Findley provided an update on the following Safe performance targets: • There have been two serious incidents reported in February and are under investigation. There have been no never events in the past 18 months • There have been 34 Healthcare associated Clostridioides difficile infection (CDI) cases since April 2022 against the CDI threshold for 2022/23 of 32 with 8 in February (5 hospital and 3 community). Dr Findley reported that these are being validated and feedback will be provided. Following a query from Mrs Crichton-Jones in relation to NHS England thresholds, Dr Findley explained that this is challenging target however the Trust is performing well. Mr Beeby provided an update in relation to Effective performance targets: • The Trust Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital Level Indicator (SHMI) shows deaths within the expected range. • There was an improvement in the average number of long stay patients in February 2023. Mrs Crichton-Jones provided an update in relation to Well Led performance targets: • Sickness absence rates have decreased, recognising the work being undertaken around the new approach to absence management. • Core training performance has improved however continues to be an area of focus via the Business Unit oversight meetings. • Progress is also being made in relation to the Trust's vacancy rate and is consistent with the current recruitment activity. Mrs T Davies, Chief Executive, queried whether there was any evidence of an increase in hospital infections due to patients staying longer in hospital. Mrs Baxter highlighted that this could be looked at however Dr Findley explained that there was no evidence of patient harm. Mrs A Stabler, Non-Executive Director, queried whether the reduction in escalation beds would also impact on patient safety and staff well-being and Mrs Davies felt that it was important to focus on transformation and partnership working to optimise flow. Mrs Stabler highlighted that discussions had taken place at the recent Patient Safety Conference in relation to some wards having team appraisals and felt that this would be a good way forward. Mrs Crichton-	

UNCONFIRMED

Agenda Item	Discussion and Action Points	Action By
	Jones reported that this has been discussed within the business units and an update will be provided in the next report. Mr A Moffat, Non-Executive Director, queried whether training plans reconciled with the staff survey results and Mrs Crichton-Jones explained that a training needs analysis exercise was being undertaken across the organisation. The Board acknowledged the work being undertaken to address the pressures impacting on the Trust's performance and after consideration, it was: **RESOLVED:** to receive the report for assurance acknowledging the workforce challenges, impact on activity recovery, long waiting times and performance.	
23/70	**NURSE STAFFING EXCEPTION REPORT:** Dr G Findley, Chief Nurse, presented the report for February 2023 which provides an exception report for nursing and midwifery staffing, including healthcare support workers, and provides assurance of ongoing work to triangulate workforce metrics against staffing and care hours. Dr Findley reported that February has continued with ongoing staffing challenges compared to January. The Trust continues to experience periods of increased patient activity with surge pressure resulting in escalation areas alongside managing delays in transfers of care. This has affected staffing resource and the clinical operating model, which is supportive of maintaining elective recovery. Staffing challenges remain due to nursing vacancies however focused work continues around the recruitment and retention of staff and managing staff attendance. Validation work is being undertaken and feedback will be provided to the Executive Team prior to Board discussion. Mrs A Stabler, queried whether a position report was available following the last six-monthly report to support the recommendations around nursing gaps and Dr Findley explained that work will continue to recruit to vacancies however an assessment for any additional posts will be worked on following the relevant governance processes therefore a report will follow as appropriate. Following discussion, it was: **RESOLVED:** to receive the report for assurance and note that work is being undertaken to address the staffing shortfalls.	
23/71	**MATERNITY UPDATE:** **Maternity Integrated Oversight Report:** Mrs L Heelbeck, Head of Midwifery, presented a summary of the maternity indicators for the Trust.	

UNCONFIRMED

Agenda Item	Discussion and Action Points	Action By
	She drew attention to guidance received from the Royal College of Midwives in relation to minimising time weighted exposure to nitrous oxide in health settings in England and Dr G Findley, Chief Nurse explained that immediate actions have been taken with colleagues from QE Facilities and a risk has been added to the Organisational Risk Register for review. Mrs L Crichton-Jones, Executive Director of People and OD, felt that it would be beneficial to discuss this with the Joint Consultative Committee to ensure trade unions are aware. Mrs Heelbeck also informed the Board that the Maternity Dashboard is being aligned to the regional North East and North Cumbria Local Maternity and Neonatal Systems dashboards and work is being undertaken via the Integrated Care Board. Therefore a review is being made of the current dashboard with the Performance team to ensure the same data is being collected. The new dashboard will be included in reports going forward however this will not include statistical process control charts. After consideration, it was: **RESOLVED:** to receive the report for assurance. Mrs Heelbeck left the meeting.	
23/72	**TRUST GREEN PLAN ANNUAL UPDATE:** Mr A Pratt, QE Facilities Associate Director, provided the Board with an update on the progress being made against the actions within the Green Plan and drew attention to the key areas of focus going forward. The Board recently completed their carbon literacy training and Mr Pratt highlighted that it is important to ensure that the vision and objectives within the Trust's Green Plan are met however this requires increased levels of organisational engagement. Discussion took place around increased promotion of the plan via social media pages and recruitment and Mrs L Crichton-Jones, Executive Director of People and OD, suggested using existing engagement groups and will ask a member of the POD team to contact Mr Pratt for discussion. After further consideration, it was: **RESOLVED:** to receive the report for assurance and note the progress against the Trust's Green Plan. Mr Pratt left the meeting.	LCJ
23/73	**EQUALITY, DIVERSITY AND INCLUSION (EDI) SIX MONTHLY UPDATE:**	

UNCONFIRMED

Agenda Item	Discussion and Action Points	Action By
	Mr K Sohanpal, EDI and Engagement Manager, provided the Board with assurance over the progress undertaken in 2022/23 following the goals which were established in 2021. Mr Sohanpal drew attention to the focus for 2023/24 which will be the delivery of the EDI Strategy and highlighted that recommendations from all mandatory reporting will be incorporated into the EDI action plan where a further update will be outlined in the next report in September 2023. This work will be led by the Human Rights Equality, Diversity and Inclusion Board which reports into the People and Organisational Development Committee. The Board acknowledged the work being undertaken and highlighted their commitment to drive this forward. Mrs A Marshall, also reported that there will be focus on equality and diversity around the forthcoming Non-Executive Director recruitment process. Mr Sohanpal will also provide support to engage with community groups around the position. Following discussion, it was: **RESOLVED:** to receive the report for assurance, noting the current position and risks. Mr Sohanpal left the meeting.	
23/74	**FREEDOM TO SPEAK UP GUARDIAN REPORT:** Mr G Rowlands, Freedom to Speak Up Guardian (FTSUG), provided an update of FTSU activity from September 2022 to 13th March 2023. Updates are also provided to the People and OD Committee and Group Audit Committee. Mr Rowlands reported that four higher risk concerns are currently under investigation and provided assurance that these have oversight within the Executive and Senior Operational teams. The Trust's FTSU policy is currently being adapted from the National FTSU Policy from NHS England and is due to be ratified in April 2023. Following a query from Mr A Moffat, Non-Executive Director, in relation to the risk ratings, Mrs L Crichton-Jones, Executive Director for People and OD, provided assurance that discussions are taking place to address the risks however it is important that the new FTSU mandatory training is completed by all staff including Board members to ensure greater understanding of the processes. After consideration, it was: **RESOLVED:** to receive the report for assurance. Mr Rowlands left the meeting.	

UNCONFIRMED

Agenda Item	Discussion and Action Points	Action By
23/75	**CYCLE OF BUSINESS:** Mrs J Boyle presented the cycle of business for the new financial year 2023/24 for review and approval. She explained that it follows a similar pattern to the previous year and will ensure that Board Committees' cycles of business align to the Board cycle to ensure appropriate and timely flows of assurance were relevant. The Board are therefore encouraged to review the cycle of business ahead of the next meeting in May 2023 and it was: **RESOLVED:** to review and approve the cycle of business for 2023/24.	
23/76	**QUESTIONS FROM GOVERNORS IN ATTENDANCE:** Questions were received in advance of the meeting from Mr Steve Connolly as below: Mr Connolly's first questions related to his recent visit to the Chemo Day Unit and sharing his findings with the Senior Team. He queried whether discussion had taken place regarding the refurbishment of the reception area and also the purchase of another fridge for the unit. Dr G Findley, Chief Nurse, responded to this by informing the Board that feedback has been shared with the senior team and they provide their full support and empowerment to the matrons in the Chemo Day Unit to take the steps they feel are required to improve the experience for our patients and colleagues. This will also be raised at the Charitable Funds Committee to provide some short-term solutions and will feed into those discussions. His second question related to the PLACE visits and his suggestion to provide PLACE Volunteers with an incentive, such as a free tea/coffee, before the visit and a free lunch after the visit. Dr Findley responded by acknowledging that the visits work very well and thanked those involved. It was agreed that tea and coffee should be offered during the process and the valuable work undertaken by our volunteers was also acknowledged. Gill highlighted that the Trust will be arranging a full celebration event for our volunteers as part of Volunteers Week to recognise their work across the Trust and to say thank you.	
23/77	**DATE AND TIME OF THE NEXT MEETING:** The next meeting of the Board of Directors will be held at 9:30am on Wednesday 24th May 2023.	

UNCONFIRMED

Agenda Item	Discussion and Action Points	Action By
23/78	**CLOSURE OF THE MEETING:** Mrs Marshall declared the meeting closed.	
23/79	**EXCLUSION OF THE PRESS AND PUBLIC:** **RESOLVED:** to exclude the press and public from the remainder of the meeting due to the confidential nature of the business to be discussed	

UNCONFIRMED

PUBLIC BOARD ACTION TRACKER

Colour	Meaning
Dark blue	Not yet started
Purple	Started and on track no risks to delivery
Amber	Plan in place with some risks to delivery
Red	Off track, risks to delivery and or no plan/timescales and or objective not achievable
Green	Complete

Agenda Item Number	Date of Meeting	Agenda Item Name	Action	Deadline	Lead	Progress	RAG-rating
22/139	27/09/2022	Risk Management Strategy	To come back to Board for approval at future meeting	31/12/2022	GF	To be reviewed with enabling strategies in February. It was felt that the risk management policy should sit above this and will be discussed at Audit Committee. March 23 – a draft risk management strategy has been developed and is currently being consulted on. This included being shared with Audit Committee. This will be presented to Board following the consultation process – expected at May Board	Purple
23/12	25/01/2023	Integrated Oversight Report	Duty of candour compliance – proposed new recording method being considered with focussed work taking place. To discuss outside of meeting	29/03/2023	GF/AS	March 23 – this is in progress and will be changing with the implementation of the new incident reporting system to replace our current provider.	Purple
23/59	29/03/2023	Constitutional Amendment	To be presented at the AMM	20/09/2023	JB	Action not yet due	Dark blue
23/60	29/03/2023	Annual Declarations of Interest	To include declaration of board members of QE Facilities	24/05/2023	DW	Completed **Action recommended for closure.**	Green
23/61	29/03/2023	Trust Strategic Aims and Objectives	Board session to be held in April with final objectives to come back to Board in May 2023	24/05/2023	JB	On agenda **Action recommended for closure.**	Green

Agenda Item Number	Date of Meeting	Agenda Item Name	Action	Deadline	Lead	Progress	RAG-rating
23/63	29/03/2023	Board Assurance Framework	To be discussed at Board session as above	24/05/2023	JB	Discussed at April session. **Action recommended for closure.**	
23/64	29/03/2023	Board Committee Assurance Report	Discussion around proposed rescheduling of committee meetings required – to be discussed at Exec Team	24/05/2023	Exec		
23/67	29/03/2023	Annual NHS Staff Survey Results	Progress on action plan to come back to Board for review	27/09/2023	LCJ/AV	Action not yet due	
23/72	29/03/2023	Trust Green Plan Update	Increased promotion of plan required via social media and recruitment. LCJ to arrange for member of POD team to contact TP	24/05/2023	LCJ/AV	OD, Learning and Development and Comms colleagues all asked to work with QEF colleagues and support this work **Action recommended for closure.**	

Report Cover Sheet Agenda Item: 7

Report Title:	**Constitutional Amendment**			
Name of Meeting:	Board of Directors			
Date of Meeting:	24 May 2023			
Author:	Jennifer Boyle, Company Secretary			
Executive Sponsor:	Alison Marshall, Chair Trudie Davies, Chief Executive			
Report presented by:	Jennifer Boyle, Company Secretary			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☒	**Discussion:** ☐	**Assurance:** ☐	**Information:** ☐
	To approve the proposed Constitutional amendment to remove the clause which prevents Board Members from serving on more than one NHS board.			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☐ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☒
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	-			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	• The current Trust Constitution prevents Board Members from serving as Board Members or Governors at any other NHS trust. • This legacy clause has been identified as a potential barrier to the recruitment of candidates to Board positions during the current Non-Executive Director recruitment. • Benchmarking demonstrates that the Trust is an outlier in this respect and it is therefore proposed to amend the Constitution as outlined in this paper.			
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	The Board of Directors is requested to review and approve the proposed change to remove the clause from the Constitution which prevents Board Members from serving on more than one NHS trust board.			

Trust Strategic Aims that the report relates to:	**Aim 1** ☐	We will continuously improve the quality and safety of our services for our patients
	Aim 2 ☒	We will be a great organisation with a highly engaged workforce
	Aim 3 ☐	We will enhance our productivity and efficiency to make the best use of resources
	Aim 4 ☐	We will be an effective partner and be ambitious in our commitment to improving health outcomes
	Aim 5 ☐	We will develop and expand our services within and beyond Gateshead
Trust corporate objectives that the report relates to:	All – having high calibre Board Members should support the delivery of the strategic objectives.	

Links to CQC KLOE	Caring ☐	Responsive ☐	Well-led ☒	Effective ☐	Safe ☐

Risks / implications from this report (positive or negative):			
Links to risks (identify significant risks and DATIX reference)	-		
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒

Constitutional Amendment

1. Introduction

1.1. The Constitution is one of the key governing documents of the Trust and sets out key requirements for how the Board of Directors and Council of Governors should operate.

1.2. Any amendment to the Constitution requires approval by both the Council of Governors and Board of Directors. Amendments require more than half of the Governors voting to approve the amendment and more than half of the Board of Directors voting to approve the amendment.

1.3. The Council of Governors will have reviewed a copy of this paper at its meeting on 17 May. A verbal update will be provided to inform Board Members of whether the Council approved the proposal.

1.4. This paper proposes an amendment in respect of the adjustment to one of the disqualification criteria for Board Members.

2. Key issues / findings

2.1. The Trust's Constitution currently includes the following clauses regarding the eligibility of Board Members to be appointed / continue in post:

7.6 **Disqualification:**

7.6.1 A person may not be a Director of the Trust if:

(a) in the case of a Non-Executive Director, they no longer satisfy paragraph 7.3.

(b) they are a person whose tenure of office as a Chair or as a Member or Director of a Health Service body has been terminated on the grounds that their appointment is not in the interests of public service, for non attendance at meetings, or for non-disclosure of a pecuniary/non-pecuniary interest;

(c) they have within the preceding two years been dismissed, from any paid employment for misconduct with a Health Service body;

(d) they are an Executive Director of the Trust, or a Governor, Non-Executive Director, Chair, Chief Executive officer of another NHS Trust;

(e) they are incapable by reason of mental disorder, illness or injury of managing and administering their property and affairs;

(f) they bring the Board of Directors or any of its Member organisations into disrepute;

2.2. Non-Executive Director recruitment is currently in progress, and clause 7.6.1 (d) has been identified as a potential barrier to the aim of recruiting high-calibre, skilled, experienced and diverse candidates to the role. This clause prevents a person from serving on the Trust Board if they are already a Governor or Board Member of another NHS trust.

2.3. A benchmarking exercise has demonstrated that other trusts typically no longer include such a strict clause in their constitutions. Some include a clause which

specifically state that a Director may not also be a Governor of the same trust, which is understandable. Other trusts have removed the clause entirely, or permit appointments to be made at the discretion of the Chair, for example, in consultation with the Council of Governors or Non-Executive Directors (depending on the role).

2.4. Our current clause is reflective of the previous culture of competition rather than collaboration within the NHS. Close working with other NHS bodies for the greater good of the wider public is now a primary principle of NHS decision-making and therefore collaboration is essential.

2.5. Removal or adjustment of the clause does not mean that potential conflicts of interest would not be considered, or that strict confidentiality would not need to apply at times, should a Board Member sit on two NHS trust boards. It would provide an option to consider the appropriateness of the appointment and hold discussions to understand any potential conflicts and reasonable mitigations. The ability of a Board Member to commit the time to two board roles would also be carefully considered and explored with any candidates prior to appointment.

2.6. At the last Council and Board meetings a constitutional amendment was proposed and passed to widen the membership boundaries of the Trust to be coterminous with the Integrated Care System (ICS). The aim was to modernise our Constitution in light of system working and enable the Trust to recruit members, Governors and Non-Executive Directors from across the whole ICS geography, increasing the chances of attracting high-calibre and diverse NED candidates.

2.7. The principle behind this proposed change is consistent – i.e. to support us to attract and recruit from a wide pool of high-calibre and diverse candidates.

2.8. As such, it is proposed the amend clause 7.6.1. (d) to read:

7.6.1. A person may not be a Director of the Trust if:

(d) they already hold the position of Governor at the Trust.

2.9. Holding the position of Governor and Board Member at the same trust would always present a clear conflict which could not be mitigated, given the role of Governors to hold the Non-Executive Directors to account for the performance of the Board. As such, this element of the clause should be maintained.

2.10. Assurance is provided that should any candidates for Board positions already hold Board positions at other trusts, full consideration will be given to potential conflicts of interest and whether they can be mitigated, along with whether they can dedicate the time required to the role.

3. Recommendation

3.1. The Board of Directors is requested to review and approve the proposed change to remove the clause from the Constitution which prevents Board Members from serving on more than one NHS trust board.

Report Cover Sheet   Agenda Item: 8

Report Title:	**Strategic Aims and Objectives for 2023-24**			
Name of Meeting:	Board of Directors			
Date of Meeting:	24 May 2023			
Author:	Executive Directors Kirsty Roberton, Deputy Director of Corporate Services and Transformation			
Executive Sponsor:	Executive Directors			
Report presented by:	Jennifer Boyle, Company Secretary			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☒	**Discussion:** ☐	**Assurance:** ☐	**Information:** ☐
	To provide the final draft of the Trust Strategic Aims and Objectives for 2023/24			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☒ *No gaps in assurance*	**Partially assured** ☐ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	The Strategic Objectives have been reviewed at various meetings as follows: Board committees have considered the objectives which have been mapped to them. EMT have reviewed the objectives with their teams March 2023 Board of Directors April 2023 Board Strategy Session			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	• This report presents the final version of the Strategic Objectives for 2023/24 • The key indicators have been aligned to the objectives • Key measures have been identified for monitoring delivery of the objectives • Strategic Objectives will be monitored via Board Sub-Committees throughout 23/24 • Progress reports will be presented to Board on a quarterly basis by the Director of Strategy, Planning and Performance			

<table>
<tr><td>Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper</td><td colspan="5">The Board is requested to review the attachment and agree the Strategic Objectives for 2023/24.</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:</td><td>Aim 1
☒</td><td colspan="4">We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>Aim 2
☒</td><td colspan="4">We will be a great organisation with a highly engaged workforce</td></tr>
<tr><td>Aim 3
☒</td><td colspan="4">We will enhance our productivity and efficiency to make the best use of resources</td></tr>
<tr><td>Aim 4
☒</td><td colspan="4">We will be an effective partner and be ambitious in our commitment to improving health outcomes</td></tr>
<tr><td>Aim 5
☒</td><td colspan="4">We will develop and expand our services within and beyond Gateshead</td></tr>
<tr><td>Trust corporate objectives that the report relates to:</td><td colspan="5">All</td></tr>
<tr><td>Links to CQC KLOE</td><td>Caring
☒</td><td>Responsive
☒</td><td>Well-led
☒</td><td>Effective
☒</td><td>Safe
☒</td></tr>
<tr><td colspan="6">Risks / implications from this report (positive or negative):</td></tr>
<tr><td>Links to risks (identify significant risks and DATIX reference)</td><td colspan="5">Risks which may pose a threat to the delivery of the corporate objectives are recognised via the Board Assurance Framework.</td></tr>
<tr><td>Has a Quality and Equality Impact Assessment (QEIA) been completed?</td><td colspan="2">Yes
☐</td><td colspan="2">No
☐</td><td>Not applicable
☒</td></tr>
</table>

					Quantity		0	0	0	0			
Strategic Aim	**Strategic Objective**	**Summary of Actions**	**How**	**Action Owner**	**Start Date**	**End Date**	**Overdue**	**Some Risk**	**Work in Progress**	**Action Complete**	**Completion Date**	**Expected Outcomes/measures**	**Comments/progress**
1) We will continuously improve the quality and safety of our services for our patients	**SA1.1 Continue to improve our maternity services in order to improve performance against key indicators and ensure improved patient outcomes by March 2024.** **Executive Lead - Chief Nurse** **Assurance Committee: Quality Governance Committee**	Assess and benchmark performance against key national inquiry reports in order to assure safety and promote learning	action plan to be developed and implemented according to findings and monitor impact via quality committee.	LH	Apr-23	Mar-24						**Delivery of the 19 safety priorities and improvement in the maternity metrics outlined and reported in the IOP**	
		Assess and Implement the agreed plan for maternity Continuity of Carer and seek to measure improved outcomes according to expected benefits aligned to leading indicators.	maternity team to be reconfigured to meet actions outlined in the MCOC plan	LH	Apr-23	Dec-23							
		Implement any actions from the maternity CQC inspection 2023	develop and implement action plan once final report is received and measure the impact, reporting via quality committee	GF/LH	Apr-23	Mar-24							
	SA1.2 Develop and implement a continuous Quality improvement plan that enables the delivery of improved performance against key indicators by March 2024 **Executive Lead - Chief Nurse** **Assurance Committee: Quality Governance Committee**	Review, refresh and implement Quality Account Priorities to ensure that they align with Trust core goals and contribute to the agenda of reducing LOS	implement the actions within the Quality Account and monitor the progress and impact on a monthly basis via divisional performance and quality governance meetings	GF	Apr-23	Mar-24						**Quality Account Priorities achieved**	
		Monitor Quality Account Priorities implementation	Monitor the implementation plan for the Quality Account Priorities at SafeCare, risk and Patient Safety Council	GF	Apr-23	Mar-24							
	SA1.3 Ensure that there is a Digital first and data led approach to transformation and improvement across all	Enhance the basics - We will provide fast, modern, safe technology and services that users want and can rely on	Undertake the national Digital Maturity Assessment, user experience surveys and develop an improvement plan.	NB	Feb-23	Sep-23						**Agreed Electronic Patient Record plan** **Improved data quality and data driven decision making** **Improved patient outcomes and staff experience**	Digital Maturity Assessment completed in draft
			Implement the data quality strategy and develop indicators that provide assurance on clinical systems use and clinical coding depth.	NB	Dec-23	Mar-24							Some digital indicators developed and built into DAG reporting. This will be shared with service representatives to support an increase in this area.
		Deliver Improvements - We will provide technology to reduce inefficiencies, poor processes and duplicate records	Develop and agree the electronic patient record outline business case with full clinical ownership.	CB	Dec-21	Dec-23							Outline business case agreed in February 23. Checkpoint requested to ensure full clinical ownership.
			Develop a systems and data exploitation plan that supports the delivery of leading indicators, supporting safe and efficient patient care.	DT/DR	Apr-23	Mar-24							Not started
		Open, share and transform - We will focus on joining up the needs of the user across the whole patient pathway	Expand access to patient record, results and images from across the region; sharing our data to support patient care cross the ICS.	CB	Dec-22	Mar-24							Global worklist testing completing, awaiting neighbouring trusts.
			Implement a patient portal to empower patients to manage their own health and care, and enable services to interact digitally with the patient.	CB	Mar-23	Dec-23							Contract in place, project work underway
		Invest in people - We will focus on enhancing the skills and knowledge of the user involving them in digital	Implement the digital skills and inclusion plan for staff and patients; undertaking a workforce survey, completing a business case if required.	CB	Nov-22	Sep-23							Talent management discussions have started in Dec 22, with a view to implement Scope for Growth talent management.

					Quantity		0	0	0	0			
Strategic Aim	**Strategic Objective**	**Summary of Actions**	**How**	**Action Owner**	**Start Date**	**End Date**	**Overdue**	**Some Risk**	**Work in Progress**	**Action Complete**	**Completion Date**	**Expected Outcomes/measures**	**Comments/progress**
2) We will be a great organisation with a highly engaged workforce	**SA2.1 Caring for our people in order to achieve improved compliance of key indicators by March 2024** **Executive Lead - Executive Director of People and OD** **Assurance Committee: People and OD Committee**	Getting the basics right and looking after you in every way we can.	Providing a working environment where all basic needs are met for all colleagues working within the organisation.	LF	Apr-23	Mar-24						**Key Indicator: Absence rate reduction to 5% by March 2024** **Even better if target of 4.8% by March 2024**	
			Working in partnership with managers to support the needs of our people.	DB	Apr-23	Mar-24							
			Embedding an organisational wellbeing culture embedded and aligned to the national Health & Wellbeing Framework.	LF	Apr-23	Mar-24							
			Target driven, efficient and effective approach to promoting and supporting attendance and a coaching approach to supporting managers.	DB	Apr-23	Mar-24							
	SA2.2 Growing and developing our people in order to improve patient outcomes and reduce reliance on high cost agency staff by March 2024 **Executive Lead - Executive Director of People and OD** **Assurance Committee: People and OD Committee**	Building our workforce and helping you be the best you can be.	Providing a professional and comprehensive customer focused Education, Learning and Development service to the organisation, working with services to ensure our people have the appropriate learning and professional development alongside a well-established core skills training programme.	SN	Apr-23	Mar-24						**Key Indicator: Vacancy rate reduction to 5% by March 2024** **Even better if target of 4% by March 2024**	
			Develop a Trust wide strategic approach to workforce planning that is informed by population health needs, local and national strategy. With an ability to forecast and horizon scan.	NB	Apr-23	Mar-24							
			Have an agreed Trust wide retention strategy which includes a customisable range of high impact, effective tools that are deployed at a local level, depending on service need.	NB	Apr-23	Mar-24							

					Quantity		0	0	0	0			
Strategic Aim	**Strategic Objective**	**Summary of Actions**	**How**	**Action Owner**	**Start Date**	**End Date**	**Overdue**	**Some Risk**	**Work in Progress**	**Action Complete**	**Completion Date**	**Expected Outcomes/measures**	**Comments/progress**
	SA2.3 Being a great place to work in order to improve staff survey outcomes and impact upon patient outcomes within 2-years. **Executive Lead - Executive Director of People and OD** **Assurance Committee: People and OD Committee**	Being a values led organisation with compassionate and inclusive leadership, where you have a long, lasting and valuable career.	Leaders will role model compassionate, inclusive and collective leadership in all of their interactions, aligning with our ICORE Values and the national Our Leadership Way Framework.	LF	Apr-23							**Key Indicator: Increase staff engagement score to 7.5% by March 2025** **Even better if target of 8.5% by March 2025**	**targets still tbc**
			Flexible working practices will be commonplace across all staffing groups.	AV	Apr-23								
			Continue to work closely with our Freedom to Speak up Guardian, enabling and supporting colleagues to Raise Concerns where they need to, encouraging and facilitating a working environment where we can all speak up and speak out about issues that concern us.	AV	Apr-23								
			Work closely with the Trust EDI and engagement lead to provide support, experience and opportunities to promote, embed and champion the Inclusion agenda and Trust strategy.	AV	Apr-23								
3) We will enhance our productivity and efficiency to make the best use of our resources	**SA3.1 Improve the productivity and efficiency of our operational services through the delivery of the New Operating Model transformation plans in order to meet required performance standards/recovery requirements by March 2024** **Executive Lead - Chief Operating Officer** **Assurance Committee: Finance and Performance Committee**	The New operating Model transformation programmes will be delivered demonstrating an improvement impact on both unscheduled care pathways and elective and planned care recovery metrics in order to achieve annual plan submissions	Detailed workplans have been developed for 23/24 for both the Unscheduled Care Programme and the Elective and planned recovery programme. These are monitored through the NOM programme Board and reported to F&P Committee through Transformation Board	JMB	Apr-23	Mar-24						**Monitored through the achievement of the key indicators (to be referenced once confirmed)**	
		Ensure estates changes relating to the new operating model are realised and the impact is assessed and measured through staff and patient satisfaction surveys	working collaboratively with QEF to realise plans, bring in on time and on budget	JMB	Apr-23	Mar-24							
	SA3.2 Achieve financial sustainability by in-year delivery of Trust CRP plan and development of robust sustainability plan for delivery within 3-years	In year activity to deliver against the financial plan through the development, implementation and monitoring of clinically led CRP plans	Use of financial accountability framework and internal focus on delivery of cost improvement programme. Supported by robust budget monitoring and reporting to F&PC - capital and revenue. Establish a monitoring forum to manage and report in month variance to plans.	KM	Apr-23	Mar-24						**Delivery of the financial projections as per submitted phased plan.** **Production of robust and achievable financial sustainability/recovery**	Weekly CRP working group established to enhance engagement and ensure early traction and transaction against efficiency target. Intention that each fortnight SMT focusses upon finance and performance to ensure continued attention on financial challenge and opportunities. Accountability framework will be operational from month two reporting.

					Quantity		0	0	0	0			
Strategic Aim	**Strategic Objective**	**Summary of Actions**	**How**	**Action Owner**	**Start Date**	**End Date**	**Overdue**	**Some Risk**	**Work in Progress**	**Action Complete**	**Completion Date**	**Expected Outcomes/measures**	**Comments/progress**
	Executive Lead - Group Director of Finance and Digital Assurance Committee: Finance and Performance Committee	Ongoing focus on financial sustainability to improve the underlying financial position through assessment of service vulnerability and sustainability and using benchmarking tools to robustly assess efficiency at scale.	Ongoing assessment of underlying run rate, increase in effective organisational communication and engagement, use of benchmarking information and HFMA checklist. Continually horizon scan for developments and opportunities. Optimise estate strategy to reduce estate and seek to increase home working to optimise recruitment and minimise costs.	KM	Apr-23	Mar-24						plan that returns the organisation to financial balance.	HFMA checklist, grip and control tool and internal audit actions being monitored by finance and performance committee. Restructure of finance function established a small team dedicated to efficiency and transformation, including use of benchmarking information. Team lead recruited to and due to commence in role in August.
		Automation of transactional processes optimising digital impact and reducing cost.	Work collaboratively with digital and transformation teams to utilise RPA function.	KM	Apr-23	Mar-24							Digital service undertaking review of current utilisation and effectiveness of virtual workers.
		Enhance capacity and capability of the finance team.	Complete recruitment to new structure and supporting organisational development programme of work.	KM	Apr-23	Mar-24							19 May meeting with additional support to focus on the organisational development work with finance function. Where appropriate it is agreed that this could include the development of the QEF finance team.
4) We will be an effective partner and be ambitious in our commitment to improving health outcomes	SA4.1 Identify key local health inequalities challenges and ensure improvement plans are in place by March 2024 Executive Lead - Medical Director Assurance Committee: Quality Governance Committee	Mitigating against 'digital exclusion' ensuring providers offer face to face care to patients who cannot use remote services and ensure more complete data collection to identify who is accessing face to face /telephone/video consultations is broken down by patient age, ethnicity, disability status	Included in the data scoping will be to review DNA and link with the learning disability team and also the MECC community teams.	AB	Apr-23	Mar-24						The delivery of an agreed health inequalities action plan and implementation of the Health Inequalities Strategy	
		A framework for action across the NHS: Core20plus5 is NHS England's new approach to tackling health inequalities. It focuses on improvements for the most deprived 20 per cent of the population (core20), reducing inequalities for population groups identified locally (plus) and accelerating improvements in five clinical areas (5).	A gap analysis to be completed across the 5 clinical areas. Maternity, severe mental health, chronic respiratory disease, early detection of cancer and hypertension.	AB	Apr-23	Mar-24							Continued from 22/23
	SA4.2 Work collaboratively as part of Gateshead Cares system to improve health and care outcomes to the Gateshead population Executive Lead - Chief Operating Officer Assurance Committee: Quality Governance Committee	Work in partnership to influence and shape the place based vision. Increase clinical visibility within place	Map out meetings to ensure appropriate representation from the trust and carry out engagement by CEO & MD with key stakeholders	AB	Apr-23	Mar-24						Gateshead strengthened commitment to tender for wider services for example 0-18yr old service	
5) We will look to utilise our skills and expertise beyond Gateshead	SA5.1 We will look to utilise our skills and expertise beyond Gateshead in order to ensure organisational sustainability and contribute towards innovative care and provision within 23/24 Executive Lead - QE Facilities Director Assurance Committee: Finance and Performance Committee	Undertake SWOT analysis of future commercial opportunities for the trust and QEF in order to prioritise and establish commercial strategy for delivery.	Stakeholder engagement internal and external	SH	Apr-23	Dec-23						Development of a commercial Strategy	
		Identify through the Making Services Sustainable work which services we can grow and develop	Engage with CSG. Clinical services to complete a review making recommendations for consideration;	NBr/KR	May-23	Dec-23						Service Sustainability Plan developed for board approval by December 2023	

Report Cover Sheet Agenda Item: 9

Report Title:	**Enabling Strategy Update**			
Name of Meeting:	Board of Directors			
Date of Meeting:	24 May 2023			
Author:	Kirsty Roberton, Deputy Director Corporate Services and Transformation			
Executive Sponsor:	Executive Directors			
Report presented by:	Executive Directors			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☒	**Discussion:** ☐	**Assurance:** ☐	**Information:** ☐
	The Trust launched its corporate strategy in 2022. There are a number of enabling strategies that have subsequently been developed through staff engagement. The list of enabling strategies for Board ratification are as follows: • Communication • People • Quality • Equality, Diversity and Inclusion • Clinical • Estates (Clinically led strategy) • Finance A Board strategy session was held on the 9th February 2023 which included Senior Management Team colleagues where the strategies were discussed, reviewed and commented on. These comments and suggested changes have now been included in the final versions of the strategies, alongside further engagement, and the following enabling strategies are presented for final ratification. • Equality, Diversity and Inclusion • Clinical • Finance In March 2023 the Board ratified the Communications, Quality and People strategies.			

<table>
<tr><td></td><td colspan="4">Wider work is being undertaken to develop the final estates strategy, as outlined in the Trust's thematic review delivery plan.</td></tr>
<tr><td>Proposed level of assurance – <u>to be completed by paper sponsor</u>:</td><td>Fully assured
☐
No gaps in assurance</td><td>Partially assured
☐
Some gaps identified</td><td>Not assured
☐
Significant assurance gaps</td><td>Not applicable
☒</td></tr>
<tr><td>Paper previously considered by:
State where this paper (or a version of it) has been considered prior to this point if applicable</td><td colspan="4">All strategies were reviewed at the Board Strategy Session held on the 9th February 2023 and final drafts reviewed by SMT on the 16th March 2023.
The Clinical Strategy has been reviewed again following updates by the Senior Management Team and Clinical Strategy Group in May 23.</td></tr>
<tr><td>Key issues:
Briefly outline what the top 3-5 key points are from the paper in bullet point format</td><td colspan="4">The feedback from the group work held on the 9th February 2023 was written up and sent to and discussed with the authors of each of the enabling strategies.

Key updates have been made to each strategy and are attached for review which covered:

• Increasing the references to the patient and how these strategies link to the impact on our patients and the delivery of the care
• Strengthening the references to people and public and patient engagement and involvement
• Simplifying the strategies to ensure they are easily digestible.
• Strategic statements of intent being displayed on a page.
• Ensuring consistent approaches to the measurability of the strategies, particularly in respect of KPIs
• Ensuring that managers are equipped to deliver the asks contained within the strategies

A high level vision of the Clinical Strategy includes:

• Optimised secondary care provision
• Providing regional level services to support the ICS and beyond
• An outstanding provider of clinical training
• Health inequalities being address
• Innovative responsive service
• Close working with Gateshead partners
• Close working with other partners within ICS
• Increasing use of digital technology for patient carer

It also incorporates research, estates, acute care, making services sustainable and Business Unit priorities. It is intended that the Clinical Strategy should be iterative.</td></tr>
</table>

<table>
<tr><td>Recommended actions for this meeting:</td><td colspan="5">Members are asked to accept the changes to the strategies presented and approve with agreement that these can be launched.</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:</td><td>Aim 1
☒</td><td colspan="4">We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>Aim 2
☒</td><td colspan="4">We will be a great organisation with a highly engaged workforce</td></tr>
<tr><td>Aim 3
☒</td><td colspan="4">We will enhance our productivity and efficiency to make the best use of resources</td></tr>
<tr><td>Aim 4
☒</td><td colspan="4">We will be an effective partner and be ambitious in our commitment to improving health outcomes</td></tr>
<tr><td>Aim 5
☒</td><td colspan="4">We will develop and expand our services within and beyond Gateshead</td></tr>
<tr><td>Trust corporate objectives that the report relates to:</td><td colspan="5">Enabling strategies should support the delivery of all corporate objectives</td></tr>
<tr><td>Links to CQC KLOE</td><td>Caring
☒</td><td>Responsive
☒</td><td>Well-led
☒</td><td>Effective
☒</td><td>Safe
☐</td></tr>
<tr><td colspan="6">Risks / implications from this report (positive or negative):</td></tr>
<tr><td>Links to risks (identify significant risks and DATIX reference)</td><td colspan="5">n/a</td></tr>
<tr><td>Has a Quality and Equality Impact Assessment (QEIA) been completed?</td><td colspan="2">Yes
☐</td><td colspan="2">No
☐</td><td>Not applicable
☒</td></tr>
</table>

#GatesheadHealth Human Rights, Equality, Diversity and Inclusion Strategy 2023/24 – 2025/2026

Draft 0.4

Last updated February 2023

Introduction

A key area of focus for Gateshead Health is to ensure that we have a diverse, inclusive and engaged culture

Gateshead Health's pledge

We are committed to being an inclusive health care provider and employer. This commitment is central to achieving our ICORE ambitions and is at the heart of NHS and Trust values.

Inclusion and equality is not about treating everyone the same, but recognising that everyone is different and that people's needs, whether they be patients, People or the public are met in different ways.

We recognise that we need to improve if we are to achieve our ambitions and become a Trust where diversity is valued and celebrated; everyone is treated with dignity and respect; and discrimination and inequalities are prevented and eradicated from all our services and functions.

The Board of Directors are committed to inclusion, delivering on the standards in Workforce Race Equality and Disability Standards (WRES and WDES), the Equality Delivery System 2 (EDS2) and ensuring diversity is valued, NOT in order to comply with regulations, but because it is the right thing to do for patient care, our People and our local population.

Legislation

NHS
Gateshead Health
NHS Foundation Trust

The Trust will continuously work towards addressing the Public Sector Equality Duty underpinned by the Equality Act 2010 by ensuring that any provision of our service pays due diligence to:

- Eliminating unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality 2010 Act.
- Advancing equality of opportunity between people who share a protected characteristic and those who do not.
- Fostering good relations between people who share a protected characteristic and those who do not.

WHY

Holding one another to account in living our values, will mainstream EDI into our core values, challenging unconscious bias and fostering diverse thinking

By fostering an inclusive culture of belonging everyone is seen, supported, respected and valued for their unique contributions

Giving value to our People by increasing opportunities to have their voices heard.

HOW THIS APPLIES IN GATESHEAD HEALTH

- Undertaking Satisfaction surveys
- Undertaking PLACE inspections
- Listening and acting on the concerns and compliments arising from Patient and Public Engagement and Experience

- Work towards establishing a Patient and Carer panel
- Supporting the needs of our People – identified via the existing People Networks
- Ensuring equity in care and service provision taking into consideration an individual's faith

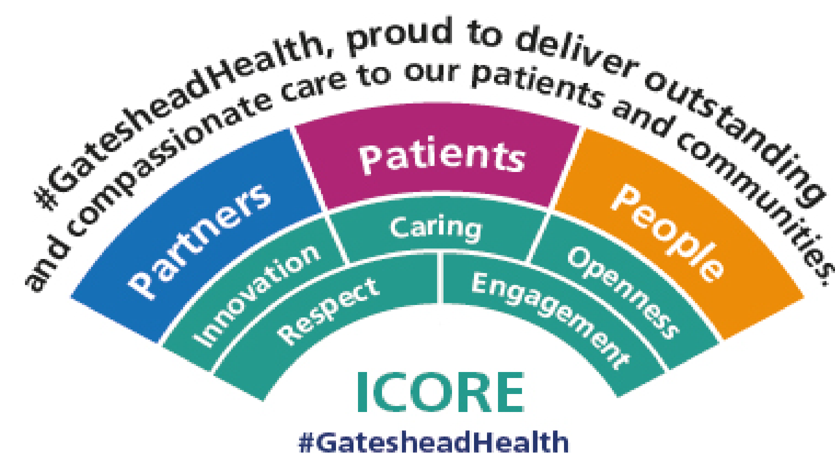
Legislation and definitions

Act	Requirement
The Human Rights Act 1998	The Human Rights Act is underpinned by the core values of Fairness, Respect, Equality, Dignity and Autonomy for all. All public bodies must comply with the convention rights
The Equality Act 2010	Protection from discrimination based on nine protected characteristics - Age - Disability - Ethnicity - Gender reassignment - Marriage & Civil Partnership - Pregnancy & Maternity - Religion or Belief - Sex - Sexual Orientation
General Equality Duty	To eliminate unlawful discrimination, harassment, and victimisation. Advance equality of opportunity. Foster good relations
Public Sector Equality Duty	From 5 April 2010 To publish relevant, proportionate information demonstrating compliance with the Equality Duty. To analyse effect of policies and practices on equality. Set specific, measurable Equality Objectives
Accessible Information Standards	Accessible Information Standard' – directs and defines a specific, consistent approach to identifying, recording, flagging, sharing, and meeting the information and communication support needs of patients, service users, carers, and parents, where those needs relate to a disability, impairment, or sensory loss.
Gender Recognition Act 2004	The GRA legislation provides a mechanism to allow trans people to obtain recognition for all legal purposes to their preferred gender role.
Workforce Disability Equality Scheme (WDES)	From April 2019 The Workforce Disability Equality Standards (WDES) is a set of specific measures that will enable NHS Organisations to compare the experiences of disabled colleagues to non-disabled colleagues, this will then be sued to develop any required actions.
Workforce Race Equality Standard (WRES)	From 1 April 2015 Must demonstrate through the nine-point Workforce Race Equality Standard (WRES) metric how we are addressing race equality issues in a range of staffing areas. Must demonstrate progress against several indicators of workforce equality, including a specific indicator to address the levels of BAME Board representation. This will be included in the Standard NHS Contract.

Ensuring a diverse, inclusive and engaged culture

We will

- embed the key principles of good experience, by continually assessing the impact and outcomes for patients of the way services are provided – demonstrating our ICORE values through our behaviours.
- Ensure our service users including all individuals from all protected groups have an opportunity to be treated and supported in a fair, equitable and inclusive manner.



We will thread the Workforce Race and Disability Equality Standards to demonstrate progress in closing the gaps between white & BME treatment & experience against nine indicators:

- Grading
- Appointments
- Discipline
- Bullying
- Career Progression
- Access to development
- Boards representative of the local population

We will thread the EDS Outcomes:

- Domain 1 – Commissioned or provided services
- Domain 2 – Workforce health and well-being
- Domain 3 – Inclusive leadership

Ensuring a diverse, inclusive and engaged culture

We believe the diversity of our people and the different perspectives we have at Gateshead Health helps us to achieve great outcomes for the patient communities that we serve.

Ensuring everyone is represented, recognised, and heard is a key part of achieving our strategic aim of being a great organisation with a highly engaged workforce.

We will do this by:

- Empowering our People in investing time in engaging with one another through inclusive networks, communities and forums
- Holding one another to account in living our values, by incorporating EDI into our core values, challenging unconscious bias and fostering diverse thinking
- Fostering an inclusive culture of belonging where everyone is seen, supported, respected and valued for their unique contributions
- Increasing opportunities for our people to have their voices heard.

Equality Diversity and Inclusion

#GatesheadHealth Corporate Strategy			Equality strategy (mandatory reporting)			
5 Strategic Aims	Strategic areas	Strategic focus areas	WRES Metrics	WDES Metrics	EDS 2	Pay Gaps
Productivity and efficiency; Growing services beyond Gateshead; Improving service quality and safety	Patients	Caring for all our patient communities	●	●	●	
		Providing safe, high quality care	●	●	●	
		Offering increasingly integrated care	●	●	●	
		Making every contact compassionate and caring	●	●	●	
Highly engaged workforce	People	Supporting the health and wellbeing of our people	●	●	●	
		Being a great place to work	●	●	●	●
		Ensuring a diverse, inclusive and equitable culture	●	●	●	●
		Working in new and collaborative ways as "one team"	●	●	●	
Partnerships and outcomes	Partners	Being a force for good	●	●	●	
		Acting as a key partner	●	●	●	
		Working with further and higher education providers	●	●	●	

What does EDI mean (1/3)

OUR LEADERSHIP

We commit to:

- In any recruitment process due regard is paid around knowledge and lived experience by individuals
- Utilising the Inclusive leadership Framework
- Involving and empowering people from the communities served.
- Encouraging local communities to sign up as a members, particularly those with lived experience.

FOR THE BOARD

We commit to the Leadership behaviours around:

- Demonstrating Honesty and Integrity
- Listening and Communicating
- Being Supportive and Approachable
- Even handed and Encouraging
- Ensuring that we are Patient centered and Compassionate
- Lead by example and are self aware
- Maintain gender equality and extend profile of other characteristics

- Work towards ensuring we are representative of the population we serve, including an increase in Board BME membership
- Board Members and Governors take a proactive approach toward Inclusive behaviour
- Board engagement with People, patients, public and community
- The Board role models the ICORE values and behaviours

What does EDI mean (2/3)

FOR OUR PATIENTS

We will:

- Gather comprehensive demography data to assess the makeup of the communities broken down via the Protected characteristics.
- Assess the access needs of groups served
- Ensure that the Patient Public Engagement and Experience (PPEE) is sustained for full involvement.
- Ensure that there is on-going support for and provision of the service user, young people and carers.
- Work towards developing innovative peers support – a listening service that develops service users and carers as volunteers (help in evaluating elements of services to ensure due diligence has been paid in respect of service delivery for all our users and carers).
- Ensure that adequate provision is there for patients where English may not be their first language.

FOR OUR ENVIRONMENT

We will:

- Ensure that our culture and ICORE values are consistently adhered to when communicating with our patients
- Use the NHS accessible Standard and work to ensure that all letters are jargon free and user friendly.
- Ensure that inclusive imagery and gender free terminology is used
- Ensure that all patients, families and carers can utilise the chaplaincy services across all faith groups;
- Work towards an inclusive provision for contemplation /prayer for non-faith groups

NHS
Gateshead Health
NHS Foundation Trust

What does EDI mean (3/3)

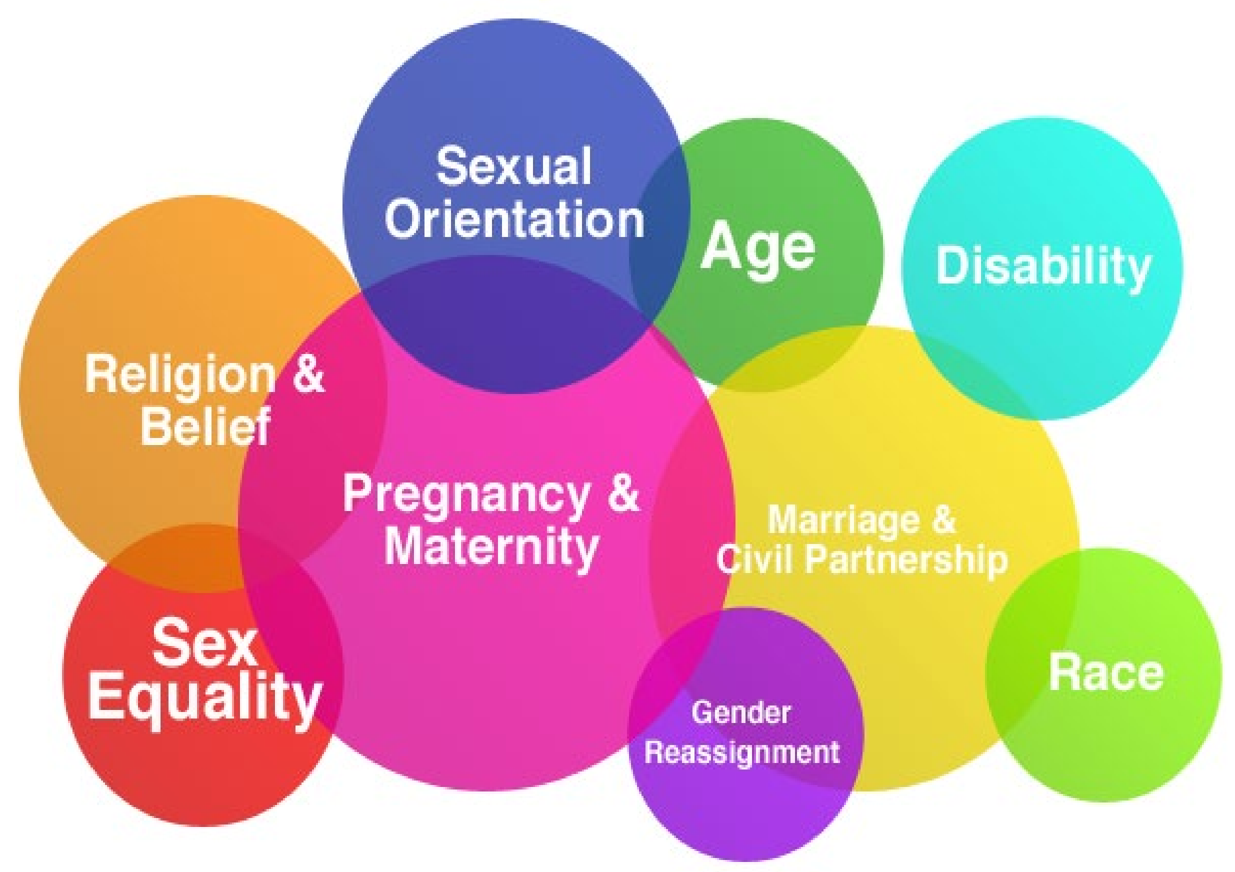
FOR OUR PEOPLE

We will:

- Ensure that all People are made aware of the demography of the population served and understand the culture, values and attitudes of the communities served
- Ensure that People are aware of Conscious and Unconscious bias that can impact upon the delivery of care.
- Involve people with lived experience in interview panels and People inductions (dependent upon the level of job being recruited to).
- Ensure that world faith days / customs are celebrated
- Ensure cognisance is paid around cultural and religious practices impacting upon holidays and food
- Enabling people to attend, and be involved in regular meetings about programmes impacting upon provision of service, this will include assessing recruitment, promotion , leadership
-

Protected characteristics

Gateshead Health
NHS Foundation Trust



Individuals may have more than just one protected characteristic. As such when addressing needs of an individual due regard will be paid in respect of the intersectionality of these protected characteristics.

[Lesbian, Gay, Bisexual, Trans – words used to denote the different ways that individuals choose to define their own gender identity]

Equality Act 2010

Gateshead Health
NHS Foundation Trust

Health inequalities (1/2)

While inequalities in health have always been a problem, the Covid-19 pandemic has shone a spotlight on inequalities and created an opportunity for change. In this strategy we make the case for developing a long-term approach to tackling health inequalities that will endure and consider past attempts, highlighting learnings for the renewed effort

To implement our health inequalities priorities, we will:

- align our thinking and connect our strategy ambitions across the organisation
- ensuring health inequalities are mainstreamed in our strategic thinking and operational intent.
- Link our ambitions to Quality Account, EDI Strategy, digital strategy, and the people strategy.

HOW THIS APPLIES TO GATESHEAD HEALTH →

- **Be proactive by taking positive action for inclusive access taking into consideration**
  - clinical acuity, social deprivation and people disadvantaged due to protected characteristics or other vulnerabilities.
- **Supporting Digital Inclusion**
  - ensuring appropriate access to care and support
- **Positive action for retention and recruitment**
  - work towards ensuring our workforce reflects the diverse populations we serve through positive action and engagement with our communities and our people.
- **Collaboration and co-design**
  - by engaging with those less frequently heard to co-design inclusive services and care pathways.
- **Exploiting our data and analysis**
  - focusing on maximising our data collection, insight, and analysis to understand the experience of those who face barriers or disadvantage to bring about equality of outcomes.

Health inequalities (2/2)

- **Empowering and upskilling our people**

  - by creating an environment of positive allyship within the workforce to ensure we are comfortable to bring our whole selves to work, feel equipped and empowered to tackle discrimination, promote inclusion, and reduce inequalities.

- **Ensure equality of outcomes**.

  - We will take a population health approach, striving to create equality of outcomes across the populations we serve by using Core20PLUS5 principles.

- **Maximising our social value**.

  - As an anchor institution we will make informed choices aimed at reducing inequalities with particular focus on purchasing locally and employing inclusively.

- **Intelligence led preventive programmes**.

  - We will implement evidence based, intelligence led and innovative preventive programmes across the Trust to maximise our impact in preventing health inequalities and promoting health and wellbeing for our workforce and the communities we serve

- **Targeting long term health condition diagnosis and management.**

  - Focus on Acute tobacco Service, Alcohol navigation posts, healthy weight including foodbanks
  - Engage with local patient groups to proactively manage health conditions

NHS
Gateshead Health
NHS Foundation Trust

Public and patient involvement

The Trust continually works towards providing the best possible care for its patients but there are occasions when patients and their families do not feel the outcome has met their expectations.

We will:

- Proactively engage with communities served to understand issues pertaining to:
  - access and accessibility
  - provide honesty, openness and a willingness to listen to the issues /complainants and work with the patients/public to rectify the problem.
- Continually welcomes comments, compliments, complaints and concerns to continually learn about how patient experience can be improved.
- Continue to listen and respond effectively to complaints and concerns to help us to avoid the same issues from occurring again, making our services better and improving services for the people who use them.
- Continue to use a variety of modes to capture the experience of patients following treatment, enabling us to monitor and assess the experiences of those accessing the service.
- Continue to collect Equality data in line with the current protected characteristics, analyse the data to assess where perceived inequalities can be addressed.
- Continue to utilise the Patient Advice and Liaison Service (PALS) service by offering confidential advice, support and information on health-related matters.
  - The service will also provide a point of contact for patient, their families, and carers. Where appropriate, those individuals utilising PALS will be forwarded a questionnaire regarding their experience of the service.

NHS
Gateshead Health
NHS Foundation Trust

Diversity & Inclusion CQC and Well Led

Progress on the WRES and the EDS is considered as one key part of the "Well led" domain in CQC inspections

Ensuring all three EDS Domains and WRES KPI are continuously monitored and reported on

Ensure the EDI Action plan in respect of EDS Domains 2 and 3 and WRES KPI are targets for continuous improvement

Not just a question for the POD Directorate / Team but for the whole Board

Provide appropriate targeted support to assist colleagues health conditions

People Network Forums and Engagement

One to one confidential Engagement

Listen to the voices of the People/ Patients / Carers and work to make changes. Cross reference PALS data to readdress inequalities

Continuously review the Key lines of Enquiry on the Well led domain

Provide appropriate counselling service including support for physical and mental health internally and externally

Engagement with patient groups, clinical groups and external stakeholders

Steps to become culturally competent

Develop the Organisational Culture	• Share Experiences, Culture and Values and celebrate diversity • Value and Vision Statements become rooted within service provision • Key National Principles become embedded in service provision • On-going Inclusion metrics discussed and implemented • On-going development of all People – Board, Clinical and non-clinical • Lead by example • Environment reflects Diversity and is inclusive
Understand the population profile and assess specific health needs	• Utilise all demography data • Access health needs • Ensure continuous patient engagement • Provide peer support • Equity of provision • Proactive Community Engagement
Advance Equality Diversity and Inclusion	• Readdress equality and inclusivity across employment and service delivery • Tackle issues pertaining to Zero Tolerance and harassment • Bespoke and training in general reflects issues of inclusion
Address health development	• Work in partnership with other providers • Promote and understand health across all Protected characteristics • Tackle social exclusion

Monitor and Evaluate

Diversity Inclusion KPIs

Trust Strategic Aim	EDI aim	KPIs	Key Output	Internal /External Focus	Timeframe Yr1	Yr2	Yr3
We will: - continuously improve the quality and safety of our services for our patients	Address and work towards reducing health inequalities and any differentials in the patient journey.	Provide appropriate and targeted training around values and Inclusion, Ensure ongoing conversations value diversity, inclusion and belonging, and liaise with stakeholders to identify the teams that need priority focus.	Have a clearer understanding of our patients groups. Cultural competency is an integrated within our everyday provision of care	Internal and External	←→	←→	←→

Gateshead Health NHS Foundation Trust

Diversity Inclusion KPIs

Trust Strategic Aim	EDI aim	KPIs	Key Output	Internal /External Focus	Timeframe Yr1	Yr2	Yr3
We will: - be a great organisation with a highly engaged workforce	Provide appropriate and targeted training around Values and Inclusion, fair and transparent recruitment, address micro aggressions, ensure ongoing conversations that value diversity, inclusion and belonging. Based on the evidence from survey results and the WRES, WDES and Stonewall diversity champions programme, targeted work will identify areas requiring improvement	Provide appropriate Recruitment and Selection Training Provide appropriate and targeted training around Values and Inclusion Have a Zero tolerance Policy around behaviours that lead to bullying and harassment of our people.	Have a clearer understanding of our people, patients and communities served Cultural competency is an integrated within our everyday understanding Change the working culture and move to a more compassionate and inclusive environment Create and deliver an updated leadership programme - to train people in the skills to become a successful leader. - equip leaders with inclusive behaviours so that they can help create an organisational culture that supports inclusion and belonging	Internal and External	⟷	⟷	⟷

Diversity Inclusion KPIs

Trust Strategic Aim	EDI aim	KPIs	Key Output	Internal /External Focus	Timeframe Yr1	Yr2	Yr3
We will - enhance our productivity and efficiency to make the best use of our resources	Deliver high quality care by understanding most effective ways of being inclusive. Consistently address faith / non faith practices and beliefs in delivering patient care within the existing financial envelope	Capture demographic data to aid in specific targeted interventions. Understanding patient demographics and culture.	- Clearer understanding of providing effective patient care taking on board the resources on offer and being fair and equitable.	Internal	←→	←→	←→

Diversity Inclusion KPIs

Gateshead Health
NHS Foundation Trust

Trust Strategic Aim	EDI aim	KPIs	Key Output	Internal /External Focus	Timeframe Yr1	Yr2	Yr3
We will - continuously improve the quality and safety of our services for our patients	Ensure clarity around pathways for all our patients taking into consideration the associated protected characteristics. Seek the views of our Networks in order to work more collaboratively and promote intersectionality and cultural normality	Review and refresh the training and development programme to support the development of inclusive practices Ensure all People networks members' voice's are represented in this work Introduce Cultural Intelligence training co-produced with patient leaders for People leading to increase in cultural competencies.	Network members will develop and grow in their own right as well as helping deliver effective patient care Address culture change required based on allyship and a greater appreciation of the different cultural norms that can cause misunderstandings and miscommunication.	Internal	←→	←→	←→

Diversity Inclusion KPIs

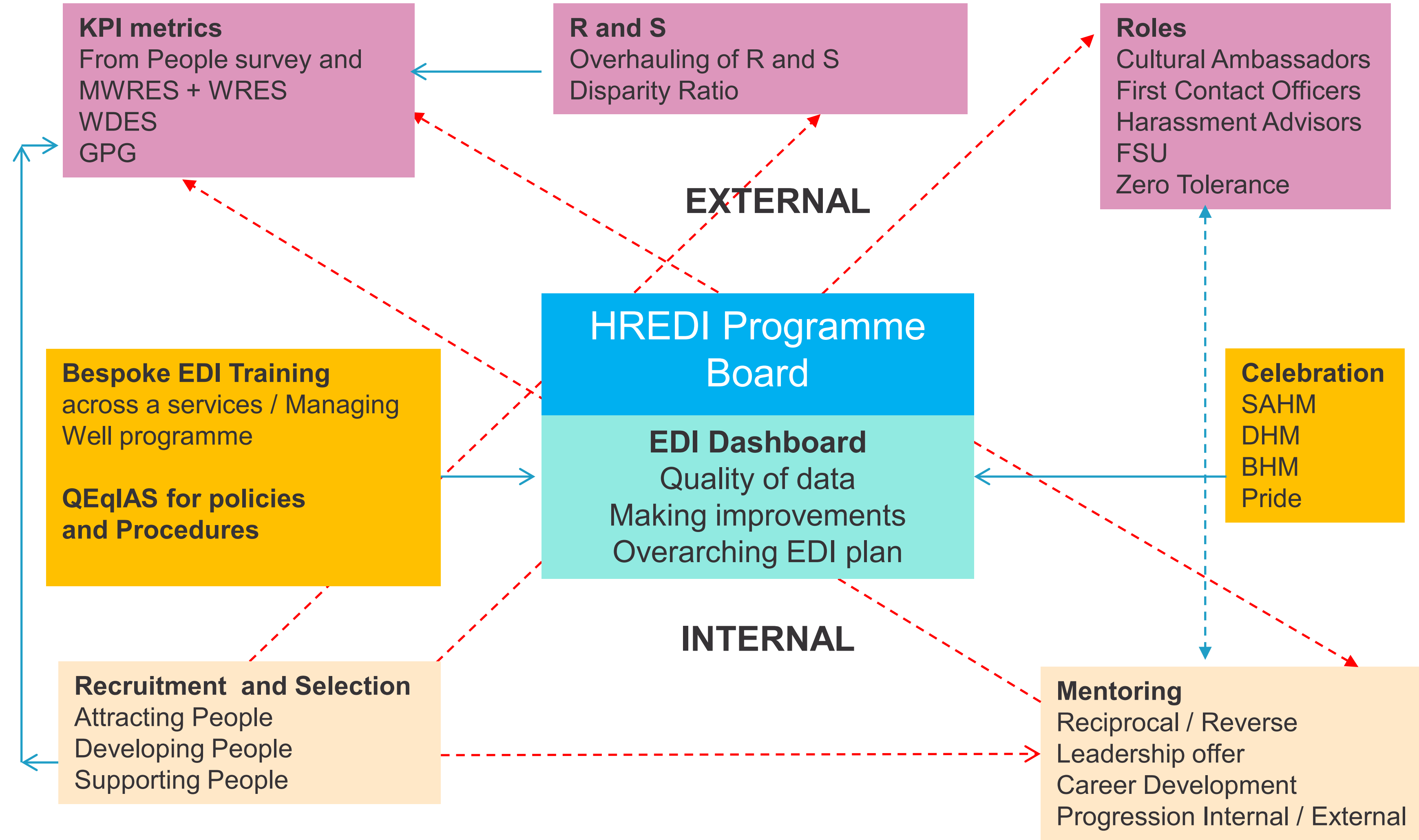
Trust Strategic Aim	EDI aim	KPIs	Key Output	Internal /External Focus	Timeframe Yr1	Yr2	Yr3
We will - be an effective partner and be ambitious in our commitment to improving health outcomes, develop and expand our services within and beyond Gateshead	Address Health Inequalities across the communities served. Engage with community groups to understand the complexities of health issues impacting upon communities served. Work with Public Health to address various campaigns around health promotion	Ensure that the system wide inclusive decision-making framework is used across all service areas and projects to ensure that health inequalities are addressed in the planning and delivery of services	Engagement with other Health partners within the ICB region will give a wider understanding across the region around Health inequalities based upon different communities accessing our services	Internal and External	↔ (arrow spans Yr1–Yr3)		

Diversity Inclusion - Delivery

EDI Strategy	How can we deliver this through our Strategy
Patients	Understanding the needs of our population and working with them to design and deliver services that meet the needs of all our patients.
People	Providing good employment opportunities for people who understand and represent the community we serve and creating a caring, inclusive, respectful working environment where everyone can flourish.
Performance	We strive to be ambitious in our aims and will measure how we perform against key equality, diversity and inclusion measures.
Partnerships	Whilst there are things we can take forward on our own, there's more we can achieve by working together with our system partners in the region

Trust HREDI programme

Gateshead Health NHS Foundation Trust



EDI action plan Gateshead Health Equality and Diversity Objectives and Action Plan 2020 – 2024

Our EDI Strategy serves as an overarching plan that outlines the rationale for action, and areas of focus. It highlights what actions we need to take in order to implement and manage progress. A high level action plan has been written and actions are monitored by the Human Rights Equality Diversity and Inclusion Board.

- Our framework of actions incorporates the statutory reporting for:

  WRES - Workforce Race Equality Standard
  WDES - Workforce Disability Equality Standard
  GPG - Gender Pay Gap
  PSED - Public Sector Equality Duty
  EDS2 - Equality Delivery System 2

Our EDI action plan will focus on the following EDI Objectives:

Ensure EDI Strategy, principles and practice are embedded into Trust Governance and assurance arrangements at every level in the Trust.	Continued improvement of service provision and patient care	Improved Equality and Diversity data collection and information	CORE and Essential Training

Evaluation and measurement

- There has been a significant focus during to establish clearer governance arrangements to take forward and monitor progress of Equality, Diversity and Inclusion activities across the Trust.
- Oversight by the HREDI Programme Board
- We have established a Human Rights Equality Diversity and Inclusion group to ensure actions are clearly set to deliver our objectives and to provide oversight to the EDI actions developed from the WRES / WDES/ EDS and GPG

Clinical Strategy-2023-2026

Andy Beeby, Medical Director

16/5/23

#GatesheadHealth, proud to deliver outstanding and compassionate care to our patients and communities.

The Clinical strategy is linked to the Corporate Strategic aims

We will continuously improve the quality and safety of our services for patients

We will be a great organisation with a highly engaged workforce

We will enhance our productivity and efficiency to make the best use of our resources

We will be an effective partner and be ambitious in our commitment to improving health outcomes

We will develop and expand our services within and beyond Gateshead

A vision for Gateshead Health NHSFT by 2026 – what will our patients our people and our wider partners see?

- Optimised secondary care provision
  - A high quality secondary care and community facility linking well with primary care and social care
  - Maximised elective function
  - Helping to relive pressure on tertiary services within the region
- Providing regional level services to support the ICS and beyond
  - Gynaecological Oncology
  - Pathology and laboratory facilities
  - Screening services
  - Breast services
  - IVF
- An outstanding provider of clinical training
- Health inequalities being addressed and equity of access to our services
- A responsive innovative provider responding to changes in clinical care
- Close working with our partners in Gateshead to ensure patients receive the right care in the right place (Primary care, Community, Home or Hospital) with integration of population based clinical strategy
- Close working with other partners within the ICS to improve health care across a wider footprint as part of the ICS "Better health and wellbeing for all" strategy published Dec 2022

Key themes

- Deliver safe, high quality, individualised and compassionate care to our patients
- Innovate for our future patients
- Anticipate future health care requirements
- Promote health and wellbeing and health inequalities
- Maximise the use of digital technology
- Work collaboratively with our partners to develop services within and beyond Gateshead and to bring resilience to more vulnerable services
- Link the development of our estate to clinical strategy
- Prioritise the transformation of acute care

Quality – Supporting the Trust Strategy

#GatesheadHealth Corporate Strategy			Clinical Strategy				
5 Strategic Aims	Strategic areas	Strategic focus areas	Safe, Effective, High Quality	Innovation	Health Inequalities	Digital	Collaboration
Productivity and efficiency / Growing services beyond Gateshead / Improving service quality and safety	Patients	Caring for all our patient communities	●	●	●	●	●
		Providing safe, high quality care	●	●	●	●	●
		Offering increasingly integrated care	●	●	●	●	●
		Making every contact compassionate and caring	●		●		●
Highly engaged workforce	People	Supporting the health and wellbeing of our people	●		●		●
		Being a great place to work	●	●	●	●	●
		Ensuring a diverse, inclusive and equitable culture			●	●	●
	Partners	Working in new and collaborative ways as "one team"	●		●	●	●
…rtnerships …d outcomes		Being a force for good	●		●		
		Acting as a key partner	●		●		
		Working with further and higher education		●			●

NHS
Gateshead Health
NHS Foundation Trust

Clinical strategy

- This strategy outlines
  - Projects that have already been identified for development and which link to the Clinically Led Estates Strategy
  - Future development opportunities that are being considered
  - How digital will be developed (Linking to the Digital Strategy)
  - People issues related to clinical strategy (linking to the People Strategy and Nursing Strategy)
  - Health and inequalities work (linked to Health & Inequality Strategy)
  - The priority work in acute care
  - Specific business unit clinical priorities and development opportunities
  - Linking to regional clinical strategic work
  - Further work required to develop the detail under the overarching strategy

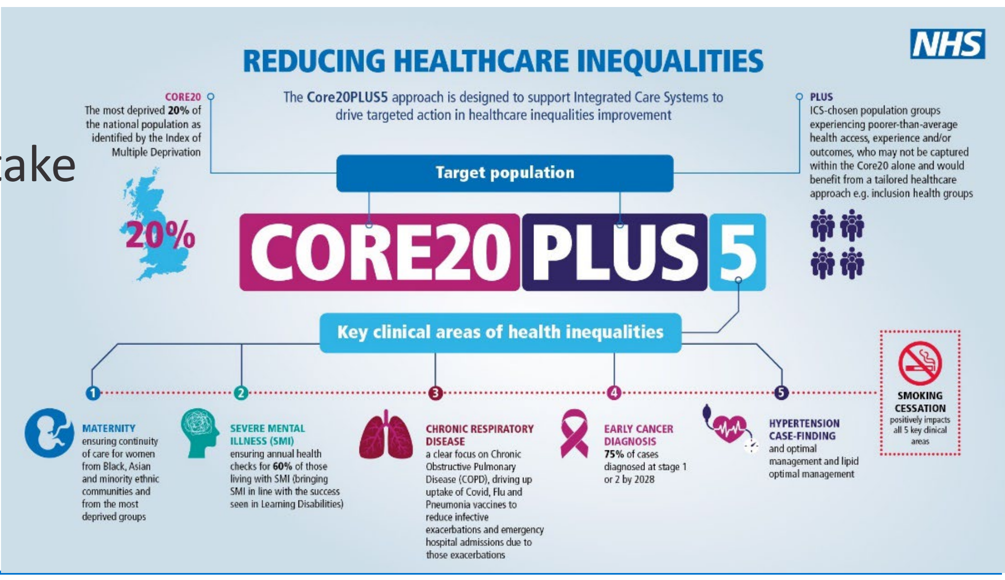
It has been developed with a range of consultation including the Clinical Strategy Group, Clinical Business units, Board strategy discussions and linking to other enabling strategies.

The strategy will need to be linked both to internal enabling strategic and wider system strategic clinical planning as these emerge.

The strategy will guide work by our Transformation Board and when opportunities arise for external funding

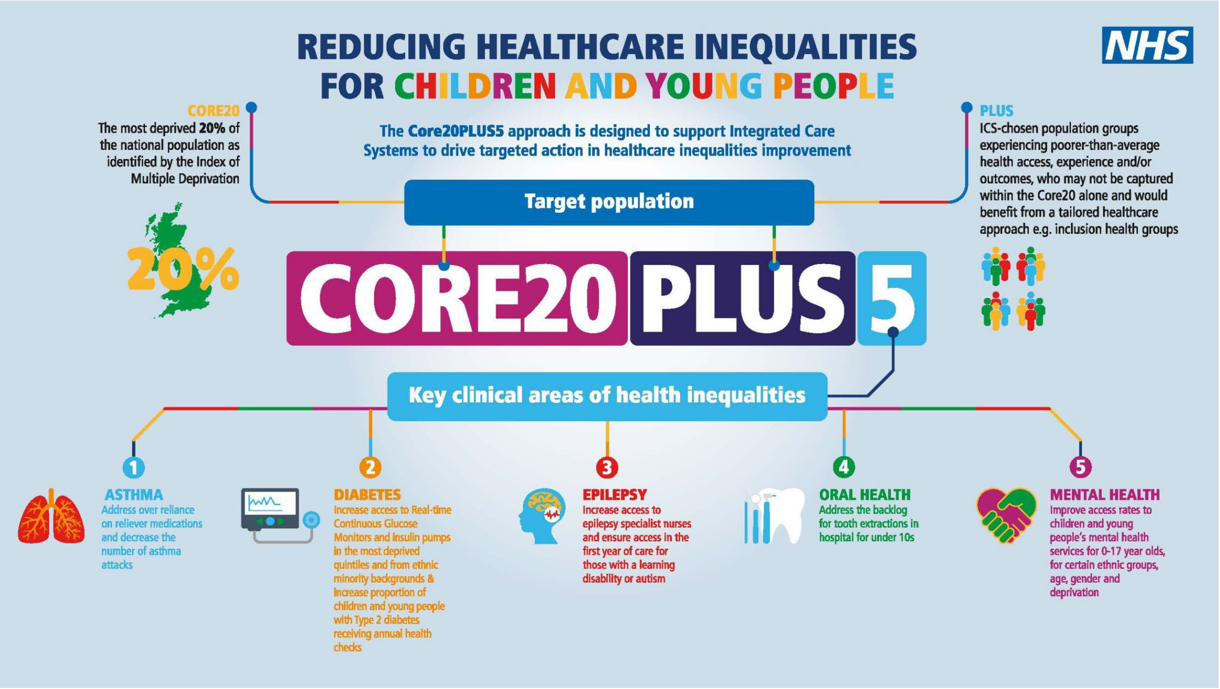
Health Inequalities

- Health inequalities are avoidable, unfair and systematic differences in health between different groups of people.
- They are rooted deep within our society, and they are widening, leading to disparate outcomes.
- This results in earlier deaths, lost years of healthy life, intergenerational effects from traumatic experiences and has a significant economic cost for society
- Core20plus5 – NHSE new approach to tackling health inequalities
  - Improvements for most deprived 20% PLUS local population grouped in 5 key clinical areas
    - Maternity – continuity of care
    - Severe Mental Illness – annual health checks
    - Chronic respiratory disease – focus on COPD & vaccine uptake
    - Early cancer diagnosis
    - Hypertension case finding



Health Inequalities – Children and Young People

- Core20plus 5 for children and young people – Improvements in 5 key areas of health inequality
  - Asthma – reducing over reliance on medications and number of attack
  - Diabetes – better access to monitoring and follow up
  - Epilepsy – better access to epilepsy specialist nurses in first year of care for those with learning disability or autism
  - Oral health – access to tooth extractions
  - Mental Health – improve access



Health Inequalities – Overarching strategy

- Consider health inequalities when prioritizing developments
- Ensuring equity of access
- Work collaboratively as part of Gateshead System and other system partners across the ICS to improve health and care outcomes for our population
- Links to Trust Health Inequalities strategy and to the ICS strategy "Better health and wellbeing for all" Dec 2022.

Fighting for a better future for Gateshead

Gateshead Health and Wellbeing Strategy
Good jobs, homes, health and friends
"Why treat people and send them back to the conditions that made them sick?"

- Give every child the best start in life
- Enable all children, young people and adults to maximise their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure a healthy standard of living for all
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill health prevention.

Digital clinical strategy

- We will increase the use of digital technology to improve services for our patients
  - Improvement in speed and availability of access in clinical areas
  - An integrated digital clinical system to reduce the need to open multiple applications and create “one version of the truth”
  - A longer term ambition to move to a full electronic patient record
  - Collaborate with others to ensure sharing of information where this is important for clinical care
  - We will be mindful of digital exclusion and ensure that we have systems that cater to all requirements
- Links to Trust Digital Strategy

Clinical Research Strategy

- We will be a research active organisation - Gateshead Health NHS Foundation Trust remains a research active organisation which ensures that our patients have access to the very latest treatments and technologies. Evidence shows clinically research active hospitals have better patient care outcomes.
- We will enable our patients to have access to relevant clinical trials - Gateshead Health NHS Foundation Trust works collaboratively with the NIHR North East and North Cumbria Clinical Research Network: (NENC CRN) which funds research into health and social care with the aim to "improve the health of the Nation through research".
- We will participate in regional and national research – The Trust aims to attract more commercial research to the region and broaden our hosted research portfolio to offer more of our patients the opportunity to participate in research.
- This links to our Research Strategy 2022 – 2027 – Our Vision – Every patient and member of staff should have the opportunity to be part of a research study and improve the health of our patients through research. Our Mission – To embed a culture of research within the Trust and make research everyone's business.

NIHR - Be Part of Research –
Exploring Health Inequalities

Research is everyone's business .....

Clinically Led estates strategy - overview
Estate developments underway

- New Operating Model
  - Estates work to improve flow through the hospital and give additional elective capacity
    - Development of Same Day Emergency care (Completed)
    - Expansion of Emergency Admission Unit (Completed)
    - Development of new elective orthopaedics ward
    - Provision of estate for safe management of Clinically Extremely Vulnerable patients (Ward 14 completed)
    - An escalation ward
    - Preassessment relocation (Completed)
- Maternity
  - Upgrade of existing estate
    - Second theatre (completed), upgrades to bereavement room and pool room (completed)
- Endoscopy
  - Reconfiguration to create additional clinical room

Links to Clinically Led estates strategy

Clinically Led Estates strategy – 5 year priorities (subject to funding)

- New maternity and paediatric outpatient unit within main building
- Cancer centre development (Tranwell)
- Respiratory Support Unit
- Community Diagnostic Centre
- Pharmacy redevelopment
- IVF off-site development
- QEH diagnostic centralisation / consolidation

Acute Care – better medical pathways

- Urgent and emergency care is at a time of crisis and current constraints mean that we will need to prioritize those with greatest needs
- We will work with our partners to help transform acute care in line with the 10 recommendations of the multi-college document “Rebuilding the NHS: better medical pathways for actue care 2022”
- We will prioritise clinical developments which are in line with these recommendations including
  - Better communication between secondary and primary care
  - Maximising our same day emergency care
  - Prioritizing patient flow and providing rapid speciality advice
  - Maximising 7 day availability of diagnostic and support services
  - Improving access to liaison psychiatry for those presenting with a mental health crisis
  - Optimising discharge planning

- Ref Royal College of Physicians: Rebuilding the NHS: Better medical pathways for acute care 2022

Clinical Training

- We will continue to develop our high quality work in clinician training
  - Training the workforce of the future
  - Developing the current workforce
- We will embed training across all our clinical areas and see it as an integral part of providing a clinical service

NHS
Gateshead Health
NHS Foundation Trust

Making Services Sustainable

- We will develop a clinically led understanding of our services and their sustainability by reviewing using the framework below
  - Services with noted national vulnerability or risk
  - Services with significant capacity and demand imbalance
  - Services with recognised recruitment challenges
  - Services with a single handed clinical model
  - Services which address significant local health inequalities
  - Services that are unable to meet quality standards
  - Services that are economically unviable
- Following review we will make a recommedation for action
  - Grow
  - Transform or
  - Collaborate
- We will also identify services which have the potential to offer support for the wider ICB and population

Business Unit clinical priorities

These will be iterative depending on prioritization, available funding, clinical developments, external priorities and ambition around time scale.

We will define our more vulnerable services and how we will make these more sustainable (eg by collaboration with partners or enhancing our existing offer)

Not all these will be achievable within the next 3 years and there will need to be future discussion through Clinical Strategy Group and decision making at Senior Management and Board level.

Principles to addressing

1 Define ambition around timescale

2 Define whether investment required or whether priority can me met within existing resource or whether external funding is required

3 Decide how they fit with priorities around health inequalities

4 Have plans ready in preparation for any external funding opportunities that become available

5 Consider the need to work with partners for more vulnerable services

Urgent and Emergency Care

Workforce	Collaboration	Digital
• Senior Decision Makers at the front door	• Increase SDEC pathways	• Tap in tap out access across UEC
• Job planning across the team and across the career span including non-medical workforce.	• GPs in UTC and into Primary Care	• "One version of the truth" • Reduce duplication • Increase efficiency
• ED nurse retention	• Bring Frailty to the Front Door	
• GIM rota stability		
• UTC Practitioner development		

Respiratory, Cardiology, Diabetes and Endocrine, Rheumatology, Gastroenterology, Haematology, PIU

Respiratory Support Unit	Out-patient activity	Virtual Wards	FoH in-reach
• Consistent delivery of NIV	• Remote consultations: digital requirements	• Expansion beyond Respiratory	• Specialty opinion to ED or EAU
• Right care and right place	• Face to face clinic environment fit for purpose	• Workforce requirements	• Promoting the specialty nurse role
• Supports recruitment and retention of nursing, medical and AHP staff	• Group clinics	• Admission avoidance through specialty nurse utilisation	
• Promotion of NIV as life saving treatment: • Decompensated T2RF • Mortality = 15-25% • NNT to avoid death (NIV) = 8	• “Hot clinics”		

Care of the Elderly, Palliative Care, Stroke

COTE	Palliative Care	Stroke
Delivery of Acute Frailty with the workforce to support it	Care of the Dying document roll out	Utilise and work with the voluntary sector
Increase delivery of therapy services in hospital and at home	Education across the Trust and into community settings: Primary Care, Care homes	Early supported discharge to appropriate setting
Collaboration with community	MDT with specialist skills: • OT • Physio • Social Worker	Collaboration with CSS, CBU and NuTH to improve pathways of care
Workforce modelling for COTE specialty services • Parkinson's Disease • Osteoporosis • Tilt table • Ortho-geriatricians		Responsive services: • TIA clinic • In-patient referrals

Elective surgical care

Theatre productivity and workforce	Estate	Collaboration	External
• Improve theatre utilisation	• Theatre and air handling upgrade	• Pelvic floor service	• Expand existing regional work (Cumbria Shoulders)
• Reduce waste, improve recycling and reduce single use reliance		• Urogynaecology	• Support other providers with waiting lists
• Recruitment and retention initiaves			
• Recover elective performance post pandemic			

Maternity

Estates	Workforce	Quality & Safety	Digital
• Move from outdated, isolated premises to new facility connected to main hospital site (Maternity & Paediatric Estates strategy)	• Increase midwifery staff to be compliant with BirthRate+	• Compliance with recommendations from part 2 of the Ockenden report	• Link neonatal and maternity Badger systems
• Interim changes to exisiting estate (2nd theatre, upgraded pool room and bereavement suite upgrade)	• Increase specialist midwife roles	• Application for stage ½ UNICEF baby friendly accreditation	• Develop maternity digital strategy

Surgical services

Anaesthetics / CCU / Preassessment	Orthopaedics	Gynae Oncology	Gynaecology
• Block Room	• Day case arthroplasty	• Cancer centre project	• Improve Rapid Access Clinic capacity
• Round the clock pain service	• Orthopaedic robot	• RAS programme	• Expand outpatient hysteroscopy
• On the day pre-op assessment		• Admission avoidance through specialty nurse utilisation	• Further expansion of IVF including potential move off site
• Appropriate pre-op optimisation for high risk / complex patients		• Leading regional approach to Gynae Oncology	

Paediatrics

Estates	Digital	Collaboration	Workforce
• Relocation from outdated premises to new facility (part of estates strategy)	• Digital outpatient solutions	• Integrated care models with primary care	• Advance practice – expansion of existing team
			• Paediatric epilepsy specialist nurse

Pathology, Therapy, Endoscopy, Screening, Pharmacy

Pathology	Therapy	Endscopy & Screening	Pharmacy
• Network working	• Expand areas of advanced clinical practice and upskill AHP's	• Role developments for nurse endoscopists	• Further develop advanced practice
• Tendering for new work to maximise use of facility	• PIFU in Dietetics	• Re-tender for bowel screening 23/24	• Increase use of pharmacy prescribing
			Enhance links with Sunderland and Newcastle Universities

Imaging, Breast services

Diagnostic Imaging	Breast services		
• Community Diagnostic Centre	• Opportunity to provide regional leadership and support neighbouring Trusts		
• Improvement to estate			
• 2nd MRI scanner			

Older Persons Mental Health, Community services

OPMH	Adult Community Services	Children	Wrap around / Social care
• Retain specialist service	• Retain community services (retendering where required)	• Work closely with schools	• Therapy input for SALT/OT/Physio/Bladder and Bowel
• Work with CNTW around dementia diagnosis and crisis service	• Develop virtual ward	• Autism service	• Podiatry modernisation
• Review current delivery to ensure in line with up to date practice	• Embed urgent community response		• Consider models for social care provision and whether we find a way to provide some of this
• Ensure best digital solution in place	• Develop work around frailty		

#GatesheadHealth
Financial Strategy 2023/24 – 2025/26

Kris Mackenzie, Group Director of Finance and Digital

9 February 2023

Where did this strategy come from?

Engagement with:

- Executive Team
- Finance and Performance Committee
- Senior Management Team
- Finance Team

Information sources:

- Best practice across the NHS
- Best practice from private sector (e.g. IBM)
- HFMA Sustainability Checklist

#GatesheadHealth Finance Vision

"Be the guardians of stability and agent of transformation. Shaping, influencing and realising the effective use of resources in becoming a financially sustainable organisation in the delivery of outstanding and compassionate care to our patients and communities."

National Context

Covid Exit	NHS Structure/Resource Allocation	Balance
• Uncertainty • Complex interactions • Return of Elective PbR	• ICS and ICB introduction • Commissioning intentions • Funding flows • Focus on productivity and efficiency	Quality vs People vs Performance vs Finance

Local Context

Demographics	People	ICS	Capacity	Wider Public Sector
• Population information • Health inequalities • Accessibility and inclusion	• Increase in demand driven by e.g. SNCT, midwifery continuity of care • Constraint in supply • Absence levels • Proximity to tertiary centre	• Forecasting balanced position for 2022/23 • Size leads to differential across former ICP ‘regions’ • Collaboration • Our own services clinical and economic sustainability	• Capacity vs demand • Productivity • Optimisation of physical capacity and estate	• Gateshead Local Authority financial challenge • North East Devolution

Finance as an Enabling Function

The **#GatesheadHealth** corporate strategy prioritises the need to:

- Ensure robust governance structures
- Ensure evidence-based decisions
- Use data and financial forecasting to make the best use of our resources

This is underpinned by the Financial Strategy

Optimum use of resources

Data intelligence and triangulation

Financial Sustainability

Driving quality improvement

Fit for purpose finance function of the future

Optimum Use of Resources

What does it mean?

The ability to maintain long-term healthy finances, maximising resources and investment for our population by ensuring value for money.

Utilising our assets in the most efficient way possible to maximise the ability to deliver outstanding and compassionate care.

How are we going to do this?

- Ensure a collective understanding and ownership of the operational underlying financial position
- Elevate support for decision making improving financial efficiency of Trust services
- Clear and transparent financial culture underpinned with strong financial governance to include procurement
- Investment in critical enabling services supported by disinvestment in services not aligned to strategy
- Collaborative working with ICS and place based partners, to include proactive contracting
- Support the organisation in eliminating waste
- Maximise commercial strategy and identify strengths

Measuring success

- Financial balance
- Positive improving benchmarking returns
- More resource to support direct patient care
- Improved clinical performance
- Ability to evidence best practice across the finance teams
- Consolidated bed base
- Positive internal audit reporting

Data Intelligence and Triangulation

What does it mean?

- Understanding of all available digital and analytical tools to form a better understanding of the information that is collected to improve our services, and making best use of these, developing intelligent workflows.
- Influence digital transformation, supported by organisational agility that prioritises collaboration and enables real-time decision making,
- Data triangulation of finance, workforce and performance to develop a comprehensive understanding of our performance
- Enabled by analytics, AI and automation, intelligent workflows connect the organisation creating more effective service provision for patients. Learning from data and improving based on feedback

How are we going to do this?

- Increasing use of technology and shared services
- Modernisation of finance, IT and data capabilities. Deploying tools and nurture capabilities and capacity that enhance digital maturity across the organisation
- Focus on reducing data complexity and converting it into information
- Put data at the centre and standardise supporting definitions
- Identify key cost drivers and capture activity

Measuring success

- Fully integrated oversight dashboard
- People and activity metrics sitting over the financial information and vice versa
- Fully automated transactional processes
- Improved data capture
- Use of data and information to drive decision making to include PLICS
- Better results in performance and risk management
- Positive KPI trajectory

Driving Quality Improvement

What does it mean?

Ensuring that resources are available to solve challenges facing service delivery. With specific process resulting in measurable improvements.

How are we going to do this?

- Use of best practice and benchmarking tools
- Evaluation of clinical and economic sustainability to include review of service pathways
- Enabling programmes/programme of work
- Capacity and demand assessment
- Investing in estate, equipment and digital
- Use of enabling tools such as RPIW/transformation programme/underpinning approach

Measuring success

- Positive benchmarking returns
- Delivery of transformation and efficiency
- Demonstration of delivery of value for money
- Improved HFMA Checklist self assessment results

Fit For Purpose Finance Function of the Future

What does it mean?

Development of a dynamic, inclusive and highly skilled finance function supported by a clear succession plan.

A finance function that enables a financially literate organisation with collective ownership for financial sustainability.

How are we going to do this?

- Review and strengthening of all governance arrangements
- Prioritise training and talent management to ensure highly skilled finance team
- Communicate mission and purpose, supporting transformation and change management to finance team
- Reskill existing finance team, to strengthen data and analytics expertise and business partnering acumen
- Championing a more agile finance function and empower teams to make changes
- Investing in digital technologies to support intelligent processes leading to higher value data and strong business partner relationships.
- Outward facing positive external relationships
- Improve offer to local Gateshead community

Measuring success

- Complete restructure and supporting organisational development programme of work
- Ownership and financial competence across organisation
- Accreditation with One NHS Finance
- Operational expertise across finance function
- Delivery and measurement of outcome based support
- Change in demographics of finance team

Assurance Report   Agenda Item: 10i

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☐
Committee Reporting Assurance:	Finance and Performance Committee			
Name of Meeting:	Board of Directors			
Date of Meeting:	Tuesday 25 April 2023			
Author:	Mrs K Mackenzie, Group Director of Finance & Digital			
Executive Lead:	Mrs K Mackenzie and Mrs J Baxter			
Report presented by:	Mr M Robson, Chair of Committee			
Matters to be escalated to the Board:				
Executive Summary: ***(outline assurances and gaps including mitigating actions)***	<u>Terms of Reference</u> The Committee reviewed the terms of reference and agreed the following amendments: • Non-Executive Directors to be added to the attendance section as they attend all Committees. • Agreed for the meeting organisation section to be tidied. • Identified previously for a POD representative to be in attendance and to be revisited. The Committee discussed the membership to include clinical representation and for further discussion at the Trust Board and cross check with other Committees therefore it can be complete as one approach. <u>Integrated Oversight Report</u> The report was presented informing that March was a challenging month due to the 72 hour Junior Doctor Industrial Action which had an impact on some of the performance metrics, and the Trust is consistently below the 85% target for the 62 day standard. It was noted that Ambulance arrivals have increased to the highest all year round with an increase to 30 and 60 minutes handover delays and we will still be benchmarked across the region. There is a planned deep dive to see how the 2 hour target can be improved for the Community Rapid Response. Audiology is still an area of risk and there is significant directive work ongoing and there is concern over the RTT with paediatrics/autism assessment being a key risk area.			

	We will be seeking Mid York's NHS advice on an effective model to improve this area and the 2023/24 recovery work is underway. The Committee acknowledged that the collaborative work with the Local Authority had taken place over the last year to reduce discharge delays and noted the outcomes from this on the improvement on LOS long waiters through improved discharge. There is also in depth work underway to further understand our 4 hours performance alongside the time of day and of the 12-hour breaches. The Committee were assured that a streamlined report is a work in progress to ensure the key areas of risk and achievements are more visible. <u>New Operating Model (NOM) benefits realisation report</u> The report was presented informing that the development of the NOM was clinically led, supports the delivery of our annual plan and aligns to our strategic aims and objectives. The estates and transformation work have progressed despite significant operational pressures with an expected completion date by September 2023. It was noted that our CEV patients are now protected in a dedicated ward area reducing clinical risk and all of the proposed schemes have been condensed into one large business case as this allowed for huge economies of scale to ensure services, patient pathways were logistically aligned and allowed for better utilisation of workforce. The Committee agreed for the requirements and the metrics to be added to the agenda for the next meeting. <u>Financial Revenue report</u> The report was presented informing that the revenue report draft year end finance figures is due for submission on Thursday and the headline figures refers to the adjusted finance position of the Trust that has returned a breakeven position. The Committee received the report and record assurance as a direct consequence of the reported 2022-2023 financial position. <u>Supply Procurement Committee Report</u> The report was presented informing the increase in the number of reports is not unusual during the approach to year end and 22 reports were considered with a combined value of £3.3m. It was noted that the Supply Procurement Committee minutes are a very comprehensive and useful addition to the Committee. <u>Capital plan and update report</u>

<table>
<tr><td></td><td colspan="2">The report was presented informing the year end spend was approximately £13m. The underspend was raised on the final CDEL of £0.7m yet the Trust had over committed by £1.5m and there are no gaps we need further reporting on.

<u>Audit One Report</u>
There were no reports for consideration this month.

<u>HFMA Action Plan monitoring</u>
Work is ongoing and there will be further updates to follow at future meetings.

<u>Transformation Board report</u>
This item was deferred and noted that the focus this month was on the NOM and this was on the agenda for the Committee.

<u>Internal Audit actions- monitoring report</u>
There were no reports for consideration this month.

<u>Organisational Risk Register</u>
The Committee reviewed the extract and asked that the following actions were carried out.
• Risk 3103 – agreed to retain as an ongoing risk. ERMG now meets monthly-all agreed to review the trust risks.
• Risk 2982 – still same as seen improvement but Mrs J Baxter will take action to review.

2 new risks have been added. · 3148 mandatory training & 2779 CQC standards.

<u>Board Assurance Framework (BAF)</u>
The BAF was updated accordingly and there will be further discussions to be had on the content.

<u>Oversight Meeting Letter – Medicine Business Unit</u>
Received for information.

<u>Finance and Performance Committee Cycle of Business 2022/23</u>
The Cycle of Business was updated accordingly.</td></tr>
<tr><td>Recommended actions for Board</td><td colspan="2">The Board is requested to note the assurances and risks identified by the Committee and be mindful of this when reviewing and discussing related agenda items.</td></tr>
<tr><td rowspan="2">Trust Strategic Aims that the report relates to:
(Including reference to any specific risk)</td><td>Aim 1
☐</td><td>We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>Aim 2
☐</td><td>We will be a great organisation with a highly engaged workforce</td></tr>
</table>

<table>
<tr><td rowspan="3"></td><td>Aim 3
☒</td><td>We will enhance our productivity and efficiency to make the best use of resources</td></tr>
<tr><td>Aim 4
☐</td><td>We will be an effective partner and be ambitious in our commitment to improving health outcomes</td></tr>
<tr><td>Aim 5
☒</td><td>We will develop and expand our services within and beyond Gateshead</td></tr>
<tr><td>Financial Implications:</td><td colspan="2">As outlined in the Finance Report paper on the agenda.</td></tr>
<tr><td>Links to Risks (identify significant risks and DATIX reference)</td><td colspan="2">Two risks from the BAF/ ORR are reflected with a high score:
3103 (Finance) Efficiency requirements cannot be achieved due to ongoing operational pressures resulting from COVID and demand on unscheduled care. CRR 20
2982- (Medicine) Risk of delay in transfer to community due to lack of social care provision and intermediate care beds, due to increased numbers of patients awaiting POC up to 30 patients in medical wards. CRR 16
Three further risks with a score of 12 are reflected:
2868 (COO) Risk to the delivery of the new Operating model due to the increase in activity and reduced workforce capacity (potentially due to covid waves), resulting in adverse impact on key performance and recovery plans. CRR 12
3128 (Finance) There is a Risk that the capital cost of delivery of the new operating model continues to increase resulting in revenue implications. CRR 12
3186 (COO) Risk to maintaining business continuity of services and recovery plans due to the estate infrastructure, age and backlog maintenance requirements which exceed the Trusts capital allocation CRR 12
Two new risks added to the ORR are reflected:
3148 (COO) Risk that the organisation is unable to release staff for mandatory training due to operational pressures and current vacancies in both medical and nurse staffing. CRR 12.
Reduced from 16 to 12 as business units' performance is improving.</td></tr>
</table>

<table>
<tr><td rowspan="1"></td><td colspan="6">

- **2779** (NMQ) Trust fails to meet the CQC Fundamental Standards resulting in potential regulatory action, harm to patients, resulting in reputational damage. CRR 12

Three risks are showing as overdue for review, and several actions remain overdue.</td></tr>
<tr><td>People and OD Implications:</td><td colspan="6">Workforce planning assumptions will form part of the annual plan submission.</td></tr>
<tr><td>Links to CQC KLOE</td><td>Caring
☒</td><td colspan="2">Responsive
☒</td><td>Well-led
☒</td><td>Effective
☒</td><td>Safe
☒</td></tr>
<tr><td rowspan="3">Trust Diversity & Inclusion Objective that the report relates to: (including reference to any specific implications and actions)</td><td>Obj.1
☐</td><td colspan="5">The Trust promotes a culture of inclusion where employees have the opportunity to work in a supportive and positive environment and find a healthy balance between working life and personal commitments</td></tr>
<tr><td>Obj. 2
☒</td><td colspan="5">All patients receive high quality care through streamlined accessible services with a focus on improving knowledge and capacity to support communication barriers</td></tr>
<tr><td>Obj. 3
☐</td><td colspan="5">Leaders within the Trust are informed and knowledgeable about the impact of business decisions on a diverse workforce and the differing needs of the communities we serve</td></tr>
</table>

Gateshead Health
NHS Foundation Trust

Assurance Report Agenda Item: 10ii

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☒
Committee Reporting Assurance:	Quality Governance Committee April 2023			
Name of Meeting:	Trust Board			
Date of Meeting:	April 2023			
Author:	Mrs A Stabler, Non-Executive Director			
Executive Lead:	Dr G Findley, Chief Nurse			
Report presented by:	Mrs A Stabler, Non-Executive Director			
Matters to be escalated to the Board:	No escalation required			
Executive Summary:	**Items received for assurance:** **Mental Health Update** The report was presented informing there has been a significant capital investment to bring the estates to the required standard and a lot of work over the past 19 months within the service to improve the overall quality. The Committee noted there are no vacancies within the Mental Health Team and the three mental health teams have been merged with a suitable accommodation sourced at the old IT Suite at Bensham. **Health Inequalities Strategy** The report was presented informing the final strategy includes the Children Core 20 plus, the Maternity Public Health Plan and the Health Inequalities Research. The Committee noted that discussions are underway to review the resources to oversee the co-ordination and delivery of the overarching action plan and therefore this still remains a risk. **Health and Safety Quarterly Report** The report was presented informing the group membership and the terms of reference of the Group Health and Safety Committee are to be reviewed and approved at the next meeting to ensure coverage and attendance. The Committee noted there is a focus on the statutory and mandatory training being mapped through ESR and the Committee will receive an update at the next meeting of progress and anticipated completion date.			

DRAFT

	Integrated Oversight Report The report was presented it was highlighted that the Hospital C-Diff target had been breached at the end of the year; in mitigation it was noted that the target for the year been reduced by 10 cases on the previous year. Assurance was given that all the C-Diff cases had been reviewed it was noted that some of the infections would have been categorised as community onset had the sample been taken earlier and work is underway to remind staff when a stool sampling should be undertaken. The Committee also noted the recent gloves are off campaign to raise awareness around when and when not to wear gloves and to ensure appropriate hand hygiene is undertaken. **Maternity Oversight Report** The report was presented informing there were no serious incidents reported during this period and the Board declaration for the Maternity Incentive Scheme has been submitted on 2 February 2023. The Committee noted we are waiting for the final CQC report. The small increase in the stillbirth rate was noted for this year however the committee also noted it is difficult to establish a trend due to the small numbers involved, the committee was assured that each case goes through a MDT perinatal mortality review tool to identify any learning. **Strategic Objectives 2022/23** The report was presented informing there are 4 strategic objectives and 17 sub actions mapped to this Committee. 14 sub actions are complete and 3 are in progress. The Committee reviewed the corporate objective monitoring action plan for assurance and completeness over the year-end position. **Quality Account 2022/23** The report was presented informing there is strong evidence provided to demonstrate the progress and achievements throughout 2022/23 for the four priority domains of patient safety, staff experience, clinical effectiveness and patient experience. The Committee noted this is a highlight presentation and a draft will be circulated in May which will be presented to the Council of Governors, ICB Oversight, Scrutiny Committee and Health Watch. **Learning from Deaths Update** The report was presented informing the SHMI is lower than expected and the HSMR is as expected. All deaths are initially scrutinised by the Trusts Medical Examiner Office with 99.1% of cases identified as being definitely not preventable and 94.9% of cases good practice was identified. **IPC BI-Annual Report**

	Deferred. **Quarterly Learning Report** The report was presented informing the first learning bulletin was signed off for publication at the SafeCare Risk and Patient Safety Council and was published early April 2023. The Committee noted that the learning library was been developed and will be launched digitally via SharePoint on 9 May 2023. The Committee requested a live demonstration of the library for the Members and the Governors. **Assurances from Strategic SafeCare Risk and Safety Council** The report was presented informing the Matrons environmental audit compliance and the QEF compliance reports were received at the meeting last week and received assurance that we have 100% compliance of the Matron walkabouts across all areas. The Committee noted there was one overdue CAS safety alert on the system and received assurance that significant work has been undertaken to address open and overdue alerts in a timely manner. **Assurances from Strategic Safeguarding Group** The report was presented informing the last meeting was held in November 2022 and have a meeting to streamline the report which has been delayed due to staffing concerns. It was noted however that all nursing posts have now been filled and the team will be fully established at the end of May. It was highlighted that the implementation of the Liberty Protection Safeguards has again been deferred nationally to 2024. **Serious Incidents Update** The quarterly report was presented informing we have 15 serious incidents ongoing of which there are 2 delayed reports from Business Units, 7 mapped to panel and 6 signed off to be sent. It was noted there were 2 fractured femurs in a fortnight and there is a downward trajectory in relation to the number of incidents reported and falls also to note the new falls documentation was to go live in Nerve Centre in May. **Safer Staffing Report** The report was presented informing the committee that 4 ward areas where staffing fell below 75% of funded establishment were Cragside Court, Ward 4, Ward 21 Elective Ortho and Ward 24. Assurances were given re mitigating actions. The committee were informed that SNCT data collection completed bi-annually in January and July of each year had been delayed due to the industrial action. The report will be presented at Board in June.

<table>
<tr><td></td><td colspan="2">The Community Business Unit implemented the MHOST (Mental Health staffing tool Assessment) from October and have now aligned with the data collection schedule noting the MHOST in June was completed but not presented therefore reference will be made in the January report.
Future reports will also indicate red flag data as per national guidance.

Proposed Clinical Audit Plan 2023/24
The report was presented informing this is for information and the Executive Team have been sighted on this.

Complaints Update
The report was presented informing there are 37 overdue complaints with 2 complaints that are ready for review and sign off and an action of a deep dive of complaints will be reviewed at the end of the week to determine next steps. The Committee were supportive of the flow chart of the 40 day timescale that was developed in the Complaints Task and Finish Group and requested for a telephone conversation to be added as a first conversation with the complaints team.

Gateshead Health Cervical Screening Visit
The final report was presented to the Committee the immediate action requested has been completed.

Items received by the Committee for information:

• Mental Health Act Compliance Minutes – January and February 2023
• Quality Strategy 2023-25
• Cycle of Business

The Committee acknowledged that there has been a significant reduction in restraints and a new policy has been implemented.</td></tr>
<tr><td>Recommended actions for Board</td><td colspan="2">Board are asked to note the work of the Committee and the assurances received and note the areas of risk identified but note the actions in place to resolve.</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to: (Including reference to any specific risk)</td><td>Aim 1
☒</td><td>We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>Aim 2
☐</td><td>We will be a great organisation with a highly engaged workforce</td></tr>
<tr><td>Aim 3
☐</td><td>We will enhance our productivity and efficiency to make the best use of resources</td></tr>
<tr><td>Aim 4
☐</td><td>We will be an effective partner and be ambitious in our commitment to improving health outcomes</td></tr>
<tr><td>Aim 5
☒</td><td>We will develop and expand our services within and beyond Gateshead</td></tr>
</table>

<table>
<tr><td>Financial Implications:</td><td colspan="6">None to Note</td></tr>
<tr><td>Links to Risks (identify significant risks and DATIX reference)</td><td colspan="6">ORR Risks, 2879 – Maternity, 2779 CQC Compliance/ Improvement, 2868 – Further wave of Covid, 2880</td></tr>
<tr><td>People and OD Implications:</td><td colspan="6">Gaps in workforce in nursing, midwifery and mental health.</td></tr>
<tr><td>Links to CQC KLOE</td><td colspan="2">Caring
☒</td><td>Responsive
☒</td><td>Well-led
☒</td><td>Effective
☒</td><td>Safe
☒</td></tr>
<tr><td rowspan="3">Trust Diversity & Inclusion Objective that the report relates to</td><td>Obj.1
☐</td><td colspan="5">The Trust promotes a culture of inclusion where employees have the opportunity to work in a supportive and positive environment and find a healthy balance between working life and personal commitments</td></tr>
<tr><td>Obj. 2
☒</td><td colspan="5">All patients receive high quality care through streamlined accessible services with a focus on improving knowledge and capacity to support communication barriers</td></tr>
<tr><td>Obj. 3
☐</td><td colspan="5">Leaders within the Trust are informed and knowledgeable about the impact of business decisions on a diverse workforce and the differing needs of the communities we serve</td></tr>
</table>

Digital Committee

Assurance Report

Agenda Item: 10iii

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☐
Committee Reporting Assurance:	Digital Committee			
Name of Meeting:	Board of Directors			
Date of Meeting:	Wednesday 24th May 2023			
Author:	Mr N Black, Chief Information Officer			
Executive Lead:	Mrs K Mackenzie, Group Director of Finance & Digital			
Report presented by:	Mr A Moffat, Chair of Committee			
Matters to be escalated to the Board:	None			
Executive Summary:	Reporting Timetable The reporting timetable has been amended following discussion at last meeting to include clinical systems as an agenda item. Organisational Strategic Objectives – Digital Of the six 22/23 objectives, three have been completed: the development and the management of the digital delivery plan and the development of a data quality plan / indicators relating to the use of clinical systems. The latter continues to be monitored by the Committee on an ongoing basis. Whilst work has progressed in relation to the other three objectives [the development of digital service workforce plan, a digital and inclusion (for staff and patients) plan and a systems exploitation plan] they have all have been delayed. Slippage was reported as being attributable to personnel changes within the services. Digital Strategy and Digital Delivery Plan Reporting of the Digital Strategy and Delivery Plan has been consolidated into an overall 'Digital Program Plan' listing all projects within the current programmes of work. One item marked in red (delayed) on the report related to the refresh of the Filefast system. This project has encountered significant technical issues regarding the connectivity of devices to scan health records. Work is ongoing to reach a solution.				

	<u>Integrated Electronic Patient Record update</u> A high level EPR business case and timeline was presented but was viewed as requiring further detail to demonstrate critical time and approval points. A draft report has been received by Channel 3 covering these issues, the updated project approach and procurement timeline. This is currently under review and will be brought to the next Committee meeting in June. <u>Digital Service Key Performance Indicators</u> The KPI report has been reworked refine the KPI's and associated targets; this was subsequently reviewed and approved at SMT. RAG ratings are now related to measurable data rather than whether an item is subjectively on or off track. It was noted that there remain multiple KPIs whose performance is below target and remain of concern. E.g those relating to Information Asset Management. <u>Digital Service Perception</u> Work to progress with POD Committee to establish an end user survey regarding perception of digital services. A deep dive is to be undertaken to understand the poor satisfaction results in the recent staff survey from Finance and Digital. <u>Regulatory and Governance</u> Progress made against open internal audit actions, however some actions that have been completed are showing as open within the report; further investigation required. The recent repeat of the Dionach Audit (penetration test and assessment process) undertaken in October 22 identified that the majority of the 13 high and critical items identified in previous testing had been resolved. Two of these items remained outstanding due to several complex issues but the Committee was reassured that these would be resolved by the time the next Dionach audit is commissioned. <u>Digital Transformation Group and Digital Assurance Group Assurance Reports & minutes of last meetings</u> It was reported that the DTG had not met in 2023 due to service pressures; although reporting packs were still collated and issued to members. It was noted that this represented a gap in assurance to Digital Committee; it was suggested that standing down of sub-committees should be authorised by the Executive team. The DAG Assurance Report was received and whilst there were no items for escalation to the DC reported, a number of items with a red RAG rating were discussed during the

<table>
<tr><td></td><td colspan="5">DC meeting. The Committee therefore asked that in future such items be highlighted for escalation in the Report.

<u>Organisational Risk Register</u>
Key risks discussed including Information Asset Owners and vacancy gaps.

<u>Board Assurance Framework (BAF)</u>
The Board Assurance Framework was updated accordingly.</td></tr>
<tr><td>Recommended actions for Board</td><td colspan="5">The Board is requested to note the assurances and risks identified by the Committee and be mindful of this when reviewing and discussing related agenda items.</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to: (Including reference to any specific risk)</td><td>Aim 1
☐</td><td colspan="4">We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>Aim 2
☐</td><td colspan="4">We will be a great organisation with a highly engaged workforce</td></tr>
<tr><td>Aim 3
☒</td><td colspan="4">We will enhance our productivity and efficiency to make the best use of resources</td></tr>
<tr><td>Aim 4
☐</td><td colspan="4">We will be an effective partner and be ambitious in our commitment to improving health outcomes</td></tr>
<tr><td>Aim 5
☒</td><td colspan="4">We will develop and expand our services within and beyond Gateshead</td></tr>
<tr><td>Financial Implications:</td><td colspan="5">None to note</td></tr>
<tr><td>Links to Risks (identify significant risks and DATIX reference)</td><td colspan="5">There are no significant risks on Datix relating to the business conducted at this meeting.</td></tr>
<tr><td>People and OD Implications:</td><td colspan="5">None to note</td></tr>
<tr><td>Links to CQC KLOE</td><td>Caring
☒</td><td>Responsive
☒</td><td>Well-led
☒</td><td>Effective
☒</td><td>Safe
☒</td></tr>
<tr><td rowspan="3">Trust Diversity & Inclusion Objective that the report relates to: (including reference to any specific implications and actions)</td><td>Obj.1
☐</td><td colspan="4">The Trust promotes a culture of inclusion where employees have the opportunity to work in a supportive and positive environment and find a healthy balance between working life and personal commitments</td></tr>
<tr><td>Obj. 2
☒</td><td colspan="4">All patients receive high quality care through streamlined accessible services with a focus on improving knowledge and capacity to support communication barriers</td></tr>
<tr><td>Obj. 3
☐</td><td colspan="4">Leaders within the Trust are informed and knowledgeable about the impact of business decisions on a diverse workforce and the differing needs of the communities we serve</td></tr>
</table>

Assurance Report Agenda Item: 10iv

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☐
Committee Reporting Assurance:	People and OD Committee – May 2023			
Name of Meeting:	Trust Board			
Date of Meeting:	May 2023			
Author:	Lisa Crichton-Jones, Director of People & OD			
Executive Lead:	Lisa Crichton-Jones, Director of People & OD			
Report presented by:	Dr R Bonnington, Non-Executive Director			
Matters to be escalated to the Board:	No formal points of escalation.			
Executive Summary: ***(outline assurances and gaps including mitigating actions)***	**Items received for assurance:** **Strategic Objectives Development 2023-24:** The report was presented providing assurance on the ongoing development of the 3 Strategic Objectives to be overseen by this committee and pending approval at the Trust Board in May 2023. These align with the People Strategy and a Leading Indicator for each objective is being developed. Further operational discussion will take place to finalise this work with the setting of a KPI with another aspirational KPI to strive towards. **Disclosure and Barring Service (DBS) Position Update:** The report was presented advising of the work underway to review the historic DBS process and recording. The TRAC recruitment system (introduced July 21) provides data and reports giving assurance as to DBS for new starters and this assurance is received in the metrics report for this committee. **Guardian of Safe Working Quarterly Report:** The report was presented informing that during the period of 1 January 2023 to 31 March 2023, Medicine and Surgery have the highest amount of exception reports and there were no fines levied and no immediate safety concerns. Work continues to provide improved Junior Doctors mess facilities and will be reported to the Senior Management Team to ensure this is resolved.			

	Guardian of Safe Working Annual Report: The report was presented and it was noted that a medical staffing bulletin has recently been implemented and well received. There have been some operational pressures in the medical staffing team which have impacted on customer care and whilst the service has improved, this will receive careful oversight and support from senior staff. It was agreed to review the content and format of this report to be clear on the purpose of the report and assurances given. **Workforce Plan – Approach, Plan and Next Steps:** The verbal update informed that the partnership and focus on workforce planning with the Whole Systems Partnership has been well received. WSP have now provided a report with recommendations for how to take this work forward and further develop strategic workforce planning across the trust. An update is scheduled to be given to the Board in June 2022 and over the next few weeks discussions at SMT / Execs will take place, with a clear understanding that our service planning for the next few years needs to drive this work. **WRES Action Plan Review 2022:** The committee noted the transfer of EDI into the People and OD Directorate and this was welcomed with the committee noting the opportunity to refresh and reposition EDI work. The report was presented informing the WRES action plan was produced centrally by NHS England and it comprised both best practice and identified areas of improvement; harassment and bullying or abuse from staff in the last 12 months against BME staff, career progression in clinical roles and likelihood of appointment from shortlisting. The low score applied to the action plan was an area of concern and the committee were assured that the EDI and Engagement Lead is exploring the approach and methodology used with other leads across the region whilst more importantly also scheduling a workshop to realign work into the EDI action plan. **EDS2 Stakeholder Engagement Update:** The committee noted that engagement approach for the next EDS2 submission was still being finalised and reiterated the importance of this across all 3 indicators. **Integrated Oversight Report:** The committee noted the ongoing development of POD metrics within the IOR and considered the key issues that included a reduction in sickness to 5.3%, an increase in core training compliance to 83.7% and the current vacancy

	rate of 6.7%, which is a reduction. There is good progress on the reduction of bank and agency spend and the bank fill rates are consistent at approximately 50%. **People and OD Additional Metrics:** The Committee received a refreshed presentation of additional people metrics (out with the IOR) which highlighted the key areas of focus across the 4 portfolio areas of the directorate. By way of example, it was noted there were 7 employee relation cases during the course of January to April 2023 and the Managing Well / Leading Well Programmes attendance levels were impacted by the Industrial Action and a number of sessions were stood down to ensure availability of people. There continues to be an increase in the number of staff attending induction and the highest proportion of leavers have less than 5 years of service. This new format will continue to evolve. **Organisational OD Plan:** The committee reflected on the work which had been on going, led by the CEO to compile the content of a thematic review report. These key themes of work have been collated including those from the GGI report and the Staff Survey. This committee will oversee the implementation of this work and retain oversight on behalf of the Board. **Culture Programme Update:** Deferred to the next Committee. **Internal Audit Report – GHE 2022-23/09 Health Roster Audit:** The Committee received the report. **People and OD Organisational Risk Register:** The Committee received the report and noted the following risks: • **3095 (POD)** - Risk to quality of care due to Industrial Action affecting staffing levels and potential impact on patient care, safety and quality – CRR 20. • **2764 (POD)** – Risk of not having the right people in right place at the right time with the right skills due to lack of workforce capacity, resources and expertise, across the organisation to support workforce planning along with regional and national supply pressures, resulting in failure to deliver current and future services that are fit for purpose – CRR 16. • **2759 (POD)** – Workforce Health & Wellbeing - Risk of adverse impact to staff health and wellbeing due to internal working conditions and pressures as well

<table>
<tr><td></td><td colspan="6">as external factors (demand, patient acuity, staffing levels, Covid, civil unrest) resulting in increasing physiological and psychological harm. – CRR 12.

Review of Effectiveness and Terms of Reference:
The report was presented informing that 9 positive responses have been received to the survey and a further review will be undertaken with an action plan to be presented to the Committee in 6 months' time.

Items received by the Committee for information:

• Gender Pay Gap Report Update</td></tr>
<tr><td>Recommended actions for Board</td><td colspan="6">Note main assurances against the strategic People and OD themes detailed and key associated risks.</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to: (Including reference to any specific risk)</td><td>Aim 1
☐</td><td colspan="5">We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>Aim 2
☒</td><td colspan="5">We will be a great organisation with a highly engaged workforce</td></tr>
<tr><td>Aim 3
☐</td><td colspan="5">We will enhance our productivity and efficiency to make the best use of resources</td></tr>
<tr><td>Aim 4
☐</td><td colspan="5">We will be an effective partner and be ambitious in our commitment to improving health outcomes</td></tr>
<tr><td>Aim 5
☐</td><td colspan="5">We will develop and expand our services within and beyond Gateshead</td></tr>
<tr><td>Financial Implications:</td><td colspan="6">No significant new financial implications to highlight to the Board.</td></tr>
<tr><td>Links to Risks (identify significant risks and DATIX reference)</td><td colspan="6">Three risks from the organisational risk register were reviewed:
2764 – Right People, Right place, Right skills – 16
2765 – Leadership and OD – 12
2759 – Health & Wellbeing – 12</td></tr>
<tr><td>People and OD Implications:</td><td colspan="6">As set out</td></tr>
<tr><td>Links to CQC KLOE</td><td>Caring
☒</td><td colspan="2">Responsive
☒</td><td>Well-led
☒</td><td>Effective
☒</td><td>Safe
☒</td></tr>
<tr><td rowspan="2">Trust Diversity & Inclusion Objective that the report relates to: (including reference to any specific implications and actions)</td><td>Obj.1
☒</td><td colspan="5">The Trust promotes a culture of inclusion where employees have the opportunity to work in a supportive and positive environment and find a healthy balance between working life and personal commitments</td></tr>
<tr><td>Obj. 2
☐</td><td colspan="5">All patients receive high quality care through streamlined accessible services with a focus on improving knowledge and capacity to support communication barriers</td></tr>
</table>

	Obj. 3 ☒	Leaders within the Trust are informed and knowledgeable about the impact of business decisions on a diverse workforce and the differing needs of the communities we serve

Chief Executive's Update to the Board of Directors

Trudie Davies

24 May 2023

Strategic Aim 1: We will continuously improve the quality and safety of our services for our patients

- Significant focus on **length of stay** to support our colleagues to care for those patients most in need. We are seeing some key improvements already – closure of escalation beds, reduction in non-elective length of stay, improvements in A&E-related metrics.
- Developing a **suite of key indicators** to help us all to more meaningfully understand and contribute towards our performance and ultimately the impact on patient outcomes. Clinical engagement to take place as part of their development.
- NHS England **Quality Assurance Visit Report – Cervical Screening**
- **Breast Services team** – achieved all cancer standards in 2022/23.
- **Positive feedback** from NHS England's Chief Commercial Officer following a visit to our **pathology department**.
- **Blaydon Urgent Care Centre** back open to full capacity.
- Head of Midwifery, Lesley Heelbeck, has taken up a prestigious secondment at NHS England as a **Maternity Improvement Advisor** for six months. We welcome Jane Conroy as Head of Midwifery during this time.
- **Annual Nursing Conference** held on 12 May.

Engagement, involvement and visits:

- ❖ Medical wards
- ❖ Gynae oncology
- ❖ Breast service
- ❖ Theatres
- ❖ Endoscopy

Strategic Aim 2: We will be a great organisation with a highly engaged workforce

- Significant focus on ensuring that our patients and colleagues remained safe during both **junior doctor and nursing strikes**.
- Government's pay offer for **Agenda for Change** colleagues accepted by most unions. Colleagues will receive payment in June.
- No pay deal has been agreed for **junior doctors.** A **consultant ballot** is to commence in June 23 with the period of potential strike action spanning from 11 July through to 26 December. The **RCN remains in dispute with a further ballot planned** to commence on 23 May.
- **Engaging with clinical leaders** through Clinical Strategy Group and working collaboratively to enhance visibility and transparency on our decision-making.
- **Governor engagement** event on 9 May.
- **Awards:**
  - 2 **SAS doctors**, Aysha Rajeev and Mike Wilkinson, won awards at the SAS Conference.
  - **Chief Nursing Officer Awards** for 3 colleagues – Michelle Reilly, Melanie Stevenson and Christine Fawcett – and certificates of achievement for a cohort of our Professional Nurse Advocates (PNAs).
- **International nursing team** has now been in post for just over a year – we have welcomed 50 international nurses, of which 42 are now UK registered staff nurses. The NMC is investigating potentially fraudulent activity at an international test centre – assurance provided that none of our current international nurses are impacted by this.
- Launch of **culture programme work** with six core workstreams.

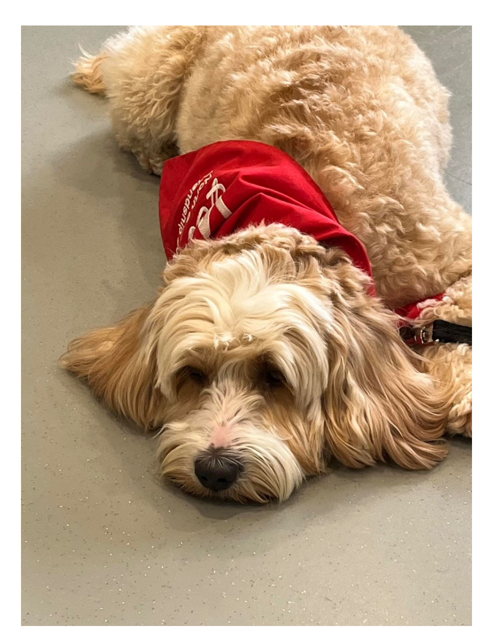
Engagement, involvement and visits:

- ❖ QE Facilities offices
- ❖ Governor engagement event

Strategic Aim 3: We will enhance our productivity and efficiency to make the best use of resources

NHS
Gateshead Health
NHS Foundation Trust

- **Good performance improvements** in respect of diagnostics, reduction in proportion of patients waiting more than 18 weeks and improvements in urgent and emergency care metrics, although they remain challenging (March data).
- **Annual planning** submission made to the Integrated Care System – challenging planning round.
- Board engagement on our **strategic objectives** for 22/23
- **Draft accounts** for 2022/23 submitted ahead of time – external audit commencing, with final submission date at the end of June.
- Commencing a **significant estates mapping exercise** to help us to ensure we utilise our best clinical estate for clinical services.
- Welcomed our staff **Welfare Dog**, Teddy. Welfare dogs help to reduce stress, improve team work, increase productivity and improve team relationships.



Strategic Aim 4: We will be an effective partner and be ambitious in our commitment to improving health outcomes

Gateshead Health
NHS Foundation Trust

- Attended first **Gateshead Committee at Place**, a sub-committee of the Integrated Care Board.
- Invited Place leads to attend an interactive session with the senior managers to develop our collaborative approach to place-based working.
- **Open Day** planned for Saturday 8th July to coincide with the NHS 75th birthday celebrations.
- Recent productive meeting held with **CBC** – attended by the Chief Executive and Medical Director.
- Appointment of **Medical Director of Operations** will enable the Medical Director to dedicate more time to our strategic ambition at place and within the ICS.
- Engagement visit with **Councillor Lynne Caffrey**, Chair of the Health and Wellbeing Board, and **Alice Wiseman**, Director of Public Health for Gateshead.

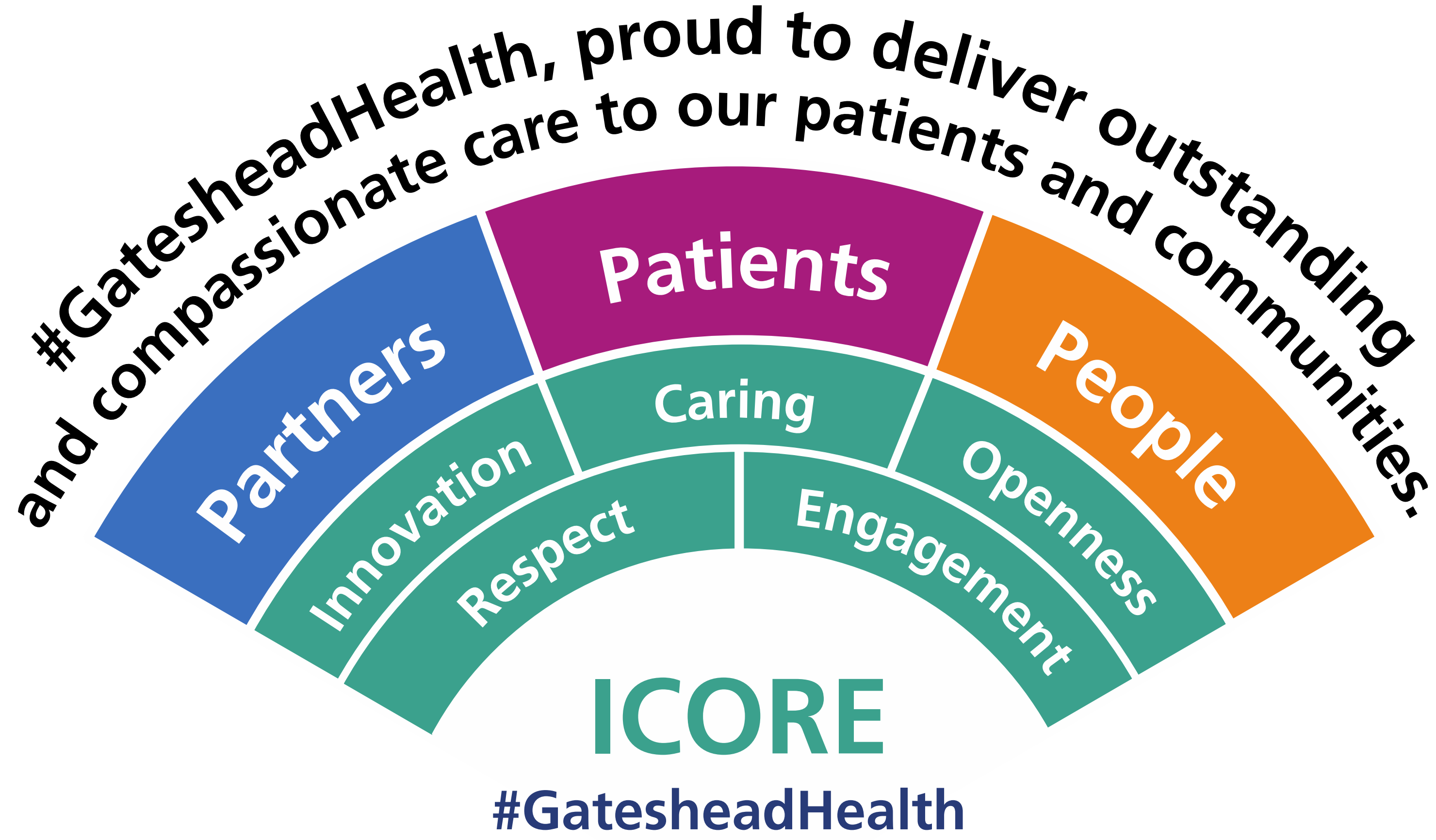
Engagement, involvement and visits:

- ❖ Gateshead Committee at Place
- ❖ Provider Collaborative meetings
- ❖ Meetings with ICB colleagues
- ❖ CBC meeting
- ❖ Meeting with local authority leads for health
- ❖ ICB Chief Executive and Chief Nurse
- ❖ Amanda Pritchard, NHS England Chief Executive

Strategic Aim 5: We will develop and expand our services within and beyond Gateshead

- **Shared strategy event held with colleagues from QE Facilities** – great opportunities to continue to work together to continue to improve patient care and experience.
- Working closely with our services to **assess opportunities to grow, transform and collaborate** in order to provide the best care for our local community and beyond via formal review process internally.
- Appointment of Nicola Bruce as **Interim Director of Strategy, Planning and Partnerships** – creates more capacity and focus, enabling a more proactive approach to the development of our strategic intent and ambition.
- **North Integrated Care Partnership Provider Collaborative** was re-established.

NHS
Gateshead Health
NHS Foundation Trust


#GatesheadHealth, proud to deliver outstanding
and compassionate care to our patients and communities.
Partners
Patients
People
Innovation
Caring
Openness
Respect
Engagement
ICORE
#GatesheadHealth

Report Cover Sheet Agenda Item: 11i

<table>
<tr><td>Report Title:</td><td colspan="4">Thematic Review</td></tr>
<tr><td>Name of Meeting:</td><td colspan="4">Board of Directors</td></tr>
<tr><td>Date of Meeting:</td><td colspan="4">24 May 2023</td></tr>
<tr><td>Author:</td><td colspan="4">Trudie Davies, Chief Executive Officer</td></tr>
<tr><td>Executive Sponsor:</td><td colspan="4">Trudie Davies, Chief Executive Officer
Alison Marshall, Chair</td></tr>
<tr><td>Report presented by:</td><td colspan="4">Trudie Davies, Chief Executive Officer</td></tr>
<tr><td rowspan="2">Purpose of Report
Briefly describe why this report is being presented at this meeting</td><td>Decision:
☒</td><td>Discussion:
☒</td><td>Assurance:
☐</td><td>Information:
☐</td></tr>
<tr><td colspan="4">To provide Board visibility on the outcome of the thematic review, including the delivery plan and the emerging key indicators.</td></tr>
<tr><td>Proposed level of assurance – <u>to be completed by paper sponsor</u>:</td><td>Fully assured
☐
No gaps in assurance</td><td>Partially assured
☒
Some gaps identified</td><td>Not assured
☐
Significant assurance gaps</td><td>Not applicable
☐</td></tr>
<tr><td>Paper previously considered by:
State where this paper (or a version of it) has been considered prior to this point if applicable</td><td colspan="4">Section 4 of the paper outlines a number of ways in which the findings of the thematic review have been shared internally and externally</td></tr>
<tr><td>Key issues:
Briefly outline what the top 3-5 key points are from the paper in bullet point format

Consider key implications e.g.
• Finance
• Patient outcomes / experience
• Quality and safety
• People and organisational development
• Governance and legal
• Equality, diversity and inclusion</td><td colspan="4">• The thematic review and delivery plan set out within this paper will form the work plan and cultural transformation plan for the Trust and is of strategic importance.
• The Trust is committed to learning from feedback, with a number of different sources used to identify the themes, trends and actions outlined in the review.
• The delivery plan will support us to achieve the key principles outlined within this paper and deliver high quality and efficient services for our patients.</td></tr>
<tr><td>Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper</td><td colspan="4">Trust Board is asked to note the content of the paper and support the plans for delivery. When investment might be required, business cases will progress through normal</td></tr>
</table>

<table>
<tr><td></td><td colspan="5">processes but will reference this overall plan for transparency.</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:</td><td>Aim 1 ☒</td><td colspan="4">We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>Aim 2 ☒</td><td colspan="4">We will be a great organisation with a highly engaged workforce</td></tr>
<tr><td>Aim 3 ☒</td><td colspan="4">We will enhance our productivity and efficiency to make the best use of resources</td></tr>
<tr><td>Aim 4 ☒</td><td colspan="4">We will be an effective partner and be ambitious in our commitment to improving health outcomes</td></tr>
<tr><td>Aim 5 ☒</td><td colspan="4">We will develop and expand our services within and beyond Gateshead</td></tr>
<tr><td>Trust corporate objectives that the report relates to:</td><td colspan="5">The thematic review delivery plan maps each action to the strategic objectives – delivery of the plan will support the achievement of all strategic objectives.</td></tr>
<tr><td>Links to CQC KLOE</td><td>Caring ☒</td><td>Responsive ☒</td><td>Well-led ☒</td><td>Effective ☒</td><td>Safe ☒</td></tr>
<tr><td colspan="6">Risks / implications from this report (positive or negative):</td></tr>
<tr><td>Links to risks (identify significant risks and DATIX reference)</td><td colspan="5">Delivery of the plan will assist in the management of a number of risks currently identified on the ORR including:
• POD 2764 - risk of not having the right people in the right place at the right time with the right skills. (16)
• COO 2945 - risk of ineffective and inefficient management of services due to availability and access to appropriate and timely BI. (12)
• CEOL2 2880 - health outcomes - Risk that Place/ICS/ICP strategy/plans do not align with our objectives to tackle health inequalities (2)
• MEDIC 2982 - risk of delayed transfers of care and increased hospital lengths of stay (16)
• NMQ 2779 - the Trust fails to meet the CQC Fundamental Standards. (16)
• CEOL2 2993 - risk of potential non-compliance with current legislation and guidance as a result of policies not being up to date. (16)</td></tr>
<tr><td>Has a Quality and Equality Impact Assessment (QEIA) been completed?</td><td colspan="2">Yes ☐</td><td>No ☐</td><td colspan="2">Not applicable ☒</td></tr>
</table>

THEMATIC REVIEW

1.0 Introduction

Gateshead Health FT is committed to the delivery of high quality and efficient services for patients. To ensure that we have collective and unitary oversight of any challenges or risks faced, the Trust Board commissioned a review of a suite of key documents with a view to producing a thematic analysis of findings.

This thematic analysis will be used to formulate the work plan and cultural transformation program of the Trust moving forward.

The review was commissioned to have full consideration of the following key principles and assumptions:

- Gateshead Health FT are committed to becoming a clinically led and management supported organisation.
- We are fully subscribed to the principles of Unitary function and are committed to developing ourselves as a team and as individuals to fulfil this function. Our work will be underpinned by strong and cohesive governance.
- We share a belief that our staff are our greatest asset and that those who do the job, know how to do it best. Therefore, this listening approach is key to ensuring trusted relationships are formed and sustained.
- Our patients come first. This means that we are committed to enhancing our role as an anchor institute to ensure that we take every reasonable opportunity to improve the health and well-being of our staff and patients within our community and health and social care economy.

2.0 Process of Review

A number of key documents were used to develop the thematic analysis alongside learning from feedback and verbal narrative that has been received.

The documents formally utilised include:

- The Institute of Good Governance Well Led review report – March 2023
- The Consultant Staff Survey – conducted by staff governors – February 2023
- The staff survey – NHS 23/24
- Anonymous letters received into the Trust during 2021/2022 and 2023

Verbal narrative was obtained from key meetings with the Trust Senior Management team, a meeting with staff side colleagues (CEO and HRD), and representatives from Medical Staff Committee (CEO/MD and HRD).

The CEO has used feedback from her induction meetings to enhance the findings and recommendations.

At the time of writing this report, the Trust has not had sight of the output of the Independent Review into alleged failures of patient safety and governance at the North East Ambulance Service (NEAS) that was commissioned in December 2022. This is referenced given that

leadership positions in NEAS and the Trust have been held by the same people and it is important to identify if there is any cross over learning.

In addition, we are expecting the output of the CQC maternity visit which has not yet published. This might influence business direction.

3.0 Findings of Review

The Thematic Analysis has revealed the following key themes which are detailed further in appendix 1.

- Strategy, Planning and Performance – The Trust has an opportunity to strengthen our strategic response and act in a more proactive and less reactive manner. This requires a longer-term view of planning.
- Clinical Engagement – The Trust has an opportunity to strengthen clinical engagement and enhance the clinical voice in management and leadership decisions. This requires some restructure of how and where decisions are made and leadership development and support for clinical colleagues.
- Board Visibility – There is an opportunity to enhance Board and Executive visibility across the organisation and into Place.
- Unitary Function and Governance – As there have been significant changes to the Board membership, there is a requirement to focus on development and unitary function. This needs to be supported by a review of governance across the organisation to ensure that there is a focus on quality and consistency of governance functions.
- Freedom to speak up and Organisational Culture – There is an opportunity to enhance the role and function of the FTSUG role in the organisation. This needs to be supported by a cultural improvement program that moves to a Just and Restorative culture and truly embeds learning from errors as business as usual.
- Communication and Stakeholder Engagement – It is essential that we review our communications internally and externally to ensure consistency of messaging and focus. Staff have asked for more face-to-face interactions with the executive team.
- Equality, Diversity, and Inclusion – The Trust is committed to this agenda but has not made the gains in core metrics that have been expected. We need to strengthen our actions in order to achieve the outcomes desired.
- Understanding our sustainable and vulnerable services – We are committed to being a sustainable organisation that provides safe and high-quality care, but we lack comprehensive overall viability of service vulnerabilities and opportunities to inform our strategy.
- QEF – There is a lack of shared viability and understanding of the role and vision of QEF. Work is required to assure governance processes between the Trust and QEF to ensure they are fit for future service provision.

In addition, colleagues have expressed a need to align and revise the Executive Director portfolios to support improvements in key areas such as information provision and digital and to assure that governance and responsibilities are clear.

During this review, an emerging risk in relation to historic DBS practice has been identified. The work to rectify this issue aligns to the work programs of improvement that are now in place.

4.0 Response to the Review – openness and transparency

To ensure that full transparency and openness is achieved, the findings have been shared in a range of forums.

1. 26th April 2023 – shared themes and learning at Board seminar presentation for initial feedback and to aid refinement.

2. 28th April 2023 – Meeting between Chair/ CEO and ICB to share knowledge and intelligence on the issues identified and to seek support for resolution.

3. 4th May 2023 – Themes and actions shared with Senior Management Team.

4. 10th May 2023 – Chief Nurse shared high levels themes and risks with CQC. CEO also shared this information with the ICB in written format for consistency.

5. 10th May 2023 – CEO and MD shared findings with Clinical Strategy Group

6. 17th May 2023 – CEO and NEDs shared findings with Council of Governors

7. 24th May 2023 – Trust Board

A risk escalation meeting with the ICB/ NHSE and CQC has been proposed but the date is yet to be confirmed.

5.0 Response to the Review – actions

A wide range of actions have been agreed or have been implemented. These are included within the detailed action plan (appendix 2), however, the highlights are:

- Interim appointment to Director of Strategy, Planning and Partnership in place with backfill (May 23);
- Appointment to Medical Director of Operations complete (May 23);
- Director portfolio reviewed and aligned to assure governance processes clear (May 23);
- Exec and SMT meeting structure and functions aligned (May 23);
- GGI commissioned to undertake Board development (May 23);
- FTSUG guardian post reviewed and revised. Full time post to be advertised in May 23;
- Reprofiling of the EDI agenda and strategy – moved to People and OD portfolio (May 23);
- Commissioned a review of vulnerable services – to conclude Q1 2023;
- Deloittes commissioned to review governance structures and reporting between Trust and QEF – Commenced May 23;
- Identification of Key Indicators (clinically owned) to guide and drive activities and support high quality performing services. To complete and implement June 23.

Specific actions to target key areas of concern have been agreed with appropriate timeline for delivery. These include examples such as clearing the complaints backlog and resolving the backlog of outdated policies.

It is expected that these actions will form the basis of the Trust core actions for the next 12-18 months on our journey to sustainability.

The key indicators are currently in development, with a consultation process currently being undertaken with colleagues from across the Trust, ensuring that this includes seeking the views and input from our clinical colleagues in particular. Following the consultation process the key indicators will be shared with the Board and can be used as a guide to success overall, linking to key items on the Board's agenda.

6.0 Conclusion and recommendation

Although the range of issues identified are of concern, the thematic analysis illustrates that improvements can be made through the delivery of a logical and comprehensive plan. Clinical engagement and leadership is key to success.

Trust Board is asked to note the content of the paper and support the plans for delivery. When investment might be required, business cases will progress through normal processes but will reference this overall plan for transparency.

Mrs Trudie Davies
Chief Executive Officer

Item 11i – Appendix 1

Thematic Review

Trudie Davies, Chief Executive

May 2023

Purpose

- To identify key themes from recent reviews, surveys and other sources of information in order to inform and influence our cultural and leadership development.
- The key stages of the thematic review are:
  1. **Identification of the themes** from the source documents, such as the consultant survey – both in terms of areas for development and things which are working well
  2. **Mapping the themes to existing work** which is already underway
  3. **Identification of additional actions**
  4. **Prioritisation Exercise** to identify the improvement plan with clear owners and timescales to assist in our development

NHS
Gateshead Health
NHS Foundation Trust

Strategy, Planning and Performance

Themes

- Vision and values well understood
- Lots of work ongoing in the development of enabling strategies
- A need for a clear lead for strategy and greater capacity for strategic planning.
- Opportunities to use data differently
- How systems can be used to generate efficiencies
- Resourcing of functions and capacity to deliver as a small trust

NHS
Gateshead Health
NHS Foundation Trust

Clinical engagement

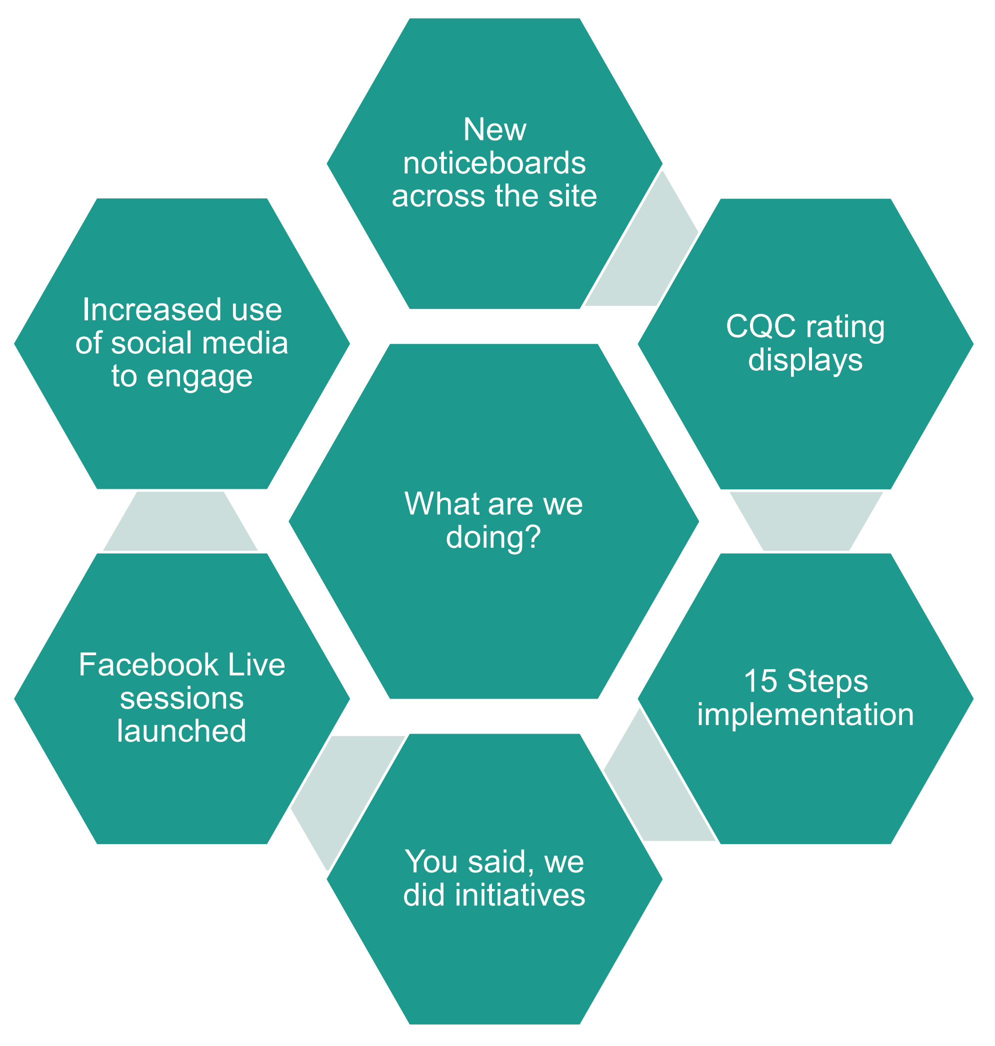
Themes

- Appetite for greater clinical engagement
- Staff capacity – impact on wellbeing and work-life balance
- Good opportunities for training and development
- Positive views on retention and Gateshead as a place to work
- Opportunities to improve communication with Board and operational managers

Board visibility

Themes

- Opportunities to increase Board Member visibility
- A need to be clear on the purpose of visits
- Increase the visibility of the wider senior team
- All building entrance signage to be consistent re: displaying CQC ratings

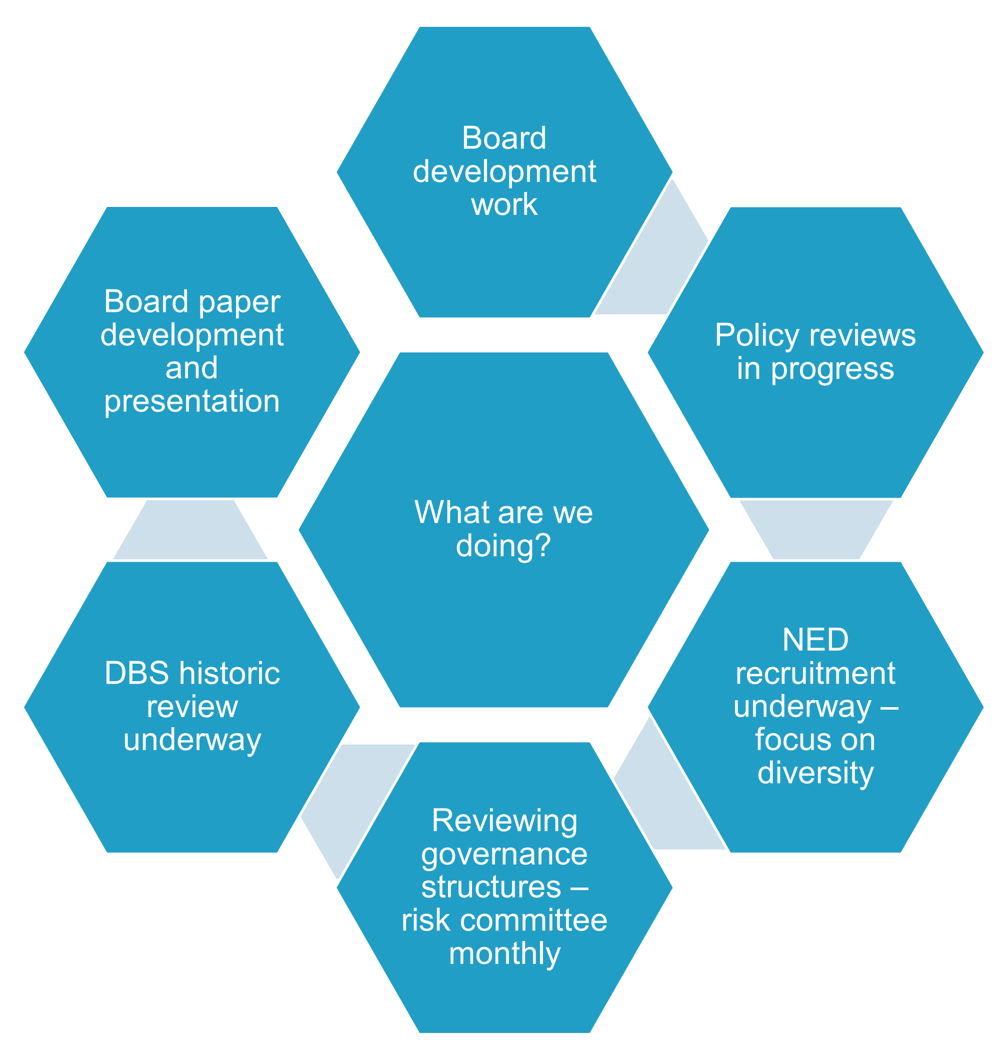


Gateshead Health NHS Foundation Trust

Unitary Board / governance

Themes

- New Board positions embedding well.
- Evidence of constructive Board challenge with opportunities to develop more strategic cross-challenge
- To focus on Board development given volume of change
- Trust is meeting-heavy and papers overly long.
- Board Assurance Framework and Executive Risk Management Group functioning well.
- A need for consistent view on top risks.
- Work to continue on addressing backlog of policies
- Review of historic DBS process and recording



Freedom to Speak Up / organisational culture

Themes

- Scope to increase visibility and understanding of Freedom to Speak Up (FTSU) as well as the confidence to speak up
- Friendly culture with compassionate and loyal staff.
- Clarify accountability structures
- Improvement methodology in place with scope to enhance this.
- Increase understanding of risk management and mitigation throughout the Trust
- A need to reflect on achievements and what is working well.

Communications and stakeholder engagement

Themes

- Corporate communications seen positively.
- A need to further publicise successes externally
- Strong position in the ICS and ICB – development of positive relationships
- Desire for internal communications to acknowledge our challenges more
- NED presentations to the Council of Governors in line with good practice
- Positive examples of engagement with GPs, patients and co-design.
- Valuable work of volunteers
- Partnership working intentions and priorities could be clearer.
- Identify ways to seek views of the hard to reach groups – addressing health inequalities.

Equality, diversity and inclusion

Themes

- ❖ Address Board diversity
- ❖ Clear Board and management commitment to equality, diversity and inclusion (EDI)
- ❖ Positive impact of staff networks
- ❖ A need to address the race disparity ratio.

Understanding sustainable and vulnerable services

Themes

- Not a consistent understanding of strengths, vulnerabilities and future plans for clinical services.
- Estates challenges for clinical and non-clinical services.

QE Facilities

Themes

- QEF internal governance and governance between QEF and the Trust
- A need for clarity on the collective vision and strategy

Item 11i – Appendix 2

Thematic Review Delivery Plan

Colour	Status
(dark blue)	Not yet started
(purple)	Started and on track no risks to delivery
(amber)	Plan in place with some risks to delivery
(red)	Off track, risks to delivery and or no plan/timescales and or objective not achievable
(green)	Complete

No.	Theme	Action	Link to strategic objectives / key indicators	Deadline	Workstream Lead	Board Sponsor	Progress	RAG-rating
1	Strategy, planning and performance	Final enabling strategies to be completed and ratification at the May 2023 Board meeting	All	24/05/23	N Bruce	T Davies	May 23 – clinical strategy to be presented to CSG on 10 May. EDI, clinical and finance strategies scheduled for May Board. Estates strategy is covered as part of action 40.	(purple)
2	Strategy, planning and performance	Refinement of the IOR at Board and Committee level to provide ward to Board exception reporting	All	30/09/23	D Renwick	K Mackenzie	May 23 – work is progressing. Business intelligence function is now within the Director of Finance portfolio which will support close working with the digital teams to deliver the IOR functionality.	(purple)
3	Strategy, planning and performance	Address the backlog of complaints within an agreed timescale	SA1.2	30/06/23	A Rayner	G Findley	May 23 - Progress has already started with a 50% reduction in the number of overdue complaints. Additional clinical resource has been added into the corporate complaints team.	(purple)

Item 11i – Appendix 2

No.	Theme	Action	Link to strategic objectives / key indicators	Deadline	Workstream Lead	Board Sponsor	Progress	RAG-rating
4	Strategy, planning and performance	Assessment of leadership resource across operational business units and corporate functions	SA2.1 SA2.2 SA2.3	31/07/23	N Halford A Rayner J Halliwell	T Davies	May 23 – Heads of Clinical Service meeting to make assessment	
5	Strategy, planning and performance / clinical engagement	Review of Director portfolios, including strategy, planning and business intelligence (including the capacity of this function)	SA2.2 SA2.3 SA4.1 SA4.2 SA5.1	31/05/23	T Davies	A Marshall	May 23 – the Group Director of Finance and Chief Operating Officer portfolios have been reconfigured to move the business intelligence function to the DoF. N Bruce has been appointed as Interim Director of Strategy, Planning and Partnerships. Medical Director of Operations appointed.	
6	Strategy, planning and performance	Development of key indicators to support performance visibility and alignment to the strategic objectives	All	30/06/23	D Renwick	K Mackenzie	May 23 – draft indicators developed and to be shared with Clinical Strategy Group for comment and input ahead of launch in June. Key indicators have been referenced throughout the strategic objective to provide clear linkage. Initial reporting of the key indicators will occur in July 23.	
7	Clinical engagement	Review decision-making at senior level to support appropriate prioritisation and ensure decisions are made at the right level based on the right information	All	31/05/23	T Davies A Beeby J Boyle	T Davies	May 23 – membership of EMT expanded and new chairs of EMT and SMT established. Work is ongoing re: aligning the cycles of business to support effective decision-making.	

Item 11i – Appendix 2

No.	Theme	Action	Link to strategic objectives / key indicators	Deadline	Workstream Lead	Board Sponsor	Progress	RAG-rating
8	Clinical engagement	To increase the face-to-face visibility of the senior team	SA2.3	31/05/23	Executives SMT	T Davies	May 23 – a dedicated weekly drop-in is in the planning stages.	
9	Clinical engagement	To develop a Trust core narrative to support collective understanding and purpose	SA2.2 SA2.3	31/05/23	H Fox	T Davies	May 23 – this is under development	
10	Clinical engagement / understanding sustainable and vulnerable services	Review of service vulnerability and sustainability	SA3.1 SA3.2 SA4.2	31/05/23 for initial templates 30/09/23 for full review completion	N Bruce	T Davies	May 23 – discussed at CSG in May and template issued for return by 31/05/23 to inform initial outputs.	
11	Clinical engagement	Review clinical leadership time allocation to ensure clinicians are supported to attend and contribute to key strategic decision making	SA2.2 SA2.3	30/06/23	N Halford	A Beeby	May 23 – initial discussions commenced as part of the Clinical Strategy Group in May.	
12	Board visibility	Share outcomes of visibility initiatives - observations,	SA2.3	30/06/23	H Fox	T Davies	May 23 – Facebook Live launched which can be used to share updates and outcomes.	

Item 11i – Appendix 2

No.	Theme	Action	Link to strategic objectives / key indicators	Deadline	Workstream Lead	Board Sponsor	Progress	RAG-rating
		successes, learnings, you said, we did						
13	Board visibility	Promotion of Board visibility and other key information such as CQC ratings through noticeboards and interactive displays	SA2.3	30/06/23	H Fox	T Davies		
14	Board visibility	Implementation of the 15 Steps Programme	SA1.2 SA2.3	30/06/23	A Rayner	G Findley		
15	Unitary Board / governance	Provide further BAF training to Board Members	All	30/06/23	J Boyle	G Findley	May 23 – training date to be identified	
16	Unitary Board / governance	Delivery of training on Board and committee paper development and presentation	All	31/07/23	J Boyle	T Davies	May 23 – guidance to be revised and circulated with opportunities to attend workshops.	
17	Unitary Board / governance	Identify informal opportunities to develop Board relationships	SA2.3	31/05/23	T Davies	A Marshall	May 23 – informal post-Board events commenced in April 23 with a plan to continue.	
18	Unitary Board / governance	To increase the frequency of review and focus on top organisational risks	All	31/05/23	G Findley	T Davies	May 23 – Executive Risk Management Group moved to monthly and now chaired by the Chief Executive	

Item 11i – Appendix 2

No.	Theme	Action	Link to strategic objectives / key indicators	Deadline	Workstream Lead	Board Sponsor	Progress	RAG-rating
19	Unitary Board / governance	To provide additional focus on Board development, including effective Board challenges	All	31/12/23	T Davies	A Marshall	May 23 – development work commissioned with the Good Governance Institute to be delivered in the coming months	
20	Unitary Board / governance	Increase the visibility and understanding of complaints responses, themes and trends with Executive Directors	SA1.2	30/06/23	G Findley	T Davies		
21	Unitary Board / governance	Consider the option of recruiting associate Non-Executive Directors to support succession planning, coaching and Board diversity	SA3.2	31/05/23	-	A Marshall	May 23 – discussion to be held as part of the May 23 Board meeting.	
22	Unitary Board / governance	Ensure consistent and effective clinical governance structures are in place at operational business unit level	All	31/12/23	Heads of Clinical Service	G Findley	May 23 – review commissioned and to be led by the Clinical Head of Service for Medicine, utilising outputs from recent review of business unit governance. Outputs to be in place and embedded by December 23. Further action Trust-wide to be developed.	
23	Unitary Board / governance	Review governance structures at operational business unit level and those	All	31/12/23	G Findley	T Davies	May 23 – the Good Governance Institute have been commissioned to lead on this review and make recommendations to the Trust.	

Item 11i – Appendix 2

No.	Theme	Action	Link to strategic objectives / key indicators	Deadline	Workstream Lead	Board Sponsor	Progress	RAG-rating
		groups reporting into Board committees to support effective assurance and escalation to Board committees and Board						
24	Unitary Board / governance	To reduce the backlog of out-of-date policies	All	30/06/23	J Boyle	T Davies	May 23 – weekly reports being prepared for SMT and demonstrating steady progress to date	
25	Unitary Board / governance	To review historic DBS process and seek assurance over completeness	SA1.2 SA2.3	30/09/23	A Venner	L Crichton-Jones	May 23 – review is underway with an update to be provided to Board.	
26	FTSU / organisational culture	Review of FTSU function required	SA1.1 SA1.2 SA2.1 SA2.2 SA2.3	31/5/23	A Venner	L Crichton-Jones	May 23 – review complete and currently advertising for a full time FTSU Guardian to increase the resource in this area	
27	FTSU / organisational culture	To ensure greater triangulation of learnings, themes and trends (including from incident reporting) and share widely to provide confidence in raising concerns	SA2.3	31/07/23	A Venner	L Crichton-Jones	May 23 – the output of the initial review will be shared at the July People and OD Committee	

Item 11i – Appendix 2

No.	Theme	Action	Link to strategic objectives / key indicators	Deadline	Workstream Lead	Board Sponsor	Progress	RAG-rating
28	FTSU / organisational culture	Develop a just and restorative culture, including embedding a learning approach to incidents	SA2.3	31/12/23	S Dyson L Farrington	G Findley L Crichton-Jones	May 23 – launched at the Patient Safety Conference in March 23. To agree the milestones as this programme spans across years.	
29	FTSU / organisational culture	Ensure risk management system is effective, accessible and fit for purpose	All	31/07/23	S Dyson	G Findley	May 23 – InPhase procured as the new risk management system with a lead in time. Training will be provided. Colleagues encouraged to review and cleanse data in current system prior to data transfer. To align to the review of clinical governance in business units.	
30	FTSU / organisational culture	Further development of an improvement culture including increased capacity and training for certified leaders	All	30/09/23	K Roberton	T Davies	May 23 – portfolio of the transformation lead has been refined to increase leadership capacity in this area to develop an embedded improvement culture	
31	FTSU / organisational culture	Promote a zero-tolerance approach to bullying and harassment	SA2.3	30/06/23	L Farrington	A Venner		
32	FTSU / organisational culture	Cultural shift to encouraging a greater focus on positive achievements, striking a realistic balance with our challenges	SA2.3	30/06/23	All Executives H Fox	T Davies	May 23 – aligning communications to the Trust core narrative	

Item 11i – Appendix 2

No.	Theme	Action	Link to strategic objectives / key indicators	Deadline	Workstream Lead	Board Sponsor	Progress	RAG-rating
33	Comms / stakeholder engagement / understanding sustainable and vulnerable services	Continued development of relationships at place and within the system and a need to define strategic intent	SA4.1 SA4.2 SA5.1	30/09/23	N Bruce A Beeby	T Davies	May 23 – redefined portfolios increased Medical Director capacity to work with the Chief Executive to develop these relationships. Director of Strategy post supporting development of our strategic intent. Key partners invited to join Executive Team and SMT for producing discussions on collaboration and joint working.	
34	Comms / stakeholder engagement	Review of senior communications capacity and resource to support external communications and promotion	All	30/09/23	K Roberton	T Davies		
35	Comms / stakeholder engagement	Explore and enhance communication channels that extend beyond digital	SA2.3	31/05/23	H Fox	T Davies		
36	Comms / stakeholder engagement / understanding sustainable and vulnerable services	Develop appropriate data, actions and resource to drive the health inequalities agenda. This includes building connectivity to place-based inequalities work and the joint strategic needs assessment	SA4.1	30/09/23	K Roberton J Clark	A Beeby	May 23 – the reprofiling of the Medical Director portfolio provides additional leadership capacity here with a clear focus on developing relationships at place.	

Item 11i – Appendix 2

No.	Theme	Action	Link to strategic objectives / key indicators	Deadline	Workstream Lead	Board Sponsor	Progress	RAG-rating
37	Comms / stakeholder engagement	Develop links with the local community and continue the focus on volunteer recruitment	SA1.2 SA2.2 SA4.1	31/07/23	H Fox	G Findley	May 23 – Open Day arranged for 8 July. Volunteer recruitment included in the Quality Account as a quality priority for 23/24.	
38	Equality, diversity and inclusion	Increase the profile, commitment and focus on the EDI agenda at Board and within the Trust – develop a clear ambition with timeframes for improvement	SA2.3	31/07/23	K Sohanpal	L Crichton-Jones	May 23 – NED recruitment includes significant focus on seeking a diverse range of candidates. Gen Equity and reverse mentoring programmes continue.	
39	Equality, diversity and inclusion	Restructure EDI into the People and OD business unit	SA2.3	30/06/23	K Sohanpal	L Crichton-Jones		
40	Understanding sustainable & vulnerable services	Full estates review to be conducted to inform future options to maximise estates spaces for clinical services	SA1.1 SA1.2 SA3.1 SA3.2 SA2.1 SA2.2	30/06/23 for initial assessment 31/03/24 for full delivery	J Baxter S Harrison	K Mackenzie	May 23 – agreed initial scope to conclude by 30/06.	
41	Understanding sustainable & vulnerable services	To develop a clear understanding of our USP and associated	SA3.1 SA4.2 SA5.1	31/05/23 for initial input re: sustainable	N Bruce	A Beeby	May 23 – Director of Strategy appointed with this action in the remit of the role. Linked to action 10.	

Item 11i – Appendix 2

No.	Theme	Action	Link to strategic objectives / key indicators	Deadline	Workstream Lead	Board Sponsor	Progress	RAG-rating
		campaigns to deliver this vision		services templates 30/09/23 for full review completion				
42	QE Facilities	Commission independent review of governance	SA1.2 SA3.1 SA5.1	30/06/23	T Davies	A Marshall	May 23 – Deloitte LLP contracted to deliver independent governance review.	
43	QE Facilities	Ensure interim leadership arrangements are in place	SA2.1 SA2.3 SA5.1	31/05/23	T Davies	A Marshall	May 23 – interim Managing Director appointed for a six-month period	
44	QE Facilities	Develop a shared vision and understanding to inform the future leadership and governance of QEF	SA2.3 SA5.1	31/05/23	S Harrison	T Davies	May 23 – collective QEF senior team and Board session held in April 23 to agree principles and risk appetite	

Agenda Item: 12ii

<table>
<tr><td>Report Title:</td><td colspan="4">Organisational Risk Register (ORR)</td></tr>
<tr><td>Name of Meeting:</td><td colspan="4">Board of Directors</td></tr>
<tr><td>Date of Meeting:</td><td colspan="4">24th May 2023</td></tr>
<tr><td>Author:</td><td colspan="4">Marie Malone, Corporate and Clinical Risk Lead.</td></tr>
<tr><td>Executive Sponsor:</td><td colspan="4">Gill Findley, Chief Nurse and Professional Lead for Midwifery and Allied Health Professionals</td></tr>
<tr><td>Report presented by:</td><td colspan="4">Gill Findley, Chief Nurse and Professional Lead for Midwifery and Allied Health Professionals</td></tr>
<tr><td rowspan="2">Purpose of Report
Briefly describe why this report is being presented at this meeting</td><td>Decision:
☐</td><td>Discussion:
☒</td><td>Assurance:
☒</td><td>Information:
☐</td></tr>
<tr><td colspan="4">To ensure the Board and Committees are clearly sighted on those risks that have an organisational -wide impact, the organisational risk register is compiled by the Executive Risk Management Group of those risks that impact on the delivery of strategic aims and objectives.

This includes risks included within the Board Assurance Framework (BAF) as well as risks identified by the Group for inclusion as having an organisational impact and impact on delivery of strategic aims and objectives.

The supporting report shows the risk profile of the ORR, includes a full register, and provides details of review compliance, and risk movements.</td></tr>
<tr><td>Proposed level of assurance – <u>to be completed by paper sponsor</u>:</td><td>Fully assured
☒
No gaps in assurance</td><td>Partially assured
☐
Some gaps identified</td><td>Not assured
☐
Significant assurance gaps</td><td>Not applicable
☐</td></tr>
<tr><td>Paper previously considered by:
State where this paper (or a version of it) has been considered prior to this point if applicable</td><td colspan="4">The attached report is now received in the Executive Team Meeting each week, and at the Executive Risk Management meeting every month.</td></tr>
<tr><td>Key issues:
Briefly outline what the top 3-5 key points are from the paper in bullet point format

Consider key implications e.g.
Finance
Patient outcomes / experience
Quality and safety</td><td colspan="4">Two risks added to the organisational risk register in period:
2779 (NMQ)- The Trust fails to meet the CQC Fundamental Standards resulting in potential regulatory action, harm to patients, decline in ratings, and resulting reputational damage. (16)</td></tr>
</table>

<table>
<tr><td>

- *People and organisational development*
- *Governance and legal*
- *Equality, diversity and inclusion*

</td><td>

- **3148 (COO)** -*There is a risk that the organisation is unable to release staff for mandatory training and medical devices training due to operational pressures and current vacancies in both medical and nurse staffing.* (12)

0 risks have been removed from the Organisational risk register and no risks have been closed.

</td></tr>
<tr><td>Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper</td><td>

The Board are asked to:

- Review the risks and actions and discuss and seek further information relating to risks as appropriate.
- Take assurance over the ongoing management of risk.

</td></tr>
<tr><td>Trust Strategic Aims that the report relates to:</td><td>
<table>
<tr><td>Aim 1
☒</td><td>We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>Aim 2
☒</td><td>We will be a great organisation with a highly engaged workforce</td></tr>
<tr><td>Aim 3
☒</td><td>We will enhance our productivity and efficiency to make the best use of resources</td></tr>
<tr><td>Aim 4
☒</td><td>We will be an effective partner and be ambitious in our commitment to improving health outcomes</td></tr>
<tr><td>Aim 5
☒</td><td>We will develop and expand our services within and beyond Gateshead</td></tr>
</table>
</td></tr>
<tr><td>Trust corporate objectives that the report relates to:</td><td>Each risk is linked to a corporate objective, see report.</td></tr>
<tr><td>Links to CQC KLOE</td><td>
<table>
<tr><td>Caring
☐</td><td>Responsive
☐</td><td>Well-led
☒</td><td>Effective
☒</td><td>Safe
☐</td></tr>
</table>
</td></tr>
<tr><td colspan="2">Risks / implications from this report (positive or negative):</td></tr>
<tr><td>Links to risks (identify significant risks and DATIX reference)</td><td>Included in report</td></tr>
<tr><td>Has a Quality and Equality Impact Assessment (QEIA) been completed?</td><td>
<table>
<tr><td>Yes
☐</td><td>No
☐</td><td>Not applicable
☒</td></tr>
</table>
</td></tr>
</table>

Organisational Risk Register

Executive Summary

To ensure the Board and Committees are clearly sighted on those risks that have an organisational -wide impact, the organisational risk register (ORR) is compiled by the Executive Risk Management Group of those risks that impact on the delivery of strategic aims and objectives.

This includes risks included within the Board Assurance Framework (BAF) as well as risks identified by the Group for inclusion as having an organisational impact and impact on delivery of strategic aims and objectives.

Following annual review of the terms of reference for Executive Risk Management Group in April, it was agreed to re-instate monthly meetings moving forward.

The supporting report shows the risk profile of the ORR, includes a full register, and provides details of review compliance, and risk movements.

This report covers the period 15th March 2023 – 15th May 2023 (extraction date for this report).

There are currently 18 risks on the ORR, 2 of which have a high score of 20 agreed by the group.

Organisational Risk Register – Movements

Following ERMG meetings in April and May 2023, there have been no removals from the ORR, although 1 risk has been increased, and 2 reduced.

The following risks has been added to the ORR:

2 risks added to the organisational risk register in period:

- **2779 (NMQ) -** *The Trust fails to meet the CQC Fundamental Standards resulting in potential regulatory action, harm to patients, decline in ratings, and resulting reputational damage*. (16)

Risk increased from 12 to 16 based on current compliance with outstanding action plan from 2019.

- **3148 (COO)** *-There is a risk that the organisation is unable to release staff for mandatory training and medical devices training due to operational pressures and current vacancies in both medical and nurse staffing.* (12)

Risk reduced from 16 as improvement in compliance noted throughout business units, with demonstrable improvement in compliance.

One further risk has been reduced:

- **2880 (CEO)** Health Outcomes - Risk that Place/ICS/ICP strategy/plans do not align with our objectives to tackle health inequalities. (2)

Score reduced from 9 as the organisations strategy is now aligned with place based inequalities work and there is clear synchrony with the ICS / ICB approach.

One risk with a high score of 20 associated with industrial action is reflected in the report:

- **2095 (POD)** Risk to quality of care due to Industrial Action of various trade unions across various sectors affecting staffing levels and potential impact on patient care, safety, and quality. (20)

Originally associated with nurses, midwives and AHPs, this risk has been reworded to reflect all staffing groups within the organisation and highlights the current climate of industrial action throughout various public sectors.

As a result, 2 further non- ORR risks associated with Industrial action have been closed:

- **3182 (CEO)** Risk of significant impact to services due to industrial action of Junior Doctors which could impact on patient safety, experience and outcomes. TRR 10

- **3181 (POD)**There is a significant risk of disruption to services due to industrial action of the education sector resulting in possible impact on patient safety, experience and quality. TRR 8

0 risks removed from the ORR during this period, and 0 Risks closed.

Risk and action review compliance is currently at 50% and 58% consecutively. Support with reviews continues to be offered by Corporate and Clinical Risk Lead.

Recommendations

The Board are asked to:

- Review the risks and actions and discuss and seek further information relating to risks as appropriate.
- Take assurance over the development and review of the Organisational Risk Register by the Executive Risk Management Group

Organisational Risk Register Report

Reporting Period: 15-Mar-2023 to 15-May-2023

Comparison Date: 14-Mar-2023

Risk Profile (Current/Managed)

Resources - 1

POD 2764 - Workforce - Risk of not having the right people in the right place at the right time with the right skills. (16)

Wellbeing - 1

POD 2759 - Workforce health & Wellbeing - Risk of adverse impact to staff health and wellbeing due to internal and external pressures (12)

Business Continuity - 3

IMT 1490 - Failure to manage Information Assets (15)

IMT 1636 - UCRF R01/R03/R20/R23 - Malware such as Ransomware Compromising Unpatched Endpoints, Servers and Equipment (10)

COO 3186 - There is a risk to ongoing business continuity of service provision due to ageing trust estate (12)

Digital - 1

COO 2945 - Risk of ineffective and inefficient management of services due to availability and access to appropriate and timely BI. (12)

Finance - 2

FIN 3103 - operational pressures result in non achievement of CRP (20)

FIN 3128 - Risk that the capital cost of delivery of the new operating model continues to increase resulting in revenue implications. (12)

Delivery of Objectives - 1

CEOL2 2880 - Health Outcomes - Risk that Place/ICS/ICP strategy/plans do not align with our objectives to tackle health inequalities (2)

Delivery of Objectives - 1

COO 2868 - New Operating Model -Risk to the delivery of the new operating model resulting in adverse impact on performance & recovery plans (12)

Effectiveness - 2

IMT 1797 - Multiple sources of clinical records stored in systems and paper format leading to potential patient harm (16)

MEDIC 2982 - Risk of delayed transfers of care and increased hospital lengths of stay (16)

Safety - 4

NMQ 3089 - Quality - Risk of quality failures in patient care due to external causes such as delayed discharges and external pressures. (12)

POD 3095 - Risk of Significant, unpricedented service disruption due to industrial action (20)

COO 3148 - Mandatory training- (including medical devices) compliance (12)

SURGE 2398 - Risk that MDT are delayed to a maternity emergency/delayed CCU transfers for maternity patients due to separate buildings (15)

Compliance - 2

NMQ 2779 - The Trust fails to meet the CQC Fundamental Standards. (16)

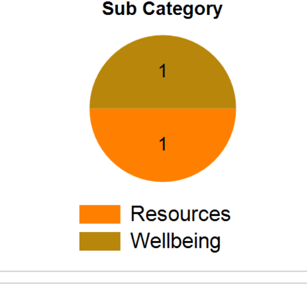
CEOL2 2993 - Risk of potential non-compliance with current legislation and guidance as a result of policies not being up to date. (16)

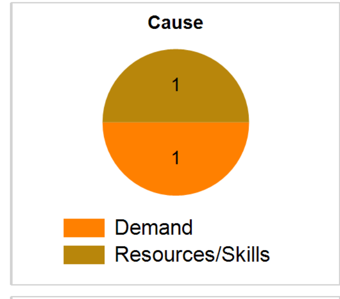
Key:	CRR -	Current Risk Rating	PRR -	Previous Risk Rating
	IRR -	Initial Risk Rating	TRR -	Target Risk Rating

Organisational Risk Register Report

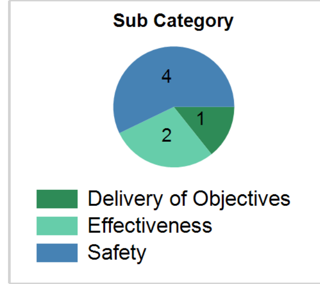
Reporting Period: 15-Mar-2023 to 15-May-2023

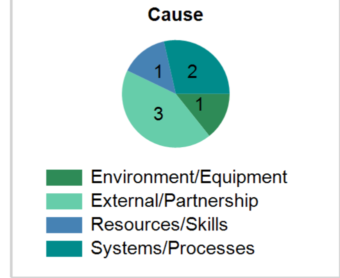
Comparison Date: 14-Mar-2023



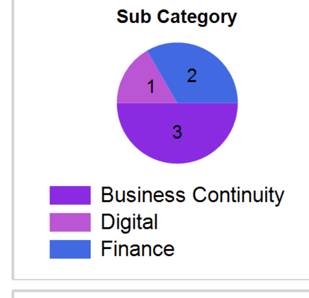


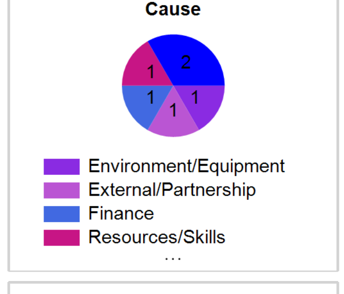
Quality Outcomes

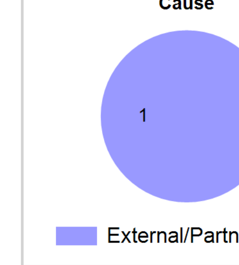




Finance & Efficiency





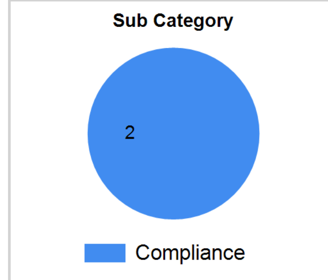


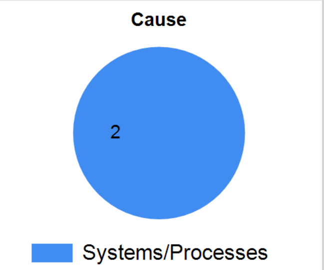
Key: **CRR** - Current Risk Rating **PRR** - Previous Risk Rating
IRR - Initial Risk Rating **TRR** - Target Risk Rating

Organisational Risk Register Report

Reporting Period: 15-Mar-2023 to 15-May-2023

Comparison Date: 14-Mar-2023





Organisational Risk Register Report

Reporting Period: 15-Mar-2023 to 15-May-2023

Comparison Date: 14-Mar-2023

Organisational Risk Register (sorted by highest CRR and risk ID) - Current/Managed Risks

Risk ID / Date Identified Handler BU Service Line Next Review Date BAF / Risk Register Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner Action Due	TRR	Latest Progress Note
3095 26/07/2022 Amanda Venner People and OD Workforce Development 04/06/2023 BU_DIR EPRR ORG HRC QGC SA1.2 Continuous Quality improvement plan, SA2.1 Protect and understand the health and well-being of our staff by looking after our workforce, SA2.2 Growing and developing our workforce	Risk to quality of care due to Industrial Action of various trade unions across various sectors affecting staffing levels and potential impact on patient care, safety and quality.	25	Industrial action working group established and meeting regularly. Focussed planning sessions have taken place to explore the planning, response and recovery elements of industrial action with reasonable worse case scenarios considered. A detailed work plan has been produced with a number of actions, lead officers and timescales citrep position updated daily Business continuity planning command and control structure will recommence in the event of industrial action Current mitigation is closer partnership working and regular local discussions with staff-side and respective trade union representatives (including RCN) as part of the IA Internal Working Group and the Sub-group of the JCC set up of command and control and coordination 12th decemner local strike committee in place from friday 9th may 23 Cancellation of some elective services to reduce need for junior medical staff. consideration of utilisation of other staffing sources- consultants and/or specialist nurses and pharmacy support review of on call teams	20	Support industrial action task and finish group	Amanda Venner 30/06/2023	9	full review of scores with AV. Deep dive suggest inherent score as of today is 25, with CRR of 20 appropriate to current climate. next review will potentially reduce risk, dependant on BMA/RCN ballots in the coming weeks.
					Implementation of JCC sub- group on industrial action	Amanda Venner 30/06/2023		

Key:				
	CRR -	Current Risk Rating	PRR -	Previous Risk Rating
	IRR -	Initial Risk Rating	TRR -	Target Risk Rating

Organisational Risk Register Report

Reporting Period: 15-Mar-2023 to 15-May-2023

Comparison Date: 14-Mar-2023

Organisational Risk Register (sorted by highest CRR and risk ID) - Current/Managed Risks

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register / Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR	Latest Progress Note
3103 22/08/2022 Kris MacKenzie Finance Finance 20/03/2023 BU_DIR COO FPC ORG BAF SA3.2 Achieving financial sustainability	efficiency requirements cannot be achieved due to ongoing operational pressures resulting from COVID and demand on unscheduled care.	20	Efficiency delivery closely monitored as part of month end reporting Redirection of transformation team to support delivery of efficiency programme	20	Negotiations with ICB re: FOT	Kris MacKenzie 08/02/2023	9	Whilst the finainacal position for 22/23 has a reduced risk, CRP delivery remains a risk to the ongoing udnerlying financial sustaianability of the organisation. Risk remains high.
					Regular CRP planning and monitoring workshops	Kris MacKenzie 28/02/2023		
1797 19/01/2016 Mark Smith Digital Health Records 05/05/2023 BAF BU_DIR DIGC ORG SA1.3 Digital where it makes a difference	Risk of failure to review appropriate information across multiple sources of clinical records stored in both system and paper format leading to potential patient harm. The trust has distributed data across a large number of systems and paper. The staff won't know where to look for information on the patient they are treating or won't look everywhere where there may be information [also impact for processes such as SARs/legal Services] The consequence of this is potential patient harm due clinical decisions being made on incomplete data, and the resulting financial effects + non compliance of legislative requirements	25	Systems management audit programme. Structured project management and change control procedures Standard operating procedures for each system	16	Implement single Document Store	Adam Charlton 31/03/2023	8	note 20/7/22 still applicable
					Develop pathway to digital health record	Mark Smith 21/08/2023		
					Develop FBC for Clinical System	Nick Black 30/09/2023		

Key: **CRR** - Current Risk Rating; **IRR** - Initial Risk Rating; **PRR** - Previous Risk Rating; **TRR** - Target Risk Rating

Organisational Risk Register Report

Reporting Period: 15-Mar-2023 to 15-May-2023

Comparison Date: 14-Mar-2023

Organisational Risk Register (sorted by highest CRR and risk ID) - Current/Managed Risks

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register / Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR	Latest Progress Note
2764 17/11/2020 Natasha Botto People and OD Human Resources 04/06/2023 BAF ORG HRC QGC SA1.1 Continue to improve our maternity services in line with the wider learning from the Ockenden review, SA1.2 Continuous Quality improvement plan, SA2.2 Growing and developing our workforce	Risk of not having the right people in the right place at the right time with the right skills across the organisation. Noting regional and national supply pressures, resulting in failure to deliver current and future services that are fit for purpose.	20	Staffing Reporting Task and finish group established. International recruitment on track. Domestic recruitment actively pursued and monitored. Over recruiting to HCSW positions. Recruitment process streamlined (RPIW). SMT discussions on longer term strategic supply pipelines for Registered Nurses have commenced, inc Registered Nurse degree apprentices and Trainee Nurse Associates. Absence Management - Refreshed policy, roll out of training, enhanced support from POD team. Local pay arrangements for hotspot and winter working. People analyst in post and initial reports developed. Retention initiatives in place to support and encourage colleagues to remain with the Trust. School and local community supply initiatives in place to attract the Trust's future workforce. Healthcare Academy Approach in Development supporting Health Care Careers across Gateshead. Approach to strategic workforce planning work with external partner, Whole Systems Partnership complete and is currently being written up. People Strategy has been developed. Workforce plan submitted as part of the Operating Plan for 2023-24.	16	Clinical Strategy	Andrew Beeby 04/06/2023	8	risk remians. no changes to score as of today
					Robust Exit Interview process	Natasha Botto 04/06/2023		
					Transfer Window	Janet Thompson 04/06/2023		
					Workforce planning to be scoped and future resource/ways of working identified.	Natasha Botto 06/06/2023		
					Health and Care Academy internal development opportunities scoped	Sarah Neilson 01/09/2023		

Key: CRR - Current Risk Rating; IRR - Initial Risk Rating; PRR - Previous Risk Rating; TRR - Target Risk Rating

Organisational Risk Register Report

Reporting Period: 15-Mar-2023 to 15-May-2023

Comparison Date: 14-Mar-2023

Organisational Risk Register (sorted by highest CRR and risk ID) - Current/Managed Risks

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register / Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR	Latest Progress Note
2779 01/07/2020 Jane Conroy Nursing, Midwifery & Quality Quality Governance 20/05/2023 BAF BU_DIR FPC ORG QGC SA1.2 Continuous Quality improvement plan	The Trust fails to meet the CQC Fundamental Standards resulting in potential regulatory action, harm to patients, decline in ratings, and resulting reputational damage.	16	CQC three phased monitoring approach CQC Action plan T&F Group Exec Complinance Group Inspection action plans Nursing Strategy and Safe Staffing planning & delivery Governance Framework Risk Management systems and processes Health & Safety Governance and processes NICE guidance governance processes Learning Disability Support processes Cancer Services delivery plans Scheduled audits of operational safety elements.	16	Develop a route map to Outstanding Ensure any areas of improvement from last inspection are in place	Jane Conroy 26/05/2023 Jane Conroy 30/06/2023	6	Trust's agreed three phased internal monitoring approach implemented and complete. This has recerntly been audited by Audit One and awaiting outcome report. Trust's CQC action plan continues to be presented monthly to SMT. CQC Action Plan T&F now in place with escalation to Exec Compliance Group and key themes and actions to SMT monthly where the CQC Action plan paper is presented. Slow progress noted in closing down 2019 acitons. Risk increased to 16 and added to the Organisational Risk Register.

Key: **CRR** - Current Risk Rating **PRR** - Previous Risk Rating
IRR - Initial Risk Rating **TRR** - Target Risk Rating

Organisational Risk Register Report

Reporting Period: 15-Mar-2023 to 15-May-2023

Comparison Date: 14-Mar-2023

Organisational Risk Register (sorted by highest CRR and risk ID) - Current/Managed Risks

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register / Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR	Latest Progress Note
2982 06/12/2021 Amy Muldoon Medical Services Medical Services - Divisional Management 01/06/2023 BAF BU_DIR COO FPC ORG SA3.1 Improve the productivity and efficiency of our operational services through the delivery of the New Operating Model and associated transformation plans, SA4.2 Work collaboratively as part of Gateshead Cares system to improve health and care outcomes to the Gateshead population	Risk of delay in transfer to community due to lack of social care provision and intermediate care beds, due to increased numbers of patients awaiting POC up to 30 patients in medical wards. This delay adds significant pressures to acute bed availability, escalation beds being required and significant risk of problems with flow through hospital impacting A&E breach standards and risk of patients being delayed within ambulances. This could result in patients remaining in hospital when medically optimised creating risk to these patients as well as other patients as bed capacity not able to meet demand. There is also a risk of patients deconditioning, resulting in failed discharge secondary to this. This could lead to increased pressures on nursing teams as well as poor patient experience and quality.	20	Daily meeting with LA to examine capacity in out of hospital system and match with demand for discharges. Target discharges of 40 per week to keep pace with demand. Monitoring of Delayed transfers of care twice weekly meeting Escalation of delays of care to the community BU and social services at twice weekly meetings. Monitoring of any levels of harm - Datix incidents. Monitoring of Breach levels and times. Monitoring of Ambulance delays. Monitoring increased LOS of medically optimised patients. Escalation of patients requiring social services support raised weekly at Discharge Systems group which includes Social services management and CCG representative. Medically Optimised meeting 2x week, passed to IPC/CCG ECIST work Pilot on 2 wards re improving discharges. Further social care provision for discharge purchased and in place from beginning of June 2022	16	System leadership post for discharge created and to be recruited to	Joanna Clark (Completed 09/05/2023)	9	rewording of risk following ERMG

Organisational Risk Register Report

Reporting Period: 15-Mar-2023 to 15-May-2023

Comparison Date: 14-Mar-2023

Organisational Risk Register (sorted by highest CRR and risk ID) - Current/Managed Risks

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR	Latest Progress Note
2993 28/01/2022 Kirsty Roberton Chief Executive Office Corporate Services & Transformation 22/03/2023 BAF BU_DIR ORG QGC SA1.2 Continuous Quality improvement plan	Risk of potential non-compliance with current legislation and guidance as a result of policies not being up to date, resulting in potential safety events and legislation and compliance breaches which may result in external scrutiny and reputational harm.	16	Policies in place for all key areas of legislation Overall policy management sat with CS&T Department (gap in leads for this work for a period) Policy system (pandora) maintained to manage and publish policies for staff to access Policy for Policies in place to provide clear direction and requirements for policy management Policies have lead 'author' and lead 'executive' Policy Review Group (PRG) in place (from Jan 22) to streamline process and target current backlog Policies include details of legislation and guidance they relate to, and information as to how compliance is monitored. Febraury 2023- starting to Monitor compliance against policies.	16	Begin to address overdue policy backlog	Kirsty Roberton 31/03/2023	3	agreement at ERMG to increase risk to 16.
					Establish process for gaining assurance over policy compliance and embed	Kirsty Roberton 31/03/2023		

Key: **CRR** - Current Risk Rating **PRR** - Previous Risk Rating
IRR - Initial Risk Rating **TRR** - Target Risk Rating

Organisational Risk Register Report

Reporting Period: 15-Mar-2023 to 15-May-2023

Comparison Date: 14-Mar-2023

Organisational Risk Register (sorted by highest CRR and risk ID) - Current/Managed Risks

Risk ID / Date Identified Handler BU Service Line Next Review Date BAF / Risk Register Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner Action Due	TRR	Latest Progress Note
1490 11/03/2014 Nick Black Digital 18/05/2023 BAF BU_DIR DIGC ORG SA1.2 Continuous Quality improvement plan, SA1.3 Digital where it makes a difference	If Information Asset Owners e.g. System administrators across business units and corporate services fail to manage their assets (e.g. patient data, staff data, corporate data, systems, and business continuity plans), there is a risk of inappropriate access/use/updating/disclosure of data.	20	Named System Administrator and Data Manager for every system Actively managed Systems Specific Security Policy (SSSP) for all systems - reviewing user access levels, training, configuration, testing, upgrade management - including business process changes etc Service owned Business Continuity Plan should systems fail Disaster Recovery Plan - how to recover the system Signed user registration forms Formal ITIL best practice change control procedure in place Formal Business case and project acceptance route through HISG Audit programme underway, focussed on critical system	15	Getting IAOs to take responsibility of their information assets	Nick Black 30/06/2023	3	Reporting continues to SMT and compliance group; also reported to Digital Committee and Trust Board. LRMP Complete 72.50% Info Asset Register Complete 11.71% Info Data Flows Complete 10.81%
					Ensure IAOs complete their Information Risk Management responsibilities	Kris MacKenzie 30/06/2023		

Key: **CRR** - Current Risk Rating **PRR** - Previous Risk Rating
IRR - Initial Risk Rating **TRR** - Target Risk Rating

Organisational Risk Register Report

Reporting Period: 15-Mar-2023 to 15-May-2023

Comparison Date: 14-Mar-2023

Organisational Risk Register (sorted by highest CRR and risk ID) - Current/Managed Risks

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register / Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR	Latest Progress Note
2398 28/12/2018 Kate Hewitson Surgical Services Obstetrics 01/06/2023 BAF BU_DIR COO ORG QGC SA1.1 Continue to improve our maternity services in line with the wider learning from the Ockenden review, SA1.2 Continuous Quality improvement plan	There is a risk of delayed treatment due to maternity estate being a separate building resulting in the potential for severe harm to mothers and babies. This was highlighted by recent HSIB reports reflecting delayed attendance times of emergency multi disciplinary teams to obstetric emergencies. Rising acuity of maternity patients and more frequent use of CCU, theatre staff and Paediatric teams creates additional likelihood of the need for these teams to attend the maternity department and delays to be incurred.	20	Pre-assessment - Women deemed likely to require critical care after elective procedures have their operation in main theatre to allow swift access to critical care. This only applies to elective patients and not emergency procedures or those in spontaneous labour. Any incidents are investigated to identify potential learning.	15	2861 action re looking into estate options	Kate Hewitson 01/06/2023	5	Total number of CCU transfers for 2022/23 was five, which is the highest number for the last five years.

Key: **CRR** - Current Risk Rating **PRR** - Previous Risk Rating
IRR - Initial Risk Rating **TRR** - Target Risk Rating

Organisational Risk Register Report

Reporting Period: 15-Mar-2023 to 15-May-2023

Comparison Date: 14-Mar-2023

Organisational Risk Register (sorted by highest CRR and risk ID) - Current/Managed Risks

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register / Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR	Latest Progress Note
2759 16/11/2020 Laura Farrington People and OD Workforce Development 04/06/2023 BAF ORG HRC SA2.1 Protect and understand the health and well-being of our staff by looking after our workforce, SA2.3 Development and Implementation of a Culture Programme (2-3 year Programme), SA4.1 Tackle our health inequalities, SA5.1 We will look to utilise our skills and expertise beyond Gateshead	Workforce Health & Wellbeing - Risk of adverse impact to staff health and wellbeing due to internal working conditions and pressures as well as external factors (demand, patient acuity, staffing levels, covid, civil unrest) resulting in increasing physiological and psychological harm.	16	Health and Wellbeing team established with Regional funding secured to fund the team until June 2023. Partnered with Talk Works to provide talking therapies and counselling services to reduce waiting times for counselling and psychological support services. Occupational health referral systems(self referral and management referral)and process in place. Occupation Health external review completed, with improvement plan now being implemented. Occupational Health Metrics discussed at POD Quality meeting. Physio appointed 24/7 catering/vending solution now in place and usage is positive Schwartz rounds commenced	12	Relaunch Health and wellbeing check ins	Amanda Venner 30/06/2023	8	reviwed today, no change
					Increase the number of Mental Health first aiders	Amanda Venner (Completed 24/02/2023)		

Key:				
	CRR -	Current Risk Rating	PRR -	Previous Risk Rating
	IRR -	Initial Risk Rating	TRR -	Target Risk Rating

Organisational Risk Register Report

Reporting Period: 15-Mar-2023 to 15-May-2023

Comparison Date: 14-Mar-2023

Organisational Risk Register (sorted by highest CRR and risk ID) - Current/Managed Risks

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register / Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR	Latest Progress Note
2868 27/04/2021 Joanne Baxter Chief Operating Officer Planning & Performance 23/04/2023 BAF COO EPRR FPC ORG QGC SA1.1 Continue to improve our maternity services in line with the wider learning from the Ockenden review, SA3.1 Improve the productivity and efficiency of our operational services through the delivery of the New Operating Model and associated transformation plans	New Operating Model - Risk to the delivery of the new operating model and associated transformation plans due to the increase in activity and reduced workforce capacity, resulting in an adverse impact on key performance and recovery plans.	20	EPRR incident response and OPEL plans in place to manage increase in demand Bed modelling completed and associated workforce plans developed winter plan developed, signed off by Board and in place Workforce management plans in place and monitoring of staff absences available Annual review and establishment of safe nursing staffing levels. Safe staffing report (nursing)produced and forecasting robust. Workforce bank in place (see linked risk) Expanded Agency usage (process for approval) Critical staff payment offer approved and in place. Workforce absence etc captured via ESR/ healthroster New operating model aligns staffing requirements to activity and service plans. Volunteers - recruitment and use Deployment Hub to improve use of available resources transformation plans in place to reduce admissions, LOS and improve discharge	12	active recruitment to vacanices	Lisa Crichton-Jones 30/09/2022	6	review date changed in line with policy
					international recruitment programme	Lisa Crichton-Jones 30/09/2022		
					complete capital programme to enable delivery of model	Joanne Baxter 29/09/2023		
					a revised focus on reducing overall LOS in medicine	Amy Muldoon 29/02/2024		

Key: CRR - Current Risk Rating; IRR - Initial Risk Rating; PRR - Previous Risk Rating; TRR - Target Risk Rating

Organisational Risk Register Report

Reporting Period: 15-Mar-2023 to 15-May-2023

Comparison Date: 14-Mar-2023

Organisational Risk Register (sorted by highest CRR and risk ID) - Current/Managed Risks

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register / Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR	Latest Progress Note
2945 14/09/2021 Debbie Renwick Chief Operating Officer Planning & Performance 27/10/2022 BU_DIR ORG	Risk of ineffective and inefficient management of services due to availability and access to appropriate and timely business intelligence to deliver and improve services	15	Programme of work established to work on improving access to BI and improve board reporting along with service line access to quality performance and workforce data Project Manager appointed to lead on this work with support from NECS. Programme involves 3 projects Static reporting – Look back - this is what we achieved Live reporting – this is how we are doing now and where we need to intervene to prevent poor performance Forecasting – these are the trends to be able to plan services much more effectively to meet demand the later two points need further development Some BI available in sitreps and excel format	12	• Work with the BU managers looking at what is available and start to build what is needed and get rid of what is not used/helpful	Debbie Renwick 31/08/2022	4	no change to risk following consultation with DR
					• Improve data quality by working with teams and provide resilience to teams doing the RTT etc	Debbie Renwick 30/09/2022		
					project groups established and PID developed and plans developed for delivery	David Thompson 30/09/2022		
3089 25/07/2022 Gillian Findley Nursing, Midwifery & Quality Quality Governance 06/03/2023 BAF BU_DIR ORG QGC SA1.2 Continuous Quality improvement plan	Quality - There is a risk of quality failures in patient care (patient safety, patient experience and effectiveness) due to external causes such as delayed discharges and pressures from other Trusts resulting in patient harm, regulatory action, and reputational impact	15	Daily report provided detailing all delayed discharges within the Trust. regular meetings now established with social care. Discharge liaison staff available to support wards and facilitate earlier discharge.	12	improve flow through hospital	Joanne Baxter 15/07/2023	6	NO change to risk or controls

Organisational Risk Register Report

Reporting Period: 15-Mar-2023 to 15-May-2023

Comparison Date: 14-Mar-2023

Organisational Risk Register (sorted by highest CRR and risk ID) - Current/Managed Risks

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register / Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR	Latest Progress Note
3128 17/10/2022 Kris MacKenzie Finance Finance 28/02/2023 BAF BU_DIR FPC ORG SA3.2 Achieving financial sustainability	There is a Risk that the capital cost of delivery of the new operating model continues to increase resulting in revenue implications.	12	Detailed scrutiny of wider capital programme undertaken to ensure robust forecasting	12	Review of in-year costs with contractor	Paul Swansbury 31/01/2023	9	Risk remains.
3148 06/12/2022 Joanne Baxter Chief Operating Officer EPRR & Site Resilience 23/04/2023 BU_DIR COO FPC MDMG ORG QGC BAF SA1.2 Continuous Quality improvement plan, SA2.2 Growing and developing our workforce	There is a risk that the organisation is unable to release staff for mandatory training and medical devices training due to operational pressures and current vacancies in both medical and nurse staffing. This could result in possible patient safety incidents.	20	Receive database from QEF, take training to ward areas promotion of training in the clinical environments	12	Support clinical environment in accessing the learning management system on site	Michael Crowe 28/04/2023	9	agreement at ERMG 4/4/23 to add to ORR.
3186 07/02/2023 Joanne Baxter Chief Operating Officer Planning & Performance 23/04/2023 BAF BU_DIR COO FPC ORG SA3.1 Improve the productivity and efficiency of our operational services through the delivery of the New Operating Model and associated transformation plans, SA3.2 Achieving financial sustainability	There is a risk to maintaining business continuity of services and recovery plans due to the estate infrastructure, age and backlog maintenance requirements which exceed the Trusts capital allocation	12	Clinically led estates strategy developed and prioritsied on priority versus affordability	12	commission full estates review as part of Bensham retraction programme	Anthony Pratt 31/07/2023	6	QEF completing a full appraisal of site as estate requirements as part of the Bensham retraction programme. Individual estate risks to services will be included on the BU risk regsiter and mitigated as far as possible by management teams and QEF.

Key: **CRR** - Current Risk Rating **PRR** - Previous Risk Rating
IRR - Initial Risk Rating **TRR** - Target Risk Rating

Organisational Risk Register Report

Reporting Period: 15-Mar-2023 to 15-May-2023

Comparison Date: 14-Mar-2023

Organisational Risk Register (sorted by highest CRR and risk ID) - Current/Managed Risks

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR	Latest Progress Note
1636 10/11/2014 Dianne Ridsdale Digital Digital Transformation and Assurance 11/07/2023 BU_DIR DIGC MDMG ORG	UCRF R01/R03/R20/R23 Malware such as Ransomware Compromising Unpatched Endpoints, Servers, Equipment or due to Lack of Hardened Build Standards. There is a risk of potential exposure to published critical cyber vulnerabilities. Laptops, workstations and medical devices compromised by ransomware or botnets, due to endpoints being susceptible to compromise through the use of obsolete, old, or unpatched operating systems and third party software, including Java. Endpoints often not monitored for patch status. Endpoints compromised more easily through dangerous browser plugins (such as Java, Flash), or unsupported browsers. Servers compromised by ransomware, due to servers susceptible to compromise through the use of obsolete, old, or unpatched operating systems and software. Servers often not monitored for patch status. Due to failure to maintain all Digital assets, including installing Operating system patches, AV patches or other software and hardware updates across the IT estate, including network equipment and medical devices. Resulting in potential harm to patients, data leaks, impacts on service delivery.	25	AV on all end points AV up to date ATP in place site wide NHSD & Microsoft group policy templates Ongoing updates routinely planned as they are released Patching regime Network fully supported and maintained	10	Review trust asset register for EOL hardware/Software	Mark Bell 28/04/2023	5	IG have reviewed Actions reviewed and extension applied to align with May DAG
					Review trust asset register for EOL hardware/Software	David Thompson 28/04/2023		

Key: CRR - Current Risk Rating; IRR - Initial Risk Rating; PRR - Previous Risk Rating; TRR - Target Risk Rating

Organisational Risk Register Report

Reporting Period: 15-Mar-2023 to 15-May-2023

Comparison Date: 14-Mar-2023

Organisational Risk Register (sorted by highest CRR and risk ID) - Current/Managed Risks

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register / Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR	Latest Progress Note
2880 30/04/2021 Mr Andrew Beeby Chief Executive Office Medical Directorate 09/08/2023 BAF ORG QGC SA4.1 Tackle our health inequalities, SA4.2 Work collaboratively as part of Gateshead Cares system to improve health and care outcomes to the Gateshead population	Health Outcomes - Risk that Place/ICS/ICP strategy and plans do not fully align with our objectives and aspirations to tackle health inequalities due to different approaches resulting in slow or no progress against health inequalities.	12	Being involved with ICS / ICP / Place in the development of work (co-production) Health Inequalities Board established.	2			2	updated review date

Organisational Risk Register Report

Reporting Period: 15-Mar-2023 to 15-May-2023

Comparison Date: 14-Mar-2023

Changes in CRR - Current/Managed Risks

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register / Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR	Latest Progress Note	PRR
2779 01/07/2020 Jane Conroy Nursing, Midwifery & Quality Quality Governance 20/05/2023 BAF BU_DIR FPC ORG QGC SA1.2 Continuous Quality improvement plan	The Trust fails to meet the CQC Fundamental Standards.	16	CQC three phased monitoring approach CQC Action plan T&F Group Exec Complinance Group Inspection action plans Nursing Strategy and Safe Staffing planning & delivery Governance Framework Risk Management systems and processes Health & Safety Governance and processes NICE guidance governance processes Learning Disability Support processes Cancer Services delivery plans Scheduled audits of operational safety elements.	16	Develop a route map to Outstanding	Jane Conroy 26/05/2023	6	Trust's agreed three phased internal monitoring approach implemented and complete. This has recerntly been audited by Audit One and awaiting outcome report. Trust's CQC action plan continues to be presented monthly to SMT. CQC Action Plan T&F now in place with escalation to Exec Compliance Group and key themes and actions to SMT monthly where the CQC Action plan paper is presented. Slow progress noted in closing down 2019 acitons. Risk increased to 16 and added to the Organisational Risk Register.	12
					Ensure any areas of improvement from last inspection are in place	Jane Conroy 30/06/2023			

Key: **CRR** - Current Risk Rating; **IRR** - Initial Risk Rating; **PRR** - Previous Risk Rating; **TRR** - Target Risk Rating

Organisational Risk Register Report

Reporting Period: 15-Mar-2023 to 15-May-2023

Comparison Date: 14-Mar-2023

Changes in CRR - Current/Managed Risks

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register / Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR	Latest Progress Note	PRR
3148 06/12/2022 Joanne Baxter Chief Operating Officer EPRR & Site Resilience 23/04/2023 BU_DIR COO FPC MDMG ORG QGC BAF SA1.2 Continuous Quality improvement plan, SA2.2 Growing and developing our workforce	Mandatory training- (including medical devices) compliance	20	Receive database from QEF, take training to ward areas promotion of training in the clinical environments	12	Support clinical environment in accessing the learning management system on site	Michael Crowe 28/04/2023	9	agreement at ERMG 4/4/23 to add to ORR.	16
2880 30/04/2021 Mr Andrew Beeby Chief Executive Office Medical Directorate 09/08/2023 BAF ORG QGC SA4.1 Tackle our health inequalities, SA4.2 Work collaboratively as part of Gateshead Cares system to improve health and care outcomes to the Gateshead population	Health Outcomes - Risk that Place/ICS/ICP strategy/plans do not align with our objectives to tackle health inequalities	12	Being involved with ICS / ICP / Place in the development of work (co-production) Health Inequalities Board established.	2			2	updated review date	9
									3

Risks Moved to Managed in Period

Risk ID	Date Identified	Risk Description	IRR	Current Controls	CRR	Action	Action Owner	TRR

Key: CRR - Current Risk Rating; IRR - Initial Risk Rating; PRR - Previous Risk Rating; TRR - Target Risk Rating

Organisational Risk Register Report

Reporting Period: 15-Mar-2023 to 15-May-2023

Comparison Date: 14-Mar-2023

Handler BU Service Line Next Review Date BAF / Risk Register Objectives						Action Due	
							0

Risks Closed in Period

Risk ID	Date Identified	Risk Description	IRR	Current Controls	CRR	Action	Action Owner	TRR	Closure Details	PRR
Handler BU Service Line Next Review Date BAF / Risk Register Objectives							Action Due (Open Actions)			
										0

Key: **CRR** - Current Risk Rating **PRR** - Previous Risk Rating
IRR - Initial Risk Rating **TRR** - Target Risk Rating

Organisational Risk Register Report

Reporting Period: 15-Mar-2023 to 15-May-2023

Comparison Date: 14-Mar-2023

Risks Added in Period

Risk ID / Date Identified Handler BU Service Line Next Review Date BAF / Risk Register Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner Action Due	TRR	Latest Progress Note Date Added to ORR
2779 01/07/2020 Jane Conroy Nursing, Midwifery & Quality Quality Governance 20/05/2023 BAF BU_DIR FPC ORG QGC SA1.2 Continuous Quality improvement plan	The Trust fails to meet the CQC Fundamental Standards resulting in potential regulatory action, harm to patients, decline in ratings, and resulting reputational damage.	16	CQC three phased monitoring approach CQC Action plan T&F Group Exec Complinance Group Inspection action plans Nursing Strategy and Safe Staffing planning & delivery Governance Framework Risk Management systems and processes Health & Safety Governance and processes NICE guidance governance processes Learning Disability Support processes Cancer Services delivery plans Scheduled audits of operational safety elements.	16	Develop a route map to Outstanding	Jane Conroy 26/05/2023	6	Trust's agreed three phased internal monitoring approach implemented and complete. This has recerntly been audited by Audit One and awaiting outcome report. Trust's CQC action plan continues to be presented monthly to SMT. CQC Action Plan T&F now in place with escalation to Exec Compliance Group and key themes and actions to SMT monthly where the CQC Action plan paper is presented. Slow progress noted in closing down 2019 acitons. Risk increased to 16 and added to the Organisational Risk Register. 04-04-2023
					Ensure any areas of improvement from last inspection are in place	Jane Conroy 30/06/2023		

Key: CRR - Current Risk Rating; IRR - Initial Risk Rating; PRR - Previous Risk Rating; TRR - Target Risk Rating

Organisational Risk Register Report

Reporting Period: 15-Mar-2023 to 15-May-2023

Comparison Date: 14-Mar-2023

Risks Added in Period

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR	Latest Progress Note / Date Added to ORR
3148 06/12/2022 Joanne Baxter Chief Operating Officer EPRR & Site Resilience 23/04/2023 BU_DIR COO FPC MDMG ORG QGC BAF SA1.2 Continuous Quality improvement plan, SA2.2 Growing and developing our workforce	There is a risk that the organisation is unable to release staff for mandatory training and medical devices training due to operational pressures and current vacancies in both medical and nurse staffing. This could result in possible patient safety incidents.	20	Receive database from QEF, take training to ward areas promotion of training in the clinical environments	12	Support clinical environment in accessing the learning management system on site	Michael Crowe 28/04/2023	9	agreement at ERMG 4/4/23 to add to ORR. 04-04-2023
								2

Risks Removed in Period

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR	Latest Progress Note / Date Removed from ORR
								0

Key: CRR - Current Risk Rating; IRR - Initial Risk Rating; PRR - Previous Risk Rating; TRR - Target Risk Rating

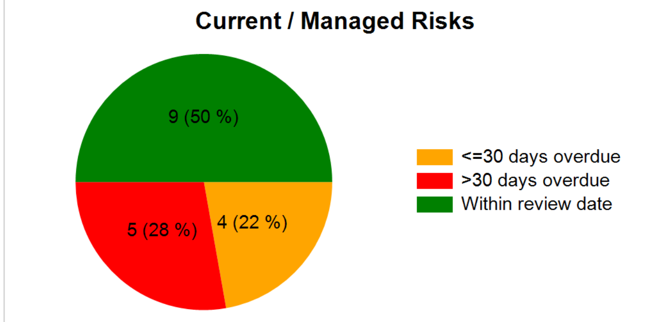
Organisational Risk Register Report

Reporting Period: 15-Mar-2023 to 15-May-2023

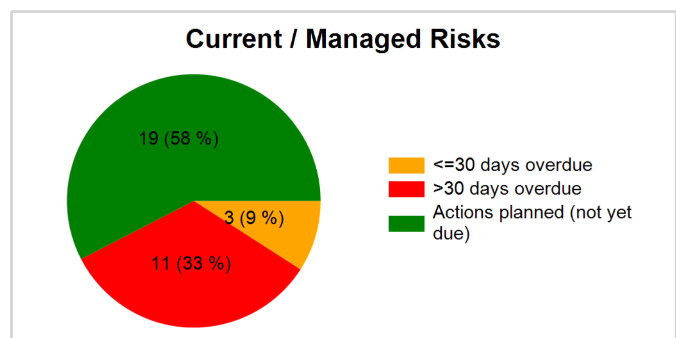
Comparison Date: 14-Mar-2023

NHS
Gateshead Health
NHS Foundation Trust

Risk Review Compliance



Risk Action Compliance



Movements in CRR

				CRR		
BU	**Service Line**	**ID**	**Risk Description**	**Mar-2023**	**Apr-2023**	**Today**
Chief Executive Office	Corporate Services & Transformation	2993	Risk of potential non-compliance with current legislation and guidance as a result of policies not being up to date.	16	16	16
	Medical Directorate	2880	Health Outcomes - Risk that Place/ICS/ICP strategy/plans do not align with our objectives to tackle health inequalities	9	9	2
Chief Operating Officer	EPRR & Site Resilience	3148	Mandatory training- (including medical devices) compliance	12	12	12
	Planning & Performance	2868	New Operating Model -Risk to the delivery of the new operating model resulting in adverse impact on performance & recovery plans	12	12	12
		2945	Risk of ineffective and inefficient management of services due to availability and access to appropriate and timely BI.	12	12	12
		3186	There is a risk to ongoing business continuity of service provision due to ageing trust estate	12	12	12
Digital		1490	Failure to manage Information Assets	15	15	15

Key: **CRR** - Current Risk Rating **PRR** - Previous Risk Rating
IRR - Initial Risk Rating **TRR** - Target Risk Rating

Organisational Risk Register Report

Reporting Period: 15-Mar-2023 to 15-May-2023

Comparison Date: 14-Mar-2023

Movements in CRR

				CRR		
BU	**Service Line**	**ID**	**Risk Description**	**Mar-2023**	**Apr-2023**	**Today**
Digital	Digital Transformation and Assurance	1636	UCRF R01/R03/R20/R23 - Malware such as Ransomware Compromising Unpatched Endpoints, Servers and Equipment	10	10	10
	Health Records	1797	Multiple sources of clinical records stored in systems and paper format leading to potential patient harm	16	16	16
Finance	Finance	3103	operational pressures result in non achievement of CRP	20	20	20
		3128	Risk that the capital cost of delivery of the new operating model continues to increase resulting in revenue implications.	12	12	12
Medical Services	Medical Services - Divisional Management	2982	Risk of delayed transfers of care and increased hospital lengths of stay	16	16	16
Nursing, Midwifery & Quality	Quality Governance	2779	The Trust fails to meet the CQC Fundamental Standards.	12	16	16
		3089	Quality - Risk of quality failures in patient care due to external causes such as delayed discharges and external pressures.	12	12	12
People and OD	Human Resources	2764	Workforce - Risk of not having the right people in the right place at the right time with the right skills.	16	16	16
	Workforce Development	2759	Workforce health & Wellbeing - Risk of adverse impact to staff health and wellbeing due to internal and external pressures	12	12	12
		3095	Risk of Significant, unprecidented service disruption due to industrial action	20	20	20
Surgical Services	Obstetrics	2398	Risk that MDT are delayed to a maternity emergency/delayed CCU transfers for maternity patients due to separate buildings	15	15	15

Key: **CRR** - Current Risk Rating; **IRR** - Initial Risk Rating; **PRR** - Previous Risk Rating; **TRR** - Target Risk Rating

Report Cover Sheet Agenda Item: 12ii

Report Title:	**Draft Risk Management Strategy**			
Name of Meeting:	Board of Directors			
Date of Meeting:	24.5.2023			
Author:	Shelley Dyson – Head of Risk and Patient Safety Marie Malone- Corporate and Clinical Risk Lead			
Executive Sponsor:	Gillian Findley – Chief Nurse			
Report presented by:	Gillian Findley – Chief Nurse			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☒	**Discussion:** ☒	**Assurance:** ☐	**Information:** ☐
	This document is the DRAFT proposed Risk Management Strategy for GHFT and QEF (Group). It outlines the reasons for the necessity of a sound risk management strategy; it gives an overview of the objectives of a risk strategy and explains the stages in the process.			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☐ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	SafeCare Risk and Patient Safety Council Trust Audit Committee QEF Board			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	By having the correct risk management strategy and implementing “best risk management practice” throughout NHS trusts There are significant opportunities for achieving: • improved quality of care, • major costs savings, • improved public perception. • reduction in clinical negligence claims This proposed strategy gives a structure to these ambitions for the Trust and QEF			
Recommended actions for this meeting:	To discuss and provide any comments and feedback prior to this strategy being agreed by the Trust.			

<table>
<tr><td>Outline what the meeting is expected to do with this paper</td><td colspan="5"></td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:</td><td>Aim 1 ☒</td><td colspan="4">We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>Aim 2 ☒</td><td colspan="4">We will be a great organisation with a highly engaged workforce</td></tr>
<tr><td>Aim 3 ☒</td><td colspan="4">We will enhance our productivity and efficiency to make the best use of resources</td></tr>
<tr><td>Aim 4 ☒</td><td colspan="4">We will be an effective partner and be ambitious in our commitment to improving health outcomes</td></tr>
<tr><td>Aim 5 ☒</td><td colspan="4">We will develop and expand our services within and beyond Gateshead</td></tr>
<tr><td>Trust corporate objectives that the report relates to:</td><td colspan="5">This overarching strategy relates to all of our corporate objectives</td></tr>
<tr><td>Links to CQC KLOE</td><td>Caring ☐</td><td>Responsive ☒</td><td>Well-led ☒</td><td>Effective ☒</td><td>Safe ☒</td></tr>
<tr><td colspan="6">Risks / implications from this report (positive or negative):</td></tr>
<tr><td>Links to risks (identify significant risks and DATIX reference)</td><td colspan="5">All risks documented in risk registers including those managed, and those yet to be identified</td></tr>
<tr><td>Has a Quality and Equality Impact Assessment (QEIA) been completed?</td><td colspan="2">Yes ☐</td><td colspan="2">No ☐</td><td>Not applicable ☒</td></tr>
</table>

Group Risk Management Strategy

DRAFT

Policy Governance information	
This is a (check one box): Policy ☐ Procedure ☐ Clinical guideline ☐ Clinical Protocol ☐ *For Clinical Guidelines and Protocols please refer to OP59 Clinical guidelines and protocols policy.*	
Applies to : **GROUP (GHNT & QEF) ☒ Gateshead Health NHS FT ONLY ☐ QE Facilities ONLY ☐**	
Policy Title	Group Strategy – Risk Management Strategy
Policy Number	
Version Number	1.0
Author(s) (Job Titles)	
Executive Sponsor	Gill Findley, Chief Nurse and Professional Lead for Midwifery and AHPs
Approving Committee/ Group	Audit Committee Board of Directors QEH and QEF
Primary Readers	All staff
Additional Readers	
Date Ratified	
Effective From	
Expiry Date	
Withdrawn Date	
Unless this copy has been taken directly from Pandora (the Trust's Sharepoint document management system) there is no assurance that this is the most up to date version. This policy supersedes all previous issues. This policy is intended for use across the Gateshead Health NHS Foundation Trust Group which includes QE Facilities Limited and its group companies/divisions. Where responsibilities state all staff, managers, senior managers, or directors, this also includes those staff groups from across group including QE Facilities Limited and its group companies/divisions.	

Version Control

Version	Release	Author/reviewer	Ratified by/authorised by	Date	Changes (Please identify Page no.)
1		Corporate and Clinical Risk Lead Head of Risk and Patient Safety	Audit Committee Board of Directors QEH and QEF		New format

Contents

1 Foreword 4

2 Introduction 5

3 Definition of terms 6

4 Risk Management Framework 7

- 4.1 Risk Culture 7
- 4.2 Leadership and Local Capability 7
- 4.3 Governance and Assurance 8
- 4.4 Risk Management Process 9
- 4.5 Risk Events, Patient Safety, Reducing Avoidable Harm & Inspiring Improvement 13
- 4.6 Risk Appetite 13
- 4.7 Board Assurance Framework (BAF) 15
- 4.8 Risk Management Maturity 16

5 Training 17

6 Diversity and Inclusion 18

7 References 18

8 Associated documentation 18

9 Intranet Information 19

10 Appendix 1 – Definition of Terms 20

11 Appendix 6 – Equality Impact Assessment (EqIA) 21

DRAFT

1 Foreword

NHS Foundation Trusts should be well governed; this includes how they oversee care for patients, deliver national standards and remain economic, efficient, and effective. As a leading provider of quality healthcare, Gateshead NHS Foundation Trust, and its subsidiary QE Facilities (QEF) (hereafter referred to as the Group) recognises that the safe effective management of risk is fundamental to effective governance arrangements, patient, and staff safety and to the overall performance of the organisation. This therefore requires a comprehensive strategic approach.

This three-year strategy outlines our commitment and strategic approach to maintaining a sound system of internal control that supports the achievement of our strategic aims and supporting objectives.

We have assessed ourselves as having a moderate appetite for risk, being prepared to take risks which offer the potential to bring benefits for our patients, staff, partners, and stakeholders.

A key focus will be to continue to strengthen corporate risk management, develop our use of risk appetite, and ensure robust risk management. This will include the elimination of avoidable harm wherever possible, and to strengthen our processes for taking appropriate action from identified learning and providing assurance that we have embedded learning and reduced re-occurrence of similar events.

The principle that managing risk is 'everybody's business' is reflected in the strategy and also the policies that support the comprehensive risk management systems already established throughout the organisation. This is fundamental to the delivery of the strategic aims and objectives in relation to patient safety, clinical effectiveness, performance, patient experience and business opportunity.

Signature of CE and Chair, and QEF MD

DRAFT

2 Introduction

Risk management is the thread that must run throughout all NHS activities and at all levels if each organisation is to provide safe, quality care in an efficient and effective manner.

This document sets out the strategic direction for risk management for the Group for the next three years. It has been developed to comply with legal and statutory requirements, assist in compliance with national standards, to promote proactive risk management and ultimately to improve the safety and quality of patient

Trust staff will be well educated in how to effectively manage risk. The Trust Board will continue to suppor and encourage an open and honest culture that is proactive in learning and sharing lessons and places effective risk management and patient safety at the heart of all activities.

Our strategic objectives for risk management for the Group for the next three years are to have an organisation which:

- Is fully risk aware where risk management is embraced within the organisation's culture and is integrated into the working practices of all grades and disciplines of staff;
- Encourages the open reporting of errors, within a fair blame culture and ensures that lessons are learned from those errors and that measures to prevent recurrence are promptly applied;
- Engages in the continual development of risk management systems to facilitate identifying which risks represent opportunities and which represent potential pitfalls; and
- Accepts that risk management is everyone's responsibility. This in turn will ensure the achievement of the organisation's overall objective which is working together to provide the best health services and care for local people.

To achieve this we will apply risk management to our decision making at all levels and ensure a structured and systematic approach to risk management is implemented throughout the organisation to deliver the risk management objectives, which are:

DRAFT

- To support the achievement of the Group’s aims and objectives.
- To support an integrated approach to risk management which includes all risks, including those related to clinical care, health and safety, financial and business planning, workforce planning, corporate and information governance, performance management, project/programme management, and education and research.
- To promote the ethos that risk management is everyone’s business and support the development of a culture which encourages the open reporting of errors, with a focus on ‘what went wrong’ not ‘who went wrong’, and ensures that lessons are learned from those errors, and that measures to prevent recurrence are promptly applied.
- To ensure effective systems and processes are in place to assist in risk identification, mitigation and management, with appropriate escalation and reporting at all levels.
- To create an environment which is not only as safe as is reasonably practicable by ensuring that risks are continuously identified, assessed and appropriately managed, but also that continuous improvement takes place.

3 Definition of terms

When we talk about risk and risk management, we want everyone to have the same understanding of what this means.

Risk is defined as:
‘The uncertainty/ possibility of loss, damage, missed opportunity, injury or failure to achieve objectives or deliver our plans as a result of an uncertain action or event.’

Clinical risk is defined as:
‘The chance of something happening to a patient during NHS care that could have or did lead to unintended or unexpected harm, loss or damage.’

This is a broad definition that may range from dissatisfaction on the part of patients at having to wait so long for treatment or at a lack of communication, to undergoing the wrong operation, or suffering permanent disability or death.

Risk management is defined by the Institute of Risk Management as:

DRAFT

'The process which aims to help organisations understand, evaluate and take action on all their risks with a view to increasing the probability of success and reducing the likelihood of failure.'

The Group aims to be proactive in its approach to the management of risk and will endeavour to identify, control and where possible eliminate the risk before incidents of actual loss or harm have occurred.

A number of different terms are used throughout this Strategy, supporting Policy (RM01) and supporting information and guidance available on the intranet. For ease these are included alphabetically at Appendix 1.

4 Risk Management Framework

4.1 Risk Culture

Risk is everyone's business and building a strong risk management culture works hand in hand with safety and compliance, working with staff to increase the understanding of risk and how it is managed within their roles and remits.

Reporting of incidents, risks or any concerns is encouraged, as it is from these that we will identify where systems and processes are failing and enable the identification of learning to ensure these are addressed and repeat occurrences prevented in the future.

4.2 Leadership and Local Capability

Effective risk management depends on proactive leadership right from the top of the organisation, through all levels of management; to facilitate risk identification, ownership and buy-in at all levels. This is supported through a comprehensive infrastructure with risk/governance groups within business units reviewing risk at local level, extending to corporate support, management and monitoring. Accountability for risk rests with the Executive Board of Directors which has a collective responsibility to ensure that safety is at the heart of everything we do, that systems are robust, the Group learns from experience and risk is managed and mitigated effectively.

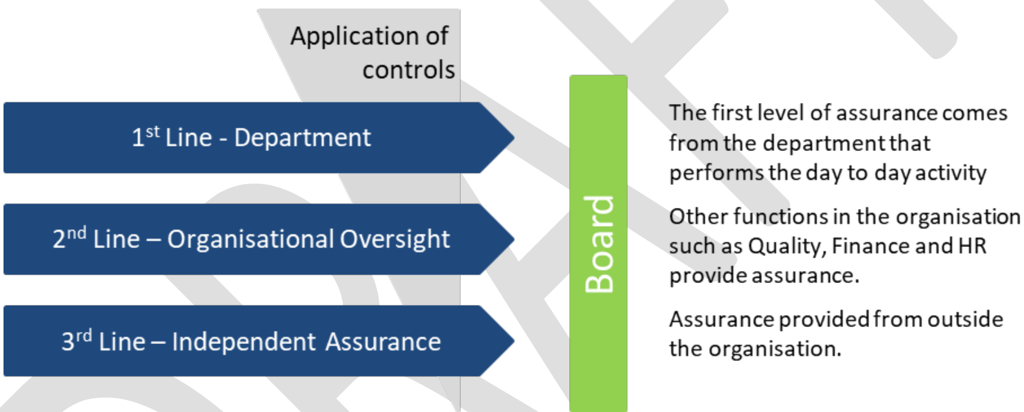
All executive directors and senior managers have clear portfolios of responsibilities and areas for which they are accountable. The Group must ensure it has adequate governance arrangements to provide assurance that robust, system-wide risk identification and check and challenge is in place to support continuous improvement and development in general.

DRAFT

The Group will ensure that members of staff at all levels are aware of their role in managing risk and that they have a responsibility in the delivery of healthcare to protect patients, carers, visitors, colleagues, themselves and the environment in which patients are cared for. As a Group we consider and utilise all guidance and best practice available to ensure we have a robust framework that satisfies all key requirements and is flexible for our needs. In this way we are able to work with the best elements of these.

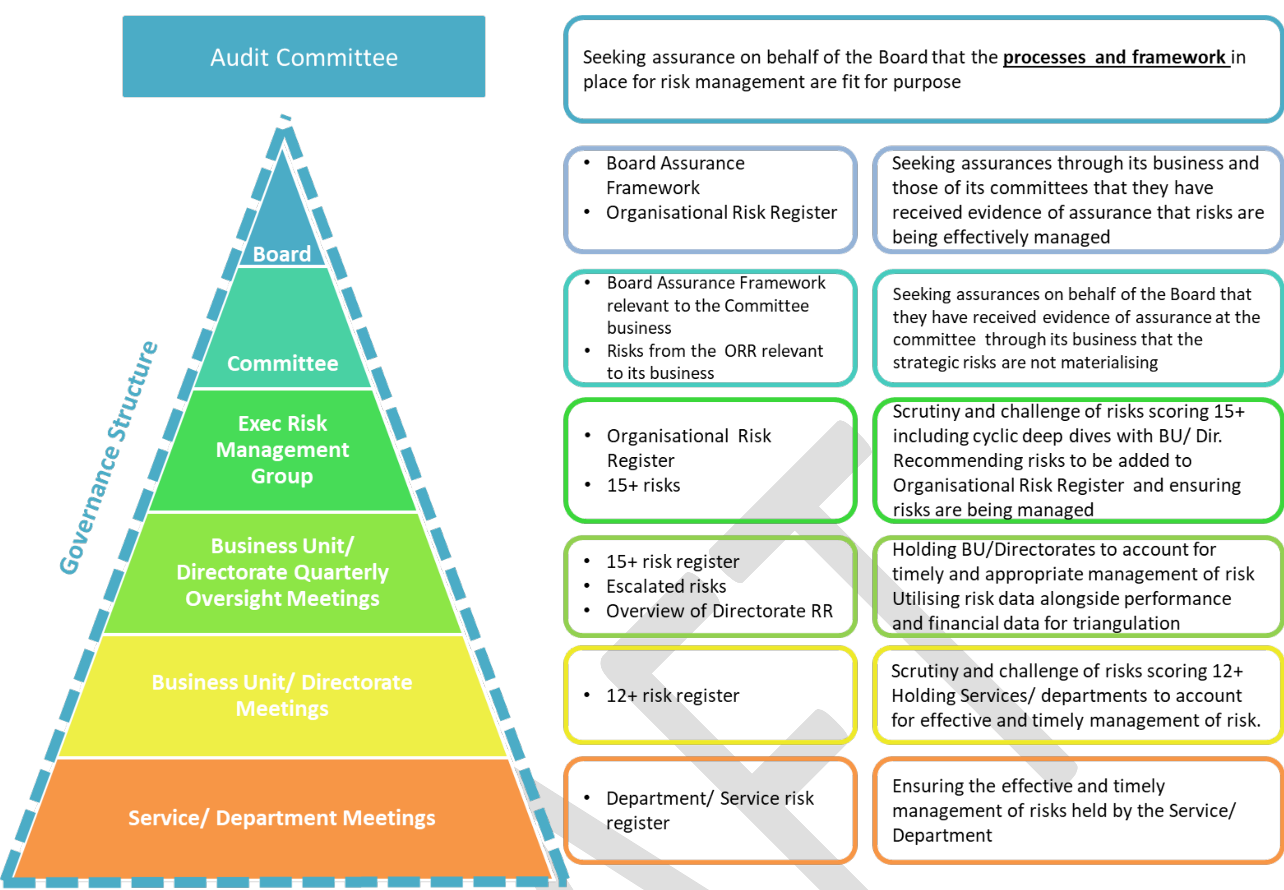
4.3 Governance and Assurance

A key component of the Group's risk management framework is providing assurance, not only about the overall risk management system but as importantly on the effectiveness of the controls and their application (action plans) being put in place to mitigate the impact of any risk. As the below diagram shows there are three levels of assurance in respect of the application of controls.



We will manage risk and gain assurance within the ward to board governance framework shown below:

DRAFT



DRAFT

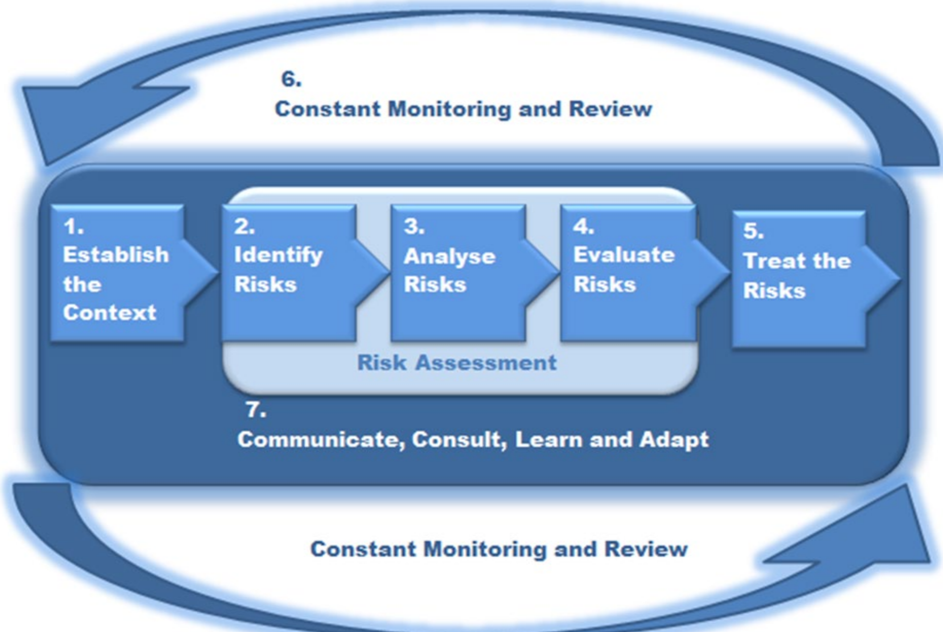
Risks added to the risk register system will be reflected as part of wider risk register reporting. As such an individual service or department risk will form part of the service or department register, but also the wider register for the Business Unit or Directorate.

Risks identified as impacting directly on the achievement of the Trusts strategic aims and priority objectives are reflected in the Board Assurance Framework (BAF) document and Organisational Risk Register.

To ensure learning and appropriate adaptation occurs in order to minimise recurrence of risks across the organisation, cross Directorate and Business Unit analysis will be undertaken. This will enable similar and cross cutting risks to be grouped and shared, enabling learning and adaptation of controls or actions.

4.4 Risk Management Process

The overall risk management process is briefly explained and shown pictorially below. Full details on the application of this within the Group Risk Management Policy (RM01).



DRAFT

Step 1 – Establish the Context

Determine the facts, situation and environment, and consider both internal and external factors. Identify and clarify which strategic aim or objective is relevant to the Business Unit, Directorate, service or area.

Step 2 - Risk Identification

Risk identification should take place on a continual basis, but particularly where new services or activities are planned, new legislation or NHS policy requirements are identified, new strategies and plans are developed, or where incidents or near misses have taken place.

A wide variety of risk assessments are undertaken throughout the group on a regular basis, for example; patient related risk assessments, workplace, environment, health and safety and security risk assessments, as well as audits and reactive assessments following incidents, complaints, claims or safety alerts. In most cases it is not appropriate or necessary for risks from these risk assessments to be entered on to the group's risk register.

Step 3 - Risk Analysis

In undertaking risk analysis the effectiveness of internal controls, both proactive (to prevent the risk event occurring) and reactive (after the risk event has occurred) should be

undertaken. When considering assurances, these are the processes by which we know that a control (or combination of controls) is working and effective or not.

Determining the relative importance of individual risks is a key element of the risk management process, enabling risk control priorities to be identified and appropriate action to be taken in response. We use the National Patient Safety Agency (NPSA) Risk Matrix as a tool to assist in assigning a consequence or likelihood level to risks.

This is achieved by:

- Assigning a level of or '**impact**' or '**consequence**' to the risk event using the consequences matrix. This matrix has the consequence 'type' down one side with indicative 'outcomes' aligned to a scale of 1-5, with 1 being negligible impact and 5 being catastrophic. Selecting the correct type and outcome during the assessment is important for consistency.
- Assigning a level of '**likelihood**' of a risk event occurring using the likelihood matrix. Again applying a score of 1-5 where 5 is almost certain.
- The two are combined on 5*5 matrix to give a score of 1-25. The higher the result the higher the risk.

All staff must follow the standardised approach to risk assessment and all risks will be scored and graded using the risk assessment (please see group Risk Management Policy).

Step 4 - Risk Evaluation
Once a risk has been analysed staff will need to decide how best to respond based on the risk appetite and the resources available. Where the current risk score is above target risk, this indicates that additional mitigating action/ risk treatment is needed. The current risk score also enables risks to be ranked so as to identify management priorities.

Step 5 - Risk Treatment
Risk treatment involves identifying the range of options for controlling or treating risk, assessing those options, preparing risk treatment plans and implementing them. The options available for the treatment of risks include:

- Tolerate (contain/accept) the risk

DRAFT

- Treat (mitigate) the risk
- Transfer the risk
- Terminate (eliminate/avoid) the risk

The response to the risk should be in proportion to the level of risk identified and in accordance with the risk appetite and tolerance levels set by the Board.

The strategic planning and capital allocation processes are linked to the risk assessment process. Business Units, specialties and departments are required to risk assess and support all bids to demonstrate that the allocation of funding will reduce or remove a risk.

Step 6 - Monitoring & Review

All risks on the risk register will be regularly monitored and reviewed, with reporting into the ward to board governance framework. Where a risk is significant, Trust-wide (or QE Facilities), and cannot be dealt with at Directorate of Business Unit level, such issues will be referred to the Executive Risk Management Group by the relevant Director.

All risks which have a current risk score at or above the Board's escalation level will be reported to the Executive Risk Management Group.

Step 7 – Communicate, Consult, Learn and Adapt

To address risk, we may need to communicate and consult widely, including with external stakeholders as appropriate, at each stage of the risk management process. Risks will be identified that have cross functional or cross Business Unit/ Directorate impacts or relevance and as such should be shared and discussed in wider groups.

Risk Register

Risks will be entered onto the risk management system, currently Datix, facilitating their management and reporting. QE Facilities are the only exception to this, maintaining a separate corporate risk register for risks with commercial sensitivity.

Where a risk has been identified in one area of the Group but has the potential to occur elsewhere, the risk and any lessons learnt should be widely shared. The Trust has in place a range of mechanisms to support this sharing of information.

DRAFT

4.5 Risk Events, Patient Safety, Reducing Avoidable Harm

While all actions may be taken to mitigate risk events, in some cases this isn't possible, or events may occur that we had no insight into. When things go wrong 'incidents' are reported, and the level of harm assessed.

While the majority of incidents will be low harm, no harm, or a near miss, there are events that cause harm, whether to a patient, member of staff, or visitor to our premises. These incidents are subject to investigation to identify and embed learning to prevent reoccurrence. We also intend to undertake more theme analysis on low harm, no harm, or a near miss events to identify learning. Incidents are reported in line with the Incident & Near Miss Reporting Policy (RM04) and Serious Incident Reporting and Management Policy (RM04a).

The Group also taking action to strengthen the systems in place to manage NHS England/NHS Improvement Patient Safety Alerts, to ensure appropriate actions are taken timely and assurance to demonstrate compliance reported.

Our systems will provide patients with the confidence that where there is a possibility that harm has been caused in the delivery of healthcare in any part of the Trust, there will be an open, honest, supportive approach taken. The Trust will endeavour to learn from experience and take all possible actions to work towards reducing all avoidable harm thereby improving patient safety.

4.6 Risk Appetite

The Good Governance Institute guide states;

Risk appetite, defined as *'the amount and type of risk that an organisation is prepared to pursue, retain or take in pursuit of its strategic objectives'*, is key to achieving effective risk management. It represents a balance between the potential benefits of innovation and the threats that change inevitably brings, and therefore should be at the heart of an organisation's risk management strategy – and indeed its overarching strategy.

Using the Good Governance Institute risk appetite matrix the Group have adopted a risk appetite statement which reflects the amount of risk it is willing to accept in seeking to achieve its strategic aims.

DRAFT

'As a healthcare organisation we are committed to continuously improving the quality and safety of our services for our patients and the wider community. Healthcare is inherently risky and healthcare interventions bring with them further risks, all of which is taken into account in determining the best options and possible outcomes for patients. As an organisation we have assessed ourselves as having a moderate appetite for risk, being prepared to take risks which offer the potential to bring benefits for our patients, staff, partners and stakeholders.'

When any risks to safety are identified the objective should always be to reduce the risk to as low a level (tolerance) as is practicable before it is accepted, or to avoid it altogether where that is an option.

As well as the overall risk appetite statement, separate statements have been agreed for each of the five risk categories reflected in the GGI risk appetite matrix. These are shown below and will be considered throughout the risk management process for both threats and opportunities.

The groups risk appetite, tolerance and escalation levels for risk will be reviewed by the Board annually and communicated to all staff.

Category Statements

Risk Appetite Level	Risk Appetite Statement	Risk Appetite, Tolerance, and Escalation
Financial/ Efficiency (Financial, Efficiency, Business Continuity)		
Open (Moderate)	We have a Moderate risk appetite for financial/Value for Money (VfM) risk. This means we are prepared to take risks which may have a financial impact, enabling our eagerness to innovate and grow whilst ensuring we minimise the possibility of financial loss, however, would not take risks that impact on the future financial stability of the organisation. However, within commercial arms of the organisation we may have a higher appetite for financial/ VfM risk which brings with it opportunity and beneficial outcomes, such risks would be assessed on a case by case basis.	Appetite - 10 Tolerance- 8-12 Escalation 15+
Regulatory/ Compliance (Compliance - CQC,SFI, IG, Fraud, Legal)		
Open (Moderate)	We have a Moderate risk appetite for Compliance/Regulatory risk. This means we are prepared to take risks which may	Appetite - 10

DRAFT

Risk Appetite Level	Risk Appetite Statement	Risk Appetite, Tolerance, and Escalation
	result in the possibility of some regulatory challenge, providing that by doing so we are doing what is best for our patients and/or staff and are reasonably confident we could challenge this successfully. The regulator and the potential sanction that could be imposed would be key within our risk assessments.	Tolerance- 8-12 Escalation-15+
Quality Outcomes (Safety, Effectiveness, Experience)		
Open (Moderate)	We have a Moderate risk appetite for Quality Outcome risks. This means we are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards. We support risks relating to innovation to deliver improved services and outcomes for our patients and staff.	Appetite - 10 Tolerance- 8-12 Escalation-15+
Reputation (Public, Partners)		
Seek (High)	We have a High risk appetite for reputational risks. This means we are prepared to take actions and decisions in the best interests of our patients and staff to ensure quality and sustainability which may have an adverse effect on the reputation of the organisation to some stakeholders.	Appetite - 15 Tolerance- 12-20 Escalation 15+
People and Resources (Resources, Wellbeing, Safety)		
Open (Moderate)	We have a Moderate risk appetite for people and resource risks. This means we are prepared to take limited risks with regards to our workforce. At the current time we are focussing on the basics, helping our staff to recover and recuperate, and increase overall wellbeing. While innovation in this area will be important going forward this will only be explored where any impact on our staff was minimal. Within our Commercial Arms, there may be a higher risk appetite and this would be explored on a case by case basis.	Appetite - 10 Tolerance- 8-12 Escalation-15+

4.7 Board Assurance Framework (BAF)

All NHS Trusts are required to use a Board Assurance Framework, as this has been proven good practice for many years in both healthcare and a range of other high-risk organisations.

The Board Assurance Framework documents the Group's high-level risks to achieving our strategic aims and priority objectives, bringing together the assurance reports, presentations and updates that provide the Board of Directors with sufficient information to enable them to take assurance that our aims and objectives are being delivered, risks are managed and effective controls are in place and actions are being completed.

Each year, the Board will review the strategic aims and objectives, and this will be followed by a workshop to confirm any existing strategic risks and identify any new risks. The Board Assurance Framework document will then be updated to reflect any changes in the aims, objectives and risks.

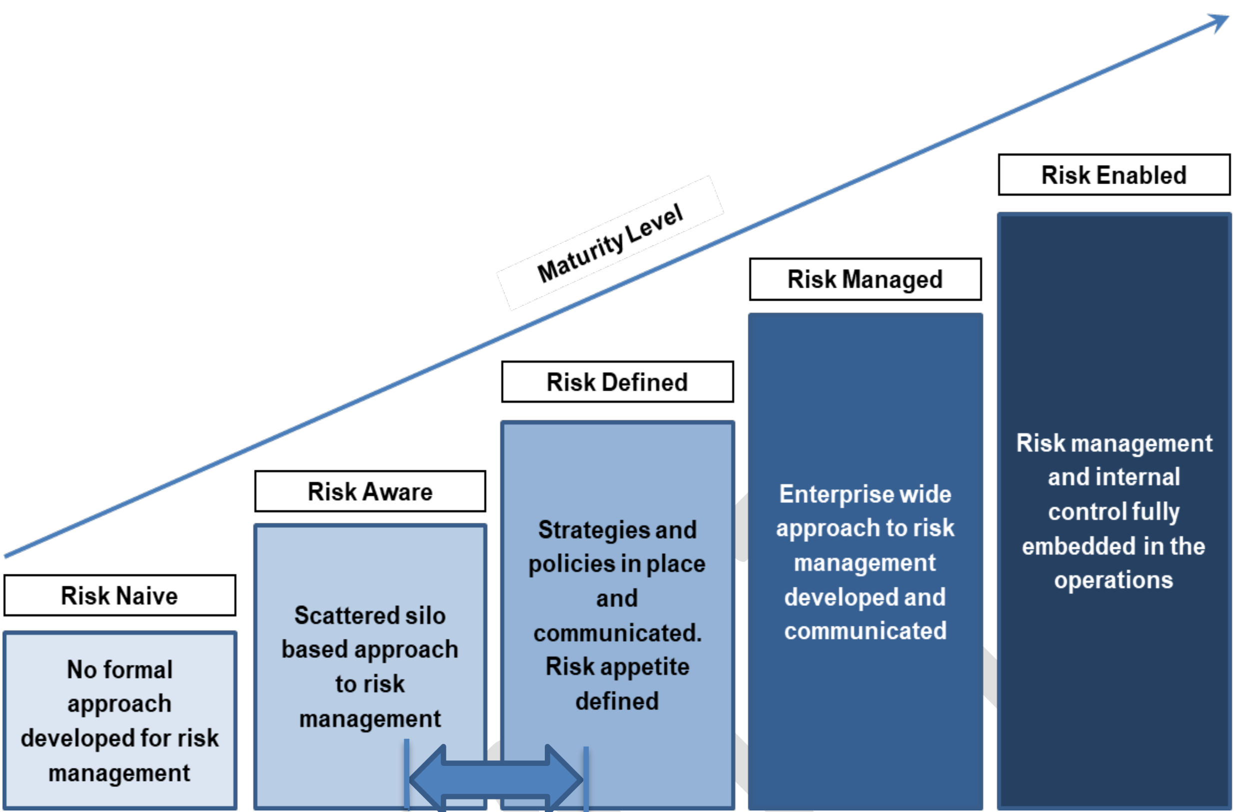
At the end of the year, assurance papers, Board Assurance Framework reports, the Opinion of the Head of Internal Audit and other major sources of assurance are taken into account by the Chief Executive Officer in the preparation of the Annual Governance Statement.

4.8 Risk Management Maturity

Risk Maturity is defined as the Groups overall approach and controls relating to risk management. High performing organisations have a significant risk appetite and a risk enabled maturity.

The risk maturity is shown at its simplest in the diagram below. Ranging from risk naïve, where there is no formal approach developed for risk management, to risk enabled, representing an organisation with risk management and internal control fully embedded in the operations.

DRAFT



The Board assessed their maturity in April 2021, and agreed that it was currently between risk aware and risk defined. This lower setting was partly as risk appetite was not set, a change in governance structures was underway, and it was recognised that a silo approach was still evident.

While these areas have been strengthened and the next review of maturity expected to reflect this improvement, the ambition of the Board is to develop risk management maturity to risk enabled.

A fuller assessment of the potential areas for development to improve our maturity will be undertaken and aligned to the objectives. The priorities will then be identified, and clear actions and timelines established, being supported and monitored by the Executive Risk Management Group.

5 Training

Training needs analysis is undertaken to assess the requirements and frequency of all training to ensure that we appropriately manage risks by ensuring staff are trained to the required levels in a number of areas and skills.

Training for all NHS staff in patient safety, including risk identification, analysis, treatment, risk registers, and culture is under national development and will form from part of the National Patient Safety Syllabus being introduced in 2022. This will be reviewed as available and any additional staff training to deliver the strategy identified and introduced, as well as ensuring that this and related policies and training align with the national syllabus and language is consistent.

6 Diversity and Inclusion

The Group is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat staff reflects their individual needs and does not unlawfully discriminate against individuals or groups on the grounds of any protected characteristic (Equality Act 2010). This strategy aims to uphold the right of all staff to be treated fairly and consistently and adopts a human rights approach. An equality analysis has been undertaken for this strategy, in accordance with the Equality Act (2010), and is included at appendix 2.

7 References

COSO (Committee of Sponsoring Organisations of the Treadway Commission) Enterprise Risk Management Framework

ISO 31000 Risk Management (2019)

National Patient Safety Agency (NPSA) healthcare risk assessment made easy

Good Governance Institute (GGI) Risk Appetite

Good Governance Institute (GGI) Board Assurance Framework

Baker Tilly - Board Assurance – A toolkit for health sector organisations (2015) NHS Patient Safety Strategy: 2021 update

Patient Safety Investigation Response Framework (PSIRF) (2020)

National Patient Safety Syllabus 2.0 (2019 updated 2021)

8 Associated Documentation

While there are many documents that support the management of risk across the Group, including a number of policy and procedural documents, clinical protocols and guidance (available via the intranet), the key Policy to assist in the implementation of this strategy is the Group Risk Management Policy (RM01)

9 Intranet Information

The Risk Management intranet pages include additional information and guidance to support this policy. This includes downloadable guides;

- Risk Management Guide,
- Risk Assessment Guide,
- Incident management system User Guide (Risk Register).

Intranet risk management pages can be found here.

DRAFT

10 Appendix 1 – Definition of Terms

Term	Definition
Board Assurance Framework (BAF)	The processes and documentation by which the Board are assured that key risks to organisational objectives are being managed. The Board Assurance Framework document summarises assurances received and planned within the committees cycle of business.
Datix	The electronic software used to host the risk registers; it also hosts the incident reporting system.
Governance	The ways in which an organisation is directed and controlled in order to achieve its objectives.
Likelihood	Used to assess probability or frequency of a risk occurring. Likelihood is expressed along a scale ranging from 'rare' to 'almost certain'.
Probability	Often used to express the likelihood of a specified event or outcome occurring. This uses percentage levels to align likelihood.
Risk	An uncertain event which, if occurred would have an effect on the achievement of objectives. It is defined as uncertainty/ possibility of loss, damage, missed opportunity, injury or failure to achieve objectives or deliver our plans as a result of an uncertain action or event.
Risk Appetite	The statement of intent from the organisation about the level risk it is prepared to accept, tolerate, or be exposed to at any point in time.
Risk Assessment	The process used to evaluate a risk with regard to the impact/ consequence if the risk is realised (on a scale of 1 to 5 (highest)) and the likelihood of the risk being realised (on a scale of 1 to 5(highest)). This is measured on a 5*5 matrix to give a score up to 25, which is the most severe.
Risk Identification	The process of determining what, where, when, why and how something could happen.
Risk Management	Is defined as 'the systematic identification of risks within an activity, system or process, and the implementation of actions which will minimise harm arising from these risks'. A key aspect of risk management is learning from events, errors, or near misses in order to reduce the risk of them recurring. Clinical risk management concentrates on identifying and correcting risks associated with direct patient care, whilst non-clinical risk management is associated with all other Trust activities.
Risk Mitigation/ Risk Treatment	The action that is/can be taken to reduce either the likelihood or impact/consequences of a risk.
Risk Maturity	The overall quality of the risk management framework.
Risk Register (Datix)	A tool for recording identified risks, the results of their analysis and evaluation, and monitoring actions and plans against them. The Risk Register is an important component of the organisation's risk management framework.
Risk Tolerance	The degree of variance from the risk appetite that the organisation is willing to accept.

DRAFT

11 Appendix 6 – Equality Impact Assessment (EqIA)

Equality Impact Assessment (Initial EqIA for Policies)
This form should be used for: • Undertaking an initial equality impact assessment on new and existing policies by: • Considering and identifying any impact on any of the protected characteristics, whether Negative, Positive or No impact. • Using information collected, to assess if further work is required to promote equality for the protected characteristics. • Using Data / feedback and prioritising if and when a full EIA should be completed • Justify reasons why a full EIA is NOT going to be completed Please indicate your response by ticking / writing in the appropriate boxes below

Policy Title	ST01 Group Risk Management Strategy
What is the main purpose (aims / objectives) of this Policy	The purpose of this strategy is to define the approach to be taken by the Group in applying risk management to its decision making at all levels and ensure a structured and systematic approach to risk management is implemented throughout the organisation to deliver the objectives.

<table>
<tr><td rowspan="5">Will patients, carers, the public or staff be affected by this Policy?</td><td></td><td>Yes</td><td>No</td><td rowspan="5">Do you have any information / data as to the numbers who are likely to be affected?

Successful risk management will bring positive safety benefits to patients, their families and carers/ public and staff.</td></tr>
<tr><td>Patients</td><td>☒</td><td>☐</td></tr>
<tr><td>Carers</td><td>☒</td><td>☐</td></tr>
<tr><td>Public</td><td>☒</td><td>☐</td></tr>
<tr><td>Staff</td><td>☒</td><td>☐</td></tr>
<tr><td rowspan="5">Have any patients, carers, the public or staff been involved in the development of this Policy?</td><td></td><td>Yes</td><td>No</td><td rowspan="5">If Yes, across any of the identified groups, how was this undertaken. If No, what future plans have been agreed for involvement

Key staff involved in the risk management processes will review the strategy (to be undertaken)</td></tr>
<tr><td>Patients</td><td>☐</td><td>☒</td></tr>
<tr><td>Carers</td><td>☐</td><td>☒</td></tr>
<tr><td>Public</td><td>☐</td><td>☒</td></tr>
<tr><td>Staff</td><td>☒</td><td>☐</td></tr>
<tr><td>What engagement method(s) did you use?</td><td colspan="4">Email sharing and feedback.</td></tr>
</table>

Thinking about each group below:

- Does or could the policy have a negative, positive or no impact on members of the protected characteristics below?
- Is there potential for the policy to promote equality of opportunity for all / promote good relations with different groups – Has a positive impact on individuals and communities.
- In relation to each protected characteristic, are there any areas where you are unsure about the impact and more information is needed?

Protected Characteristics	Yes	No	Not Sure / Unclear	If the answer is Yes, or Unsure/ Unclear, please indicate why this is the case and then complete a full EqIA
Age	☐	☒	☐	
Disability	☐	☒	☐	
Gender Reassignment	☐	☒	☐	
Marriage and Civil Partnership	☐	☒	☐	
Pregnancy and maternity	☐	☒	☐	
Race	☐	☒	☐	
Religion or belief	☐	☒	☐	
Sexual orientation	☐	☒	☐	
Other socially excluded group	☐	☒	☐	

As member of Gateshead NHSFT staff carrying out a review of a new or existing policy you are required to complete this EIA by law. By stating that you have **not** identified a negative impact, you are agreeing that the organisation has **not** discriminated against any of the protected characteristics. Please ensure that you have the evidence to support this decision as the Trust will be liable for any breaches in the Equality Legislation.

Name of completing manager	Job title	Date of assessment
Name of reviewing equality lead	**Job Title**	**Date approved**

DRAFT

The completed form and draft policy needs to be sent by email to the Equality, Diversity Inclusion and Engagement Manager, Kuldip Sohanpal at Kuldip.sohanpal2@nhs.net

Report Cover Sheet

Agenda Item: 13

Report Title:	**Annual Plan 2023/24**			
Name of Meeting:	Trust Board			
Date of Meeting:	24 May 2023			
Author:	Mrs Kris Mackenzie, Group Director of Finance and Digital			
Executive Sponsor:	Mrs Kris Mackenzie, Group Director of Finance and Digital			
Report presented by:	Mrs Kris Mackenzie, Group Director of Finance and Digital			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☒	**Assurance:** ☒	**Information:** ☒
	This report provides Board with an update on the final submission of the 2023/24 revenue and capital financial plan.			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☐ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☒
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	Finance and Performance Committee 23 May 2023			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	The financial plan projects a revenue deficit of £12.588m and a capital spend of £27.345m. The final plan was submitted ahead of the deadline of noon on 4 May 2023.			
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	To receive the final version of the financial plan for 2023/24.			

<table>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:</td><td>Aim 1
☒</td><td colspan="4">We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>Aim 2
☐</td><td colspan="4">We will be a great organisation with a highly engaged workforce</td></tr>
<tr><td>Aim 3
☒</td><td colspan="4">We will enhance our productivity and efficiency to make the best use of resources</td></tr>
<tr><td>Aim 4
☐</td><td colspan="4">We will be an effective partner and be ambitious in our commitment to improving health outcomes</td></tr>
<tr><td>Aim 5
☐</td><td colspan="4">We will develop and expand our services within and beyond Gateshead</td></tr>
<tr><td>Trust corporate objectives that the report relates to:</td><td colspan="5"></td></tr>
<tr><td>Links to CQC KLOE</td><td>Caring
☐</td><td>Responsive
☐</td><td>Well-led
☒</td><td>Effective
☐</td><td>Safe
☐</td></tr>
<tr><td colspan="6">Risks / implications from this report (positive or negative):</td></tr>
<tr><td>Links to risks (identify significant risks and DATIX reference)</td><td colspan="5"></td></tr>
<tr><td>Has a Quality and Equality Impact Assessment (QEIA) been completed?</td><td colspan="2">Yes
☐</td><td>No
☐</td><td colspan="2">Not applicable
☒</td></tr>
</table>

1 Introduction

1.1 The final 2023/34 financial plan was submitted in compliance with the deadline of noon on 4 May 2023.

1.2 This paper sets out the figures that were included in the final plan.

1.3 Please note that the figure referred to for revenue relate to the adjusted financial performance and not the reported surplus against income and expenditure.

2 2023/24 Revenue Financial Plan

2.1 The draft revenue plan prepared for presentation at Trust Board on 26 April 2023 projected a deficit of £17.984m for 2023/24. However, on the morning of the Board meeting additional funding was allocated to the Trust and a revised assessment of the financial position was shared projecting a deficit of £12.723m. In anticipation of potential further amendments, the Trust Board delegated authority to the Group Director of Finance and Digital to proceed with the submission of the annual plan with the caveat that any subsequent changes to the figures would not be material. A final adjustment of £0.135m was reflected in the submitted plan.

2.2 The impact for Gateshead is **a final projected revenue deficit of £12.588m**.

3 2023/24 Capital Financial Plan

3.1 As per the figures approved by Board on 21 March 2023, the **total planned expenditure on capital remains £27.345m** as per table 1. Note that the plan submitted reflects £26.345m, with the additional £1.000m being a Board sanctioned over-commitment to support the installation of the 2nd MRI scanner.

Capital Modelling	£000
CDEL	9,469
PDC - CDC	14,376
PDC - 2nd MRI	2,500
Cash - 2nd MRI	1,000
Draft Capital Programme	**27,345**

Table 1: Capital Programme

3.2 Board will remember that the approved proposal is to fund this from internal sources (including depreciation and cash) and external sources (for PDC). This proposal is detailed in table 2.

Capital Funding	£000
Net depreciation	7,249
PDC - CDC	14,376
PDC - 2nd MRI	2,500
Cash	3,220
Draft Capital Programme	**27,345**

Table 2: Proposed Capital Funding

4 Risks

4.1 There remain a significant number of risks to delivery of the draft financial plan as the Trust continues to transition out of the interim financial framework and into a period of short-term

financial planning. The following risks have been considered by Executive Team, and once fully assessed and risk scored will be presented to the Executive Risk Management Group during May 2023.

- Risk of non-achievement of 2023/24 revenue plan of £12.588m deficit resulting from:
    - Activity is not delivered in line with planned trajectories, leading to reduction in income
    - Risk that not all activity is being fully counted and appropriately coded limiting access to appropriate funding
    - Risk that efficiency requirements are not delivered
    - Risk that financial mitigations assumed in plan are not realised
    - Risk of increase in costs resulting from further industrial action
    - Risk of cost implications resulting from unfunded services e.g. escalation beds, winter pressures above plan
- Capital plan may be impacted by:
    - Inflationary pressures – revenue consequence
    - Availability of materials/equipment impacting on ability to deliver timely capital projects and capacity required to manage any surge
    - Short notice and non-recurrent national funding – PDC revenue consequence
- Risk of conflict between the ICS plan and organisational targets

5 Next Steps

5.1 Next steps to be undertaken by the organisation are:

- The financial plan has been translated into budgets and is being used to inform divisional budgets/control totals for utilisation as part of the accountability framework. It is anticipated that the formal sign off of these will take place in time for month 2 reporting.
- Financial risks and associated scoring to be considered by ERMG.
- To continue to work with the ICB to inform further analysis of the underlying financial position.
- To focus on development of a recovery plan with the intention of returning the organisation to financial balance as soon as possible.

6 Summary

6.1 The Trust Board is asked to note the submission of the financial plan before noon on 4 May 2023:

- **Recommendation that Board notes the submission of 2023/24 planned revenue deficit of £12.588m**
- **Recommendation that Board notes the submission of 2023/24 capital plan of £27.345m**
- **Recommendation that Board notes the next steps to be monitored via Finance and Performance Committee**

Report Cover Sheet Agenda Item: 14

Report Title:	**Integrated Oversight Report**			
Name of Meeting:	Trust Board			
Date of Meeting:	24th May 2023			
Author:	Deborah Renwick & Jon Gaines and IOR Reporting Leads			
Executive Sponsor:	Kris Mackenzie			
Report presented by:	Deborah Renwick			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☒	**Assurance:** ☒	**Information:** ☐
	To summarise performance in relation to strategic aims, key NHS standards, requirements and KLOE's to outline the risks and recovery plans associated with COVID -19. This report covers the reporting period March & April 2023			
Proposed level of assurance – to be completed by paper sponsor:	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☒ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*				
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	Following feedback from Committee's & GGI CQC Preparation-Rapid Diagnostic Report this overview report and the IOR continue to be reviewed and revised. The covering report does not seek to replicate all the detail in the IOR, rather give a high-level overview of the key themes and triangulate areas where appropriate. Detail for each area can be sourced from the IOR. Whilst pressures and challenges remain across the Trust, there are significant improvement in other areas. Points to note are: There were six SI's reported in April, 2x moderate harm and 4 x severe harm. Patient feedback via Friends and family tests (FFT's) showed improving positive scores and response rates in April. Average safer staffing levels were all within expected range, however daily challenges and operational pressures continue to maintain adequate staffing levels. One of the SI's (falls from a height) correlates to a ward area flagged as an outlier in the safer staffing metrics. Vacancy rates improved to 4.7%, achieving the Trust target of 5%, turnover improved to 1.4%. Sickness absence levels are now meeting the 5% target.			

<table>
<tr><td colspan="1"></td><td colspan="2">Staff engagement scores from the Q4 Pulse survey improved across all domains, although we still benchmark below the national average.

Despite the pressures we reduced our general and acute beds from 466 in March to 448 in April, supporting better staffing levels and improvements in CPPD in month.

Average length of stay improved from 5.23 to 4.68 days. There was a further improvement reducing long stay patients from 90.6 per day to 88.8 per-day. UEC performance measures improved across the board, with notable improvements in patients waiting for a bed with zero 12-hour trolley waits.

Pre-emptive actions and forward planning to minimise the impact of Industrial Action on patient care meant that only 28 theatre sessions, 89 outpatient clinics and 10 endoscopy lists were cancelled. Resulting in 571 patients being re-listed or re-booked. Industrial action along with annual leave and bank holidays continue to impact on planned activity levels, performance against key measures and also the ability to reduce waiting lists in with the plan:

• Elective activity at 90.4% of planned levels
• Diagnostic activity is at 95.4% of planned levels.

Key performance headlines are:
o RTT <18 weeks waiters performance is at 69.9% (92% target)
o RTT waiting-list list increased by 509 patients from 12,880 to 13,389 (251 over plan)
o Diagnostic performance is at 89.1% (95% target) endoscopic modalities now pose a risk; the department are deploying insourcing to support improvement trajectories.
o 4/8 cancer standards are achieving their targets in April.
o Patient waiting over 62 days increased to 64 (within planned levels)</td></tr>
<tr><td>Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper</td><td colspan="2">This report seeks to provide assurance in respect of the strategic aims 1,2,3 and 4.
The recommendations to the Committee are to receive this report, discuss the potential implications and note the improvements in key areas, noting the impact of IA in elective recovery and the impact on waiting times.</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:</td><td>Aim 1
☒</td><td>We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>Aim 2
☒</td><td>We will be a great organisation with a highly engaged workforce</td></tr>
<tr><td>Aim 3
☒</td><td>We will enhance our productivity and efficiency to make the best use of resources</td></tr>
<tr><td>Aim 4
☒</td><td>We will be an effective partner and be ambitious in our commitment to improving health outcomes</td></tr>
<tr><td>Aim 5
☐</td><td>We will develop and expand our services within and beyond Gateshead</td></tr>
<tr><td>Trust corporate objectives that the report relates to:</td><td colspan="2">3) We will enhance our productivity and efficiency to make the best use of our resources.</td></tr>
</table>

<table>
<tr><td></td><td colspan="6">SA3.1 Improve the productivity and efficiency of our operational services through the delivery of the New Operating Model and associated transformation plans.

SA3.2 Achieving financial sustainability</td></tr>
<tr><td>Links to CQC KLOE</td><td>Caring
☒</td><td>Responsive
☒</td><td colspan="2">Well-led
☒</td><td>Effective
☒</td><td>Safe
☒</td></tr>
<tr><td colspan="7">Risks / implications from this report (positive or negative):</td></tr>
<tr><td>Links to risks (identify significant risks and DATIX reference)</td><td colspan="6">• Activity levels & Elective Recovery
• Continued growth in RTT waiting lists and the ability to reduce long waiters.
• Growth in 2-week referral rates
• Risk of patient flow and challenges to achieving all UEC performance measures
• Workforce engagement
• Impact of Industrial Action</td></tr>
<tr><td>Has a Quality and Equality Impact Assessment (QEIA) been completed?</td><td colspan="2">Yes
☐</td><td colspan="2">No
☐</td><td colspan="2">Not applicable
☒</td></tr>
</table>

INTEGRATED OVERSIGHT REPORT – May BOARD

1. Introduction

This report summarises performance across key NHS standards, requirements and KLOE's outlining the risks and ongoing recovery plans associated with COVID -19 as set out in the IOR. IOR reports performance predominantly retrospectively where data is validated, signed off and submitted (as highlighted in the contents page of the IOR). Where indicative data is provided in the IOR it is identified as such.

2. Key issues & findings

2.1 A judgement of strong performance was highlighted as part of the Trust ICB oversight meeting (20th April), within an information pack the ICB provided stating in relation to the NHS Oversight Framework the Trust was demonstrating ***"Strong delivery in terms of the NHS oversight framework metrics. When compared to other providers in England, with 17/39 (43.5%) metrics in the highest performing quartile, and 20/39 (51%) metrics in the inter quartile range.***"

2.2 Under the Safe, Effective and Caring domains, the majority of indicators are performing well and/or not triggering concern or displaying Special Cause Variation (75% of metrics for Safe, 83% of metrics for Effective and 100% for Caring).

Strategic Aim 1: We will continuously improve the quality and safety of our services for our patients.

3 Caring Domain

3.1 Patient Friends & Family Tests (FFT): Inpatient/daycase services saw an improvement in the percentage of patients reporting a positive experience to 96.4% in April compared to 94.4% in the previous month. National Benchmarking data for February shows we remain above the national average of 95%, with GH 97.6%. Response rates are also improving overall to 9.1%.

A&E services also demonstrated continued improvement in patients reporting a positive experience from 84.1% to 87.7% in April. Benchmarking data for February shows that we remain above the national average of 80% with performance at 81.9%. Response rates also improved from 5.1% to 5.2% in April.

Themes identified from patients who rated their experience as 'poor or very poor' include long waits, staff attitude, and a perception of lack of responsiveness to patient needs.

3.2 Formal complaints volumes are within expected range, verbal communications and clinical treatment complaints continue to feature. The distribution of complaints is spread across all clinical areas proportionately. Overdue complaints have reduced significantly in the last six months, from 68 to 33 outstanding at the end of April.

4 Safe Domain

4.1 **Six Serious Incidents (SI's)** were reported to StEIS in April. Two incidents caused moderate harm to patients, one as a result of a medical devises or equipment error and the other because of an incorrect diagnosis. Four of the SI's caused severe harm, 2 related to a non-controlled drug incident, 2 related to falls from a height. One of the SI's occurred on ward which is flagged as an exception in the safer staffing report.

4.2 The new HCAI tolerance/allowances has now been released, the 2023/24 national objective for Clostridioides difficle infection (C.Diff) is no more than 21 cases attributed to the Trust. There were 4 CDI's in April, zero were hospital onset (HOHA) 2 were community onset (COCA) and 1 case was community indeterminate (COIA) and 1 community acquired (COCA). The trust is therefore reporting 2 cases against the annual allowance.

4.3 There were 468 patient safety incidents reported in April – 3% resulted in moderate, severe, or major harm. Patient falls, delays, or failure to treat patients and medication errors remain the top three contributors in thematic analysis.

4.4 Three covid outbreaks were declared in April, however the incidence of nosocomial cases fell significantly. There are no outstanding safety alerts and there were no MRSA cases reported in April 2023.

Strategic Aim 4: We will be an effective partner and be ambitious in our commitment to improving health outcomes.

5 Effective Domain

5.1 HSMR is showing deaths 'As Expected' with a score of 100.9 against the national average figure of 100. The SHMI is showing lower than expected deaths with the latest figure of 0.86, below the national average of 1.00. Mortality review data for the last 12 months demonstrates that 98.9% of deaths reviewed were 'Definitely not preventable' with 95.3% of cases reviewed identified as 'Good practice'. 84 cases in the period require a review by the Mortality Council and/or the ward-based team.

5.2 General and Acute beds open in April averaged 448 for the month, still above the planned NOM beds of 434, however a significant reduction from 466 in April. Occupancy levels increased from 94.7 in March to 95% in April, with levels peaking at 97.9% on the last weekend in April.

5.3 There were on average 40 patients in beds each day in April who no longer met the criteria to reside, against an ambition to reduce to 15-18 patients. The April figure still represents a 23% improvement rate on November's position of 52 patients.

5.4 There was also a significant improvement (10%) within the process of discharge process measurement, measuring the improvements between Medically optimised (MO) and discharge improving from 2,925 to 2,630 days.

5.5 Over-all length of stay fell from 5.23 days to 4.68 days in April 23. Super stranded patient bed days (LoS>21 days) decreased 90.6 to 88.8. Readmission rates remain within SPC control limits.

Strategic Aim 3: We will enhance our productivity and efficiency to make the best use of our resources.

6 Responsive Domain

6.1 **Ambulance handovers** have improved: 48% of handovers were within 15 mins of arrival, 97% were within 30 mins and 19 patients waited longer than 60 mins, representing a reduction of 51 patients in March. The Trust continues to benchmark well across the ICS.

6.2 **Total waits in ED** > 12 hours were at 2.7% for April, an improvement on March's performance of 5.6% and there were no 12-hour trolley waits for a bed. An improvement trend is now seen against the 4-hour target with 74.2% of our patients waiting less than four hours to be seen and treated. This places the Trust 43/137 of Trusts – just outside of the upper quartile.

6.3 **Rapid response performance at 68.5%**, below the 70% target. Targeted support and training is underway to improve data capture and support staff in collecting and capturing data.

6.4 **Diagnostic** performance deteriorated in April, falling to 89.1% from 92.5% of patients waiting less than 6 weeks. Pressures are now apparent in the endoscopy department, delays in the 5th endoscopy room are contributing to performance pressures; insourcing is planned for May to recover the position. The latest benchmarking places us better than the latest national average and ICS averages.

6.5 **Cancer Waiting Times**: The trust continues to meet the 28 Day Faster Diagnosis target, 31 days to treatment standard and 31-day subsequent chemotherapy treatments and 62 days from screening to treatment standards. 2 week waits, 31 days to first definitive treatments, subsequent surgical treatments, and 62 days from GP referral to treatment are currently not meeting their standards.

Referral rates into cancer services continue to exceed pre-pandemic levels circa 130%. Planned activity levels in outpatients are below expected levels in key tumour groups. All tumour sites did not achieve the 2-week wait target, and pressures continue in LGI, Gynae, lung, urology, and Upper GI. At the end of April, the long waiters increased to 64 (within planned levels of 65).

6.6 **Referral to Treatment 18 weeks**: Industrial action, bank holidays and annual leave have all reduced activity levels and increased waiting times. In April the number of patients on the waiting list increased to 13,389 and the proportion of patients waiting less than 18 weeks deteriorated to 69% from 71%. RTT Waiters > 52 weeks increased from 86 to 98 at the end of April. Paediatric long waiters and pain services are at most risk. Plans to address pain capacity deficits will start in September, with locum cover being sought in the interim, paediatric pathway options are still under review in light of the new national guidance in pathway management. Short-term options include pathway reviews with administrative and clinical triage.

6.7 A trust wide validation exercise is currently underway to review patients waiting using net-call. Plans to roll out across the Trust will commence in June – which is expected to yield between 8% and 16% reduction in waiters.

6.8 The top-down planning exercise will identify capacity deficits at milestone points across all pathways – this exercise will support business planning and recovery across all areas of elective care.

Strategic Aim 2: We will be a great organisation with a highly engaged workforce.

7 Well Led Domain

7.1 Our quarterly Pulse workforce survey response rate improved from 1.7% in Q3 to 2.3% in Q4, still below the national average of 9.8%. All of our scores across engagement, advocacy, involvement, and motivation improved, although we are still below the national average.

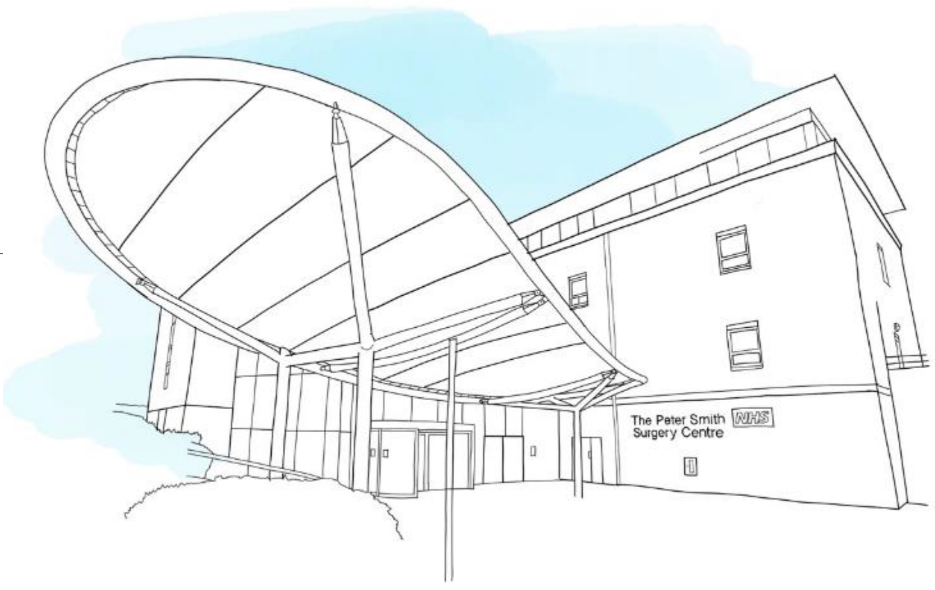
7.2 Vacancy rates in March improved to 4.7%, achieving and below our 5% target, and our staff turn-over is also much improved at 1.4%. Sickness absence rates are also now within our local target of 5%.

7.3 Average safe staffing levels were all within expected ranges, but do not reflect the daily challenges and operational pressures to maintain adequate staffing levels. There were three wards flagged as exceptions. One of the areas flagged with average staffing levels below 75% reported an adverse event which resulted in harm.

7.4 Agency spend continues to demonstrate a reduction and is at 2% of the pay bill in April. There has been a noticeable reduction of both medical and nursing spend in April 23. Total bank spend has remained constant since May 22 for all workforce groups.

Integrated Oversight Report

Overall rating for this trust	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Outstanding
Are services responsive?	Good
Are services well-led?	Good
Are resources used productively?	Requires improvement



May 2023 Committees

Data: March / April 2023

THIS PACK IS BEST VIEWED ON SCREEN IN SLIDESHOW MODE

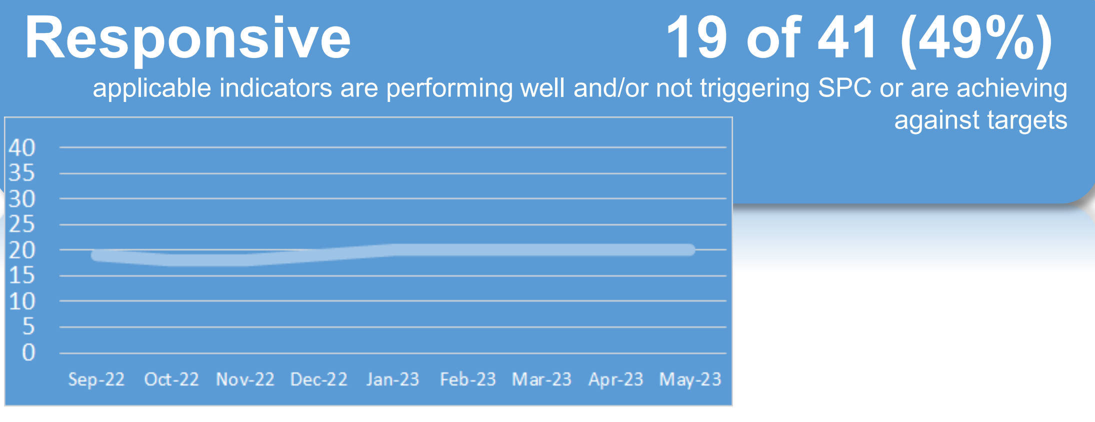
Contents	Pages	Reporting Period	Data Quality Signoff
Summary of KLOE	3		
Safe			
Serious Incidents reported to StEIS and Medication errors per 1000 FCEs	4	April 23	***
Datix - Patient Safety Incidents	5	April 23	***
Infection Prevention & Control	6 – 7	April 23	***
Effective			
Hospital Standardised Mortality Ratio and Summary Hospital Level Mortality Indicator	8	Oct 20 to Feb 23 / Aug 20 to Dec 22	***
Discharge & Delays	9	Jan 22 to Apr 23	*
Long Length of stay patients	10	April CDS	***
Efficiency and Productivity – Theatres	11	April 23	***
Responsive			
Urgent & Emergency Care	12	April 23	***
Ambulance handover delays	13	April 23	***
Community Waiting List and 2hr Rapid Response	14	WList April / RR Mar final/April unvalidated	***/ ***/ **
Elective Recovery	15	April 23	***
Diagnostics Activity and 6w Performance	16 - 17	April 23	***
RTT	18	April 23	***
Cancer	19 - 22	March / April (indicative)	**
Duty of Candour Verbal Compliance	23	April 23	***
Complaints	24 - 25	April 23	***
Well Led			
Sickness	26	April 23	***
Core Training	27	April 23	***
Appraisals	28	April 23	***
Vacancy WTE/& not available in time for report SIP and Vacancies	29	April 23	***
Agency and Bank Spend	30	April 23	***

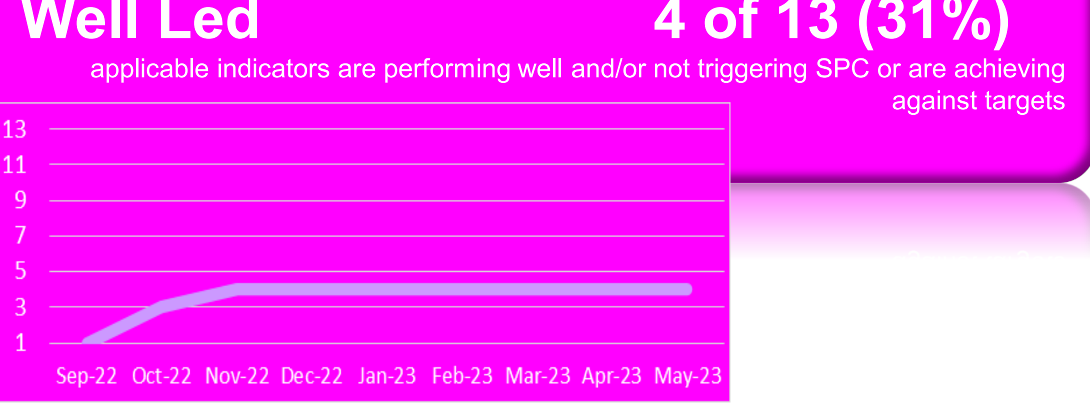
Key to Data Quality Signoff:

*** Signed off Unlikely to change,
** Subject to validation,
* snapshot position

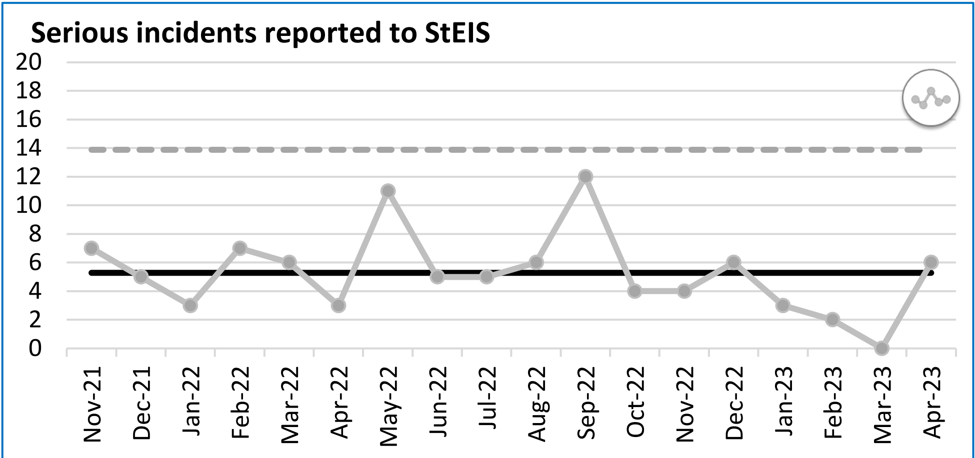
= New operating model measures

KLOE Summary: Indicators performing against target





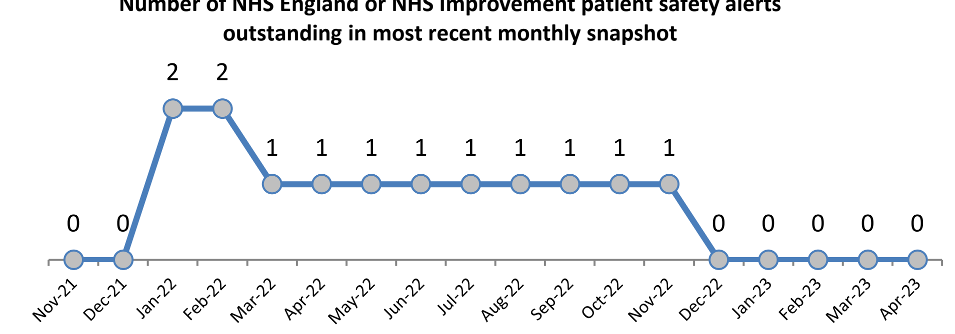
Serious Incidents reported to StEIS and Medication errors per 1000 FCEs

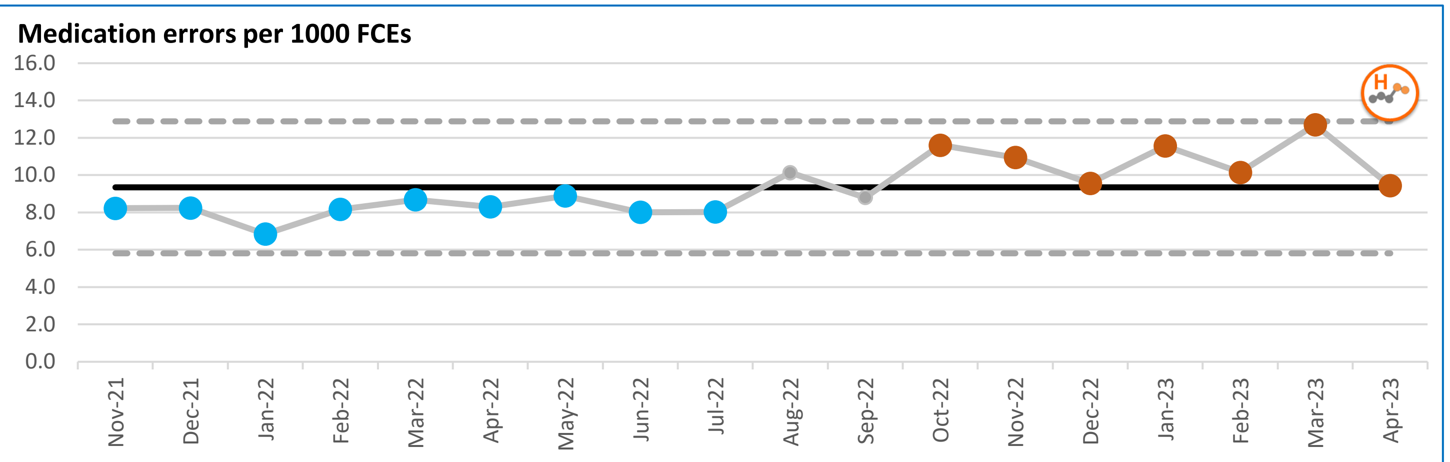


Serious Incidents reported to StEIS

There were 6 SI's declared in April 2023. 2 were moderate harm with 1 the result of medical devices / equipment use error and 1 as a result of incorrect diagnosis. 4 were for severe harm, 2 the result of a non-controlled drug incident
1 fall from height (bed) and 1 fall from height (toilet).

National Patient Safety Alerts -There are currently no open National Patient Safety Alerts beyond the closed deadline date (latest data available provided from national dataset).





Situation

Medication event rates are monitored each month as part of a set of safety metrics. There is currently no national benchmarking of this metric. This is monitored based on comparison of the Trust event trends. Special cause variation in April 2023 with 9.4 medication events per 1000 finished consultant episodes.

Assessment

A shift in the medication errors rate is observed from October 2022 with the last seven consecutive months above the 18 month mean. This increased reporting is predicted to be sustained and may increase further with the implementation of the new more accessible reporting system. A total of 64 medication events were observed in April, 54 (84.3%) were categorised as no harm, 10 (15.7% as low harm,) there were no moderate harm or severe harm incidents in the month.

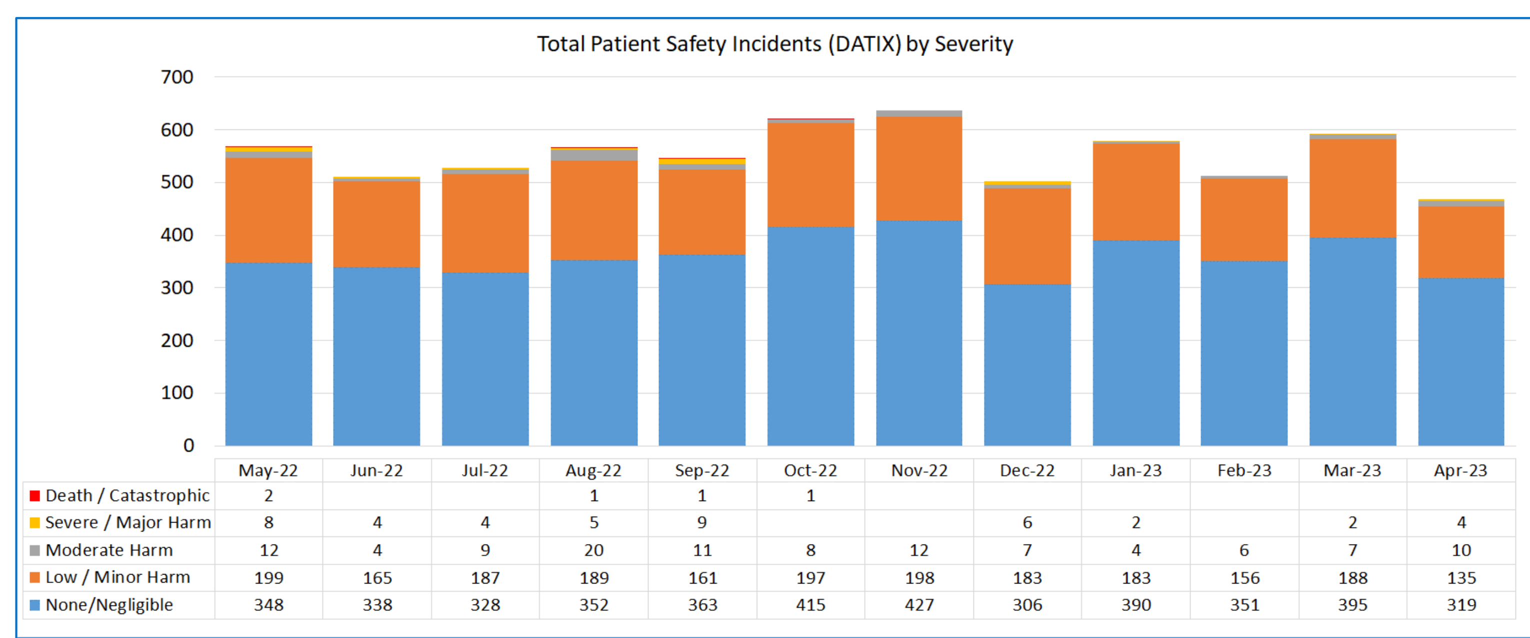
Actions

Medication incidents are analysed quarterly by the Trust Medicines Safety Officer (MSO) for presentation and action at Medicines Governance Group. March data was presented on 17TH April with themes identified and actions taken.

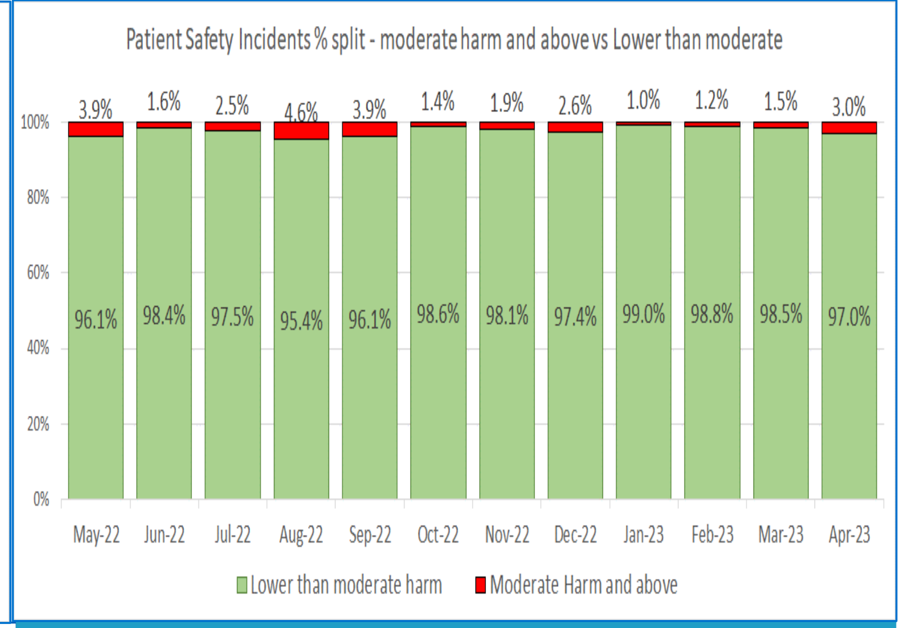
Recommendations

The Trust continues to support the reporting of all medication events so that opportunities for learning can be identified and shared. The MSO continues to work collaboratively with the patient safety team to ensure learning and action from medicines events.

Datix - Patient Safety Incidents - included to provide high level information from Datix incidents



	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
Death / Catastrophic	2			1	1	1						
Severe / Major Harm	8	4	4	5	9			6	2		2	4
Moderate Harm	12	4	9	20	11	8	12	7	4	6	7	10
Low / Minor Harm	199	165	187	189	161	197	198	183	183	156	188	135
None/Negligible	348	338	328	352	363	415	427	306	390	351	395	319



Top 10 Reasons (all incidents) May-22 to Apr 23

1. Patient falls (1571)
2. Medication (881)
3. Pressure damage (633)
4. Delay / failure to treat / monitor (535)
5. Discharge or transfer issue (490)
6. Infection prevention & control (327)
7. Maternity / foetal / neonatal (316)
8. Communication Failure (297)
9. Pathology sample issues (199)
10 Patient accident (non fall) (150)

- The volume of Patient safety incident (DATIX) are provided for the rolling 12 months, by level of harm (top left).
- Over the past 12 months an average of 552 incidents have been logged each month, with monthly figures varying between 468 and 637.
- The chart shows severity consistently is predominantly recorded as 'No harm and Low harm'.
- Patient falls, Medication, and Pressure damage continue to be the top 3 incident types by volume, as they have been since this reporting began (bottom left).
- On average 2.4% of incidents each month have been recorded as moderate harm or above (top right), but months ranged from 1.0% to 4.6%. Monthly average of 13 incidents in actual numbers.
- Patient falls, Delay / failure to treat / monitor, and medication are typically the top two incident types in this group (bottom right), with Results / investigations issues, IPC and medication third this reporting period.

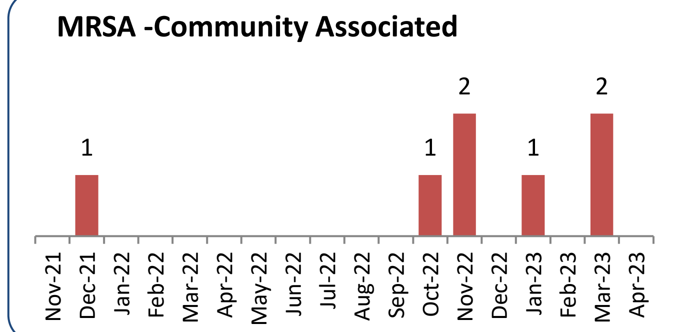
Top 10 Reasons (moderate & above) Nov 22 – Apr 23

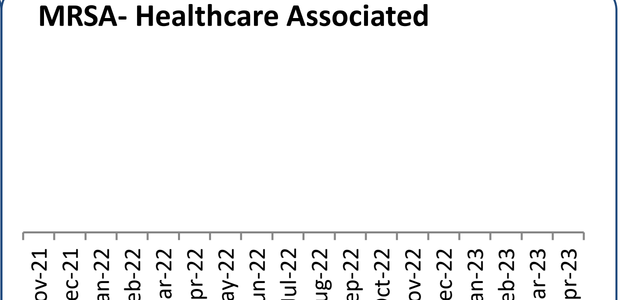
1. Patient falls (24)
2. Delay / failure to treat / monitor (13)
3. Results / investigations issues (e.g. scans/specimens/X-rays) (3)
4. Infection prevention & control (3)
5. Medication (3)
6. Information technology (2)
7. Maternity / Foetal / Neonatal (2)
8. Communication Failure (2)
9. Information Governance (2)
10. Violence, abuse and harassment (1)

IPC – Healthcare Associated Infections

MRSA

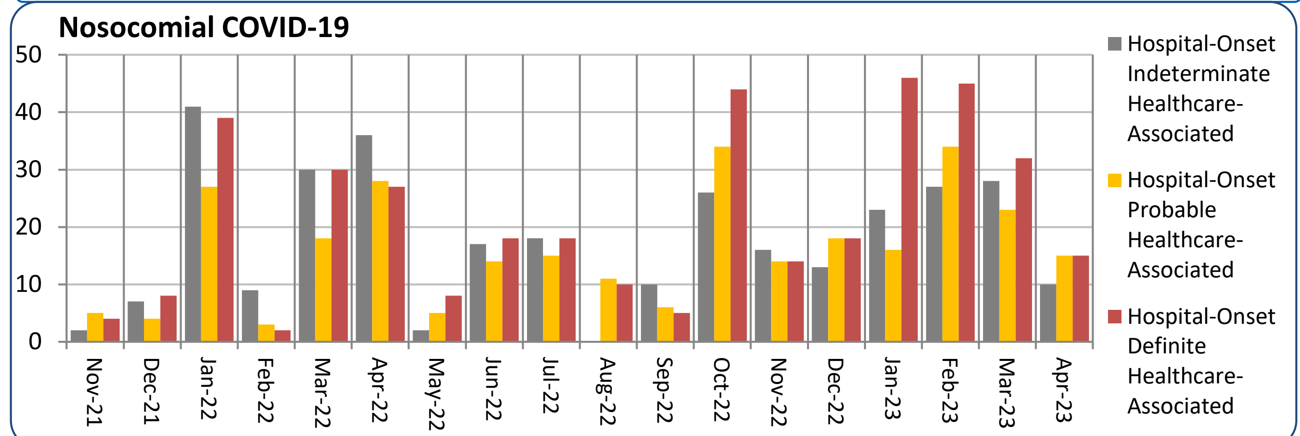
The Trust adopts the national aspiration of a zero MRSA blood stream infections (BSI). The trust has had zero incidence of Healthcare Associated MRSA BSI in the preceding 12 months and 7 community healthcare associated MRSA BSI's from November 21, of which 6 were between Oct 22 and March 23.





Nosocomial COVID 19 cases

All Healthcare associated COVID cases are reported and investigated through the DATIX system. 3 Outbreaks related to COVID were declared within the organisation. The incidence of nosocomial cases in April fell significantly from previous months, and in line with prevalence. We continue to operate a hybrid model to place patients if we cannot isolate on their base ward.

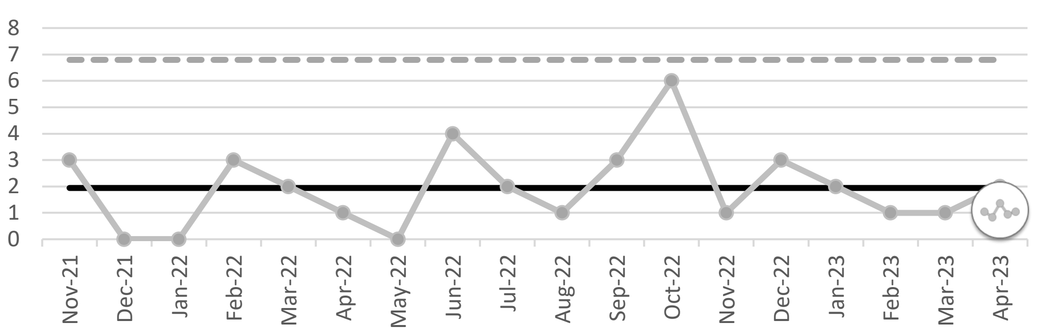


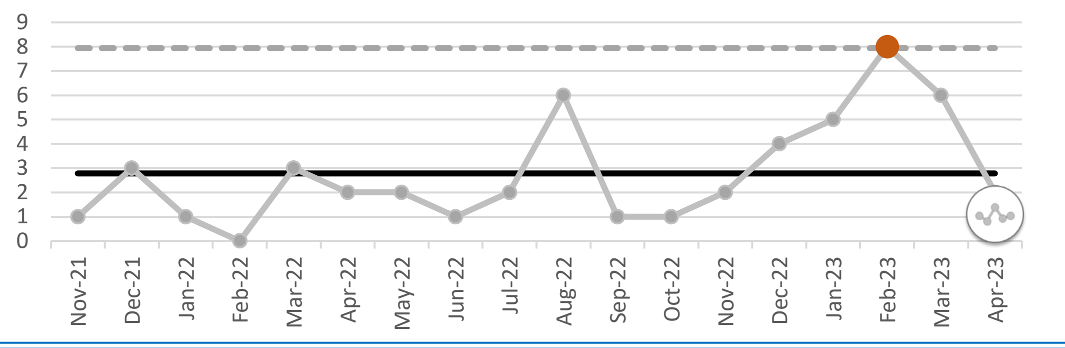
Clostridiodes Difficile Infection

- The Trust has reported 41 Healthcare associated CDI cases in 22/23, against the CDI threshold 32. In April, the Trust reported 4 CDI's, this shows a reduction of 3 from March.

Of the 4 CDIs

- 0 were Hospital Onset (HOHA),
- 2 Community Onset (COCA),
- 1 Community Indeterminate (COIA) and 1 Community Acquired (COCA)
- All Healthcare Associated Infections are investigated and any learning shared with the relevant business units.





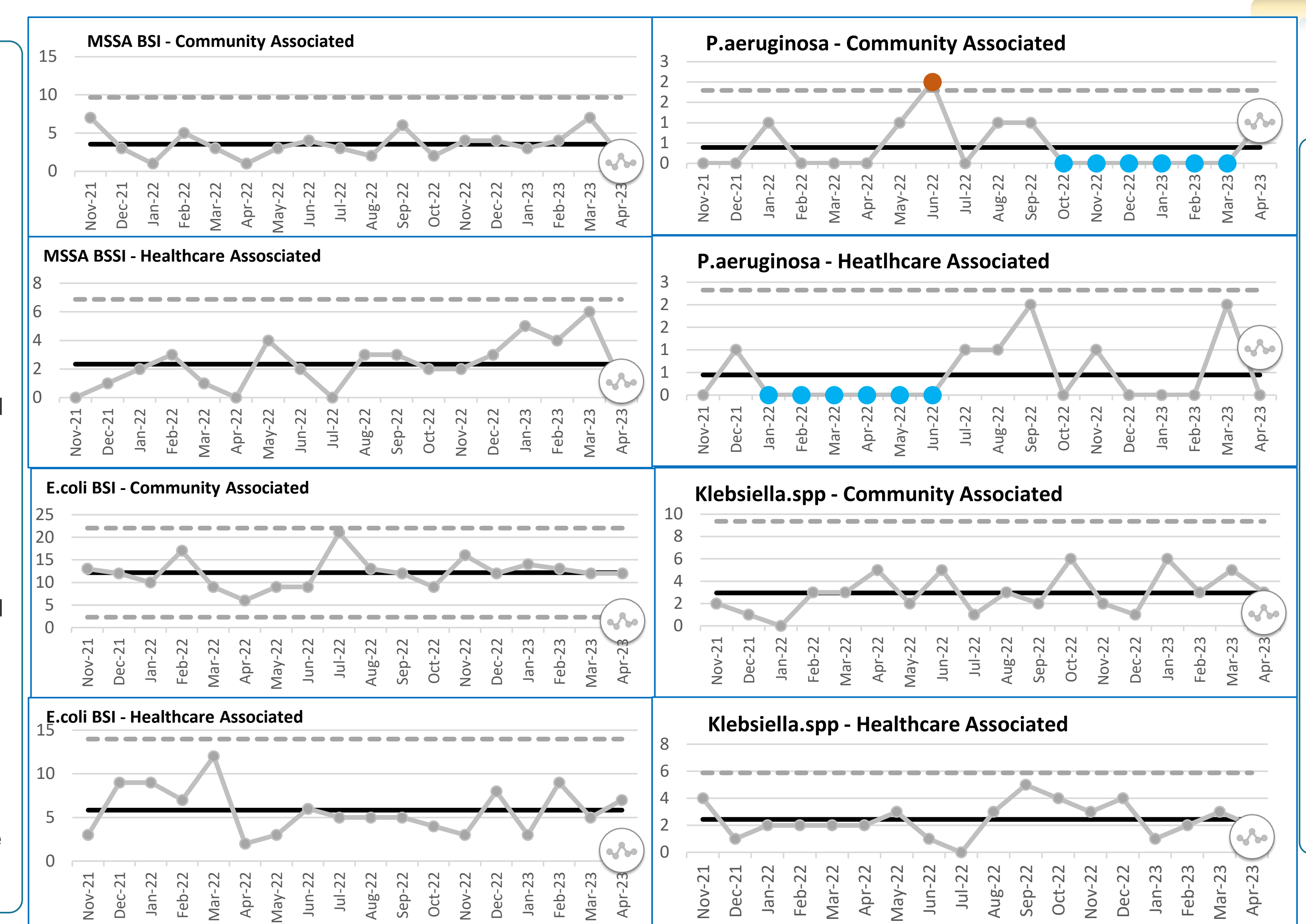
IPC – Healthcare Associated Infections

Safe

NHS Gateshead Health NHS Foundation Trust

MSSA & E Coli

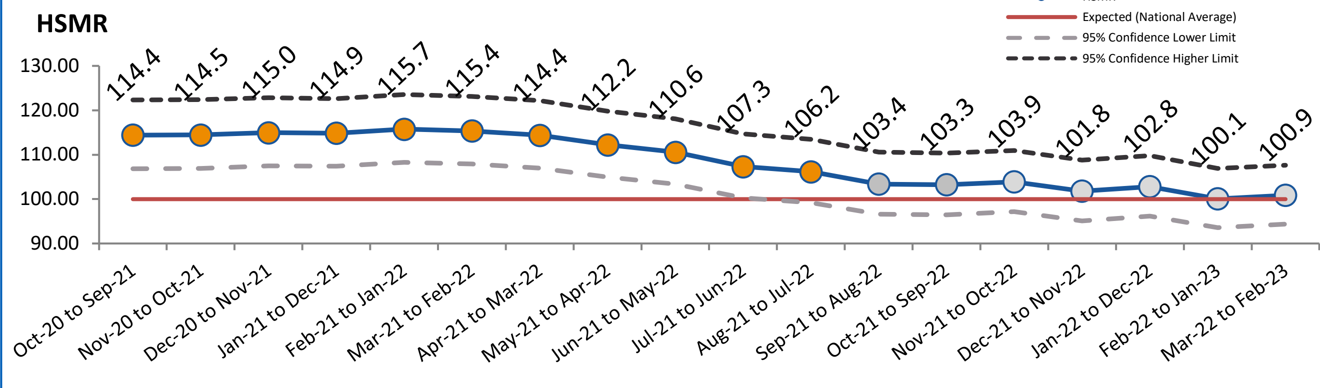
- All Healthcare associated BSI are reviewed and actions are initiated if necessary.
- NHS England has not set an Healthcare Associated MSSA BSI threshold for 2022/23
- The Trust has reported 1 Healthcare Associated and 2 Community Associated MSSA BSI during April 2023.
- This shows a decrease from March.
- The Trust has reported 7 Healthcare Associated E. coli during April 2023 – 4 HOHA's and 3 COHA's.
- There is now a regional hydration network to discuss the rise in gram negative bacteraemia's which Gateshead will be a part of going forward.

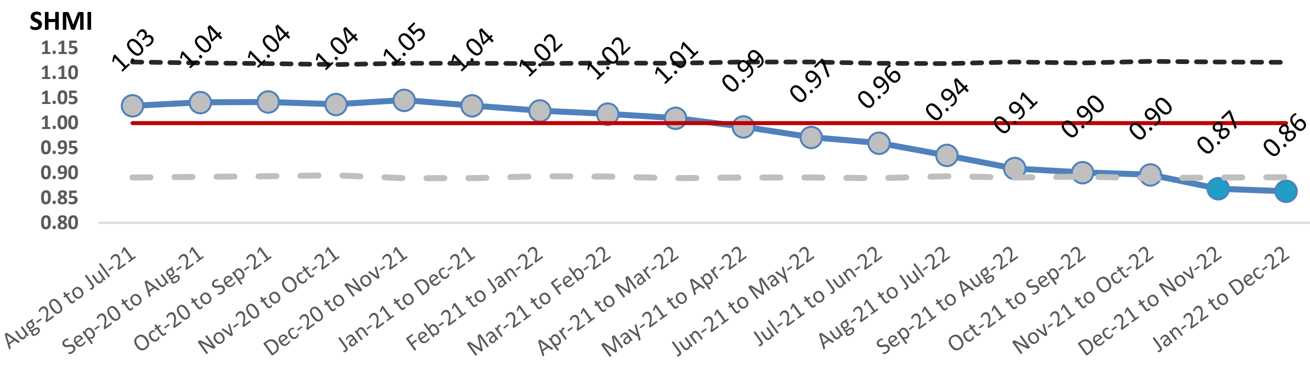


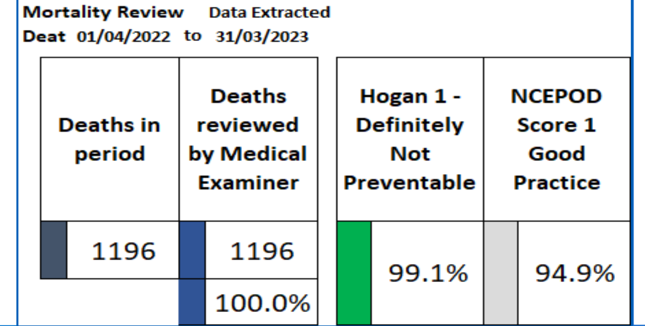
P. aeruginosa & Klebsiella spp

- All Healthcare associated BSI are reviewed and learning are initiated if necessary, any BSI's are investigated and learning ,themes fed back to the relevant BU's.
- The Trust has reported 1 P. aeruginosa community acquired BSI and 5 Healthcare associated Klebsiella spp during April 2023.

Report by exception: Effective – Hospital Standardised Mortality Ratio and Summary Hospital-Level Mortality Indicator







Mortality Review Data Extracted
Deat 01/04/2022 to 31/03/2023

Deaths in period	Deaths reviewed by Medical Examiner	Hogan 1 - Definitely Not Preventable	NCEPOD Score 1 Good Practice
1196	1196	99.1%	94.9%
	100.0%		

Background - The HSMR and SHMI are measurement tools that consider observed hospital deaths (and deaths within 30 days of discharge for the SHMI) with the an expected number of deaths based on certain risk factors identified in the patient group. The HSMR is risk adjusted on palliative care coding whereas the SHMI is not.

Assessment .

- The HSMR is showing deaths ‘As Expected’ with a score of 100.9 against the national average figure of 100.
- The SHMI is showing lower than expected deaths with the latest figure of 0.86, below the national average of 1.00
- Mortality review data for the last 12 months demonstrates that 98.9% of deaths reviewed were ‘Definitely not preventable’ with 95.3% of cases reviewed identified as ‘Good practice’.
- 84 cases in the period require a review by the Mortality Council and/or the ward based team.

Cases scoring more than Hogan 1 are subject to a review at Mortality Council, the majority of these cases are also patient safety incidents and would go through the Trusts Serious Incident Panel. Since the inception of the Medical Examiner Service in September 2020, all deaths are reviewed and cases may be escalated for additional investigations i.e. Mortality Council, patient safety investigation.

Actions

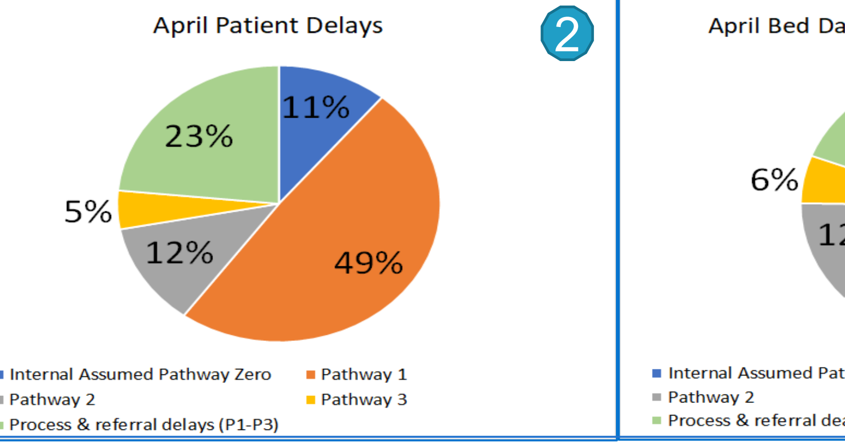
- The new mortality review process went live on the 10th October 2022 involving initial scrutiny and grading by the Medical Examiners Office and subsequent referral where appropriate.
- The process for reviewing deaths were patients had a serious mental illness diagnosis.
  - The process is embedded for those over 65, however the process to review under 65s relies on input from CNTW which has not yet been finalised, hence the backlog of those cases.

Recommendation - Continue to inform & note actions undertaken at Mortality and Morbidity steering group and Quality Governance Committee via the Integrated Oversight Report and Mortality Paper.

Discharge & Delays NOM

1 Patients who do not meet the Criteria to Reside (DMCR), Discharges & Delayed Discharges

	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
Average total no. patients who DMCR that Day	128	119	139	121	123	122	128	133	132	117	135	132	131	130	123	119
Average Daily Discharges	66	70	79	47	77	79	78	76	80	77	83	76	79	79	80	80
Patients who DMCR (SITREP snapshot) daily average	62	50	61	44	46	44	50	57	52	40	52	56	53	51	43	40



3 April Bed Days Lost since Medical Optimistion: Internal Assumed Pathway Zero 11%; Pathway 1 52%; Pathway 2 12%; Pathway 3 6%; Process & referral dealys (P1-P3) 19%

4 No of days between medically optimised and discharged - for Discharged Patients

(Monthly chart, Jan-22 to Apr-23; y-axis 1000–3000)

5 Bed Occupancy (Apr 22 to date)

(y-axis: % beds occupied, 86.0%–100.0%; x-axis 01-Apr to 12-May; legend: % Beds Occupied (daily); % Bed Occupied (rolling 7 day average))

Charts 1-2 – Discharge and Delay – Discharges Jan 22 to present

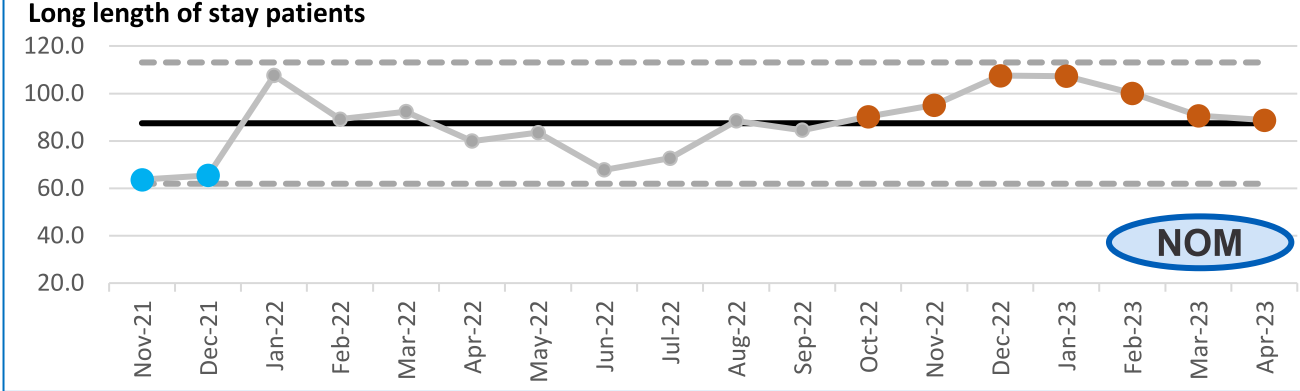
During the day (on average) 127 patients don't meet the criteria to reside. We discharge on average 77 of these patients per day (61%):

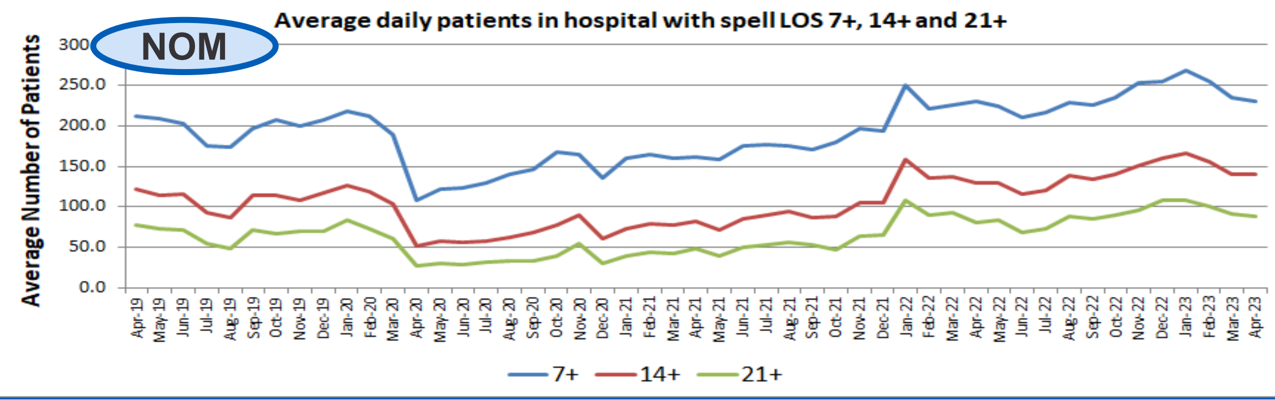
- 53% of the discharges occur before 5pm (circa 41 patients) (10% of these discharges occur before 12 noon (4 of the 41 patients)
- 47% of the discharges occur after 5pm (36 patients)
- 39% of the remaining patients continue to occupy a hospital bed (51)
- Figure 4 shows the total number bed days accrued since medical optimisation **for discharged patients**. April has seen a significant reduction from March, and is the lowest monthly total since June 2022. This is a positive trend as average discharges this month have remained consistent with March indicating that few days on average were being lost per discharged patient.

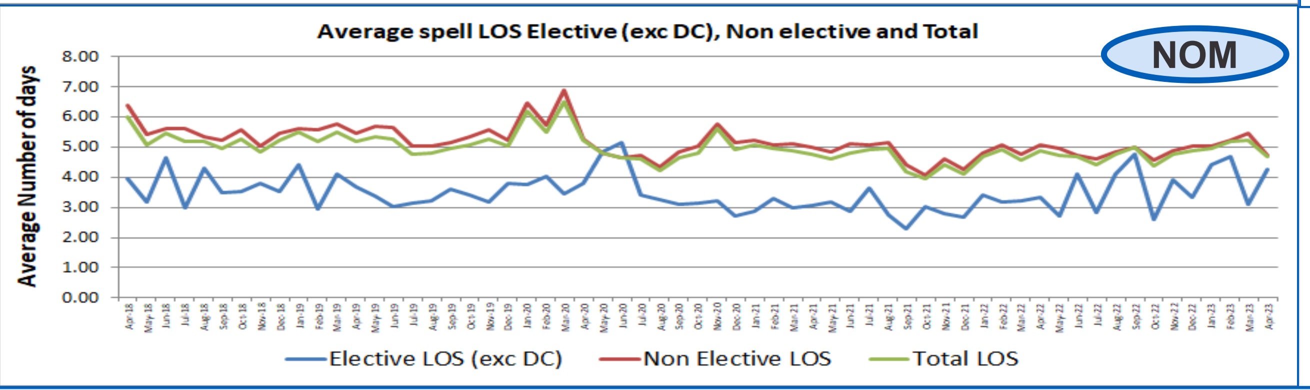
April Update:

- Av. daily admissions: 91 per day (81 Mar) (range 58–143) / Average daily discharges: 87 per day (range 37-124) (84 Mar)
- CTR average daily patients – 119 per day lowest since October 2022 (123 Mar)
- CTR average discharges - 80 per day (80 Mar)
- 57% of discharges occur before 5pm (58% Mar)
- Figure 2 & 2 demonstrate in April that Pathways 1-3 accounted for 66% of the patients and 70% bed day delays, Internal assumed pathways zero and process and referral delays account for 34% of the patients and 30% of the bed days delayed.
- Average daily number of patients who no longer meet the criteria to reside continued to reduce to 40, the lowest since October 2022 Out of area patients continue to account for variable proportions of our Hub discharges (Sunderland/Durham/South Tyneside)
- Trust has the highest bed occupancy levels in ICS since June 22. April bed occupancy average 94.9% (ICS average 91.7% April)
- Bed occupancy remains consistently well above 92% threshold, using 7 day rolling average basis, and increased in later part of April.

Report by exception: Long Length of Stay Patients







Situation

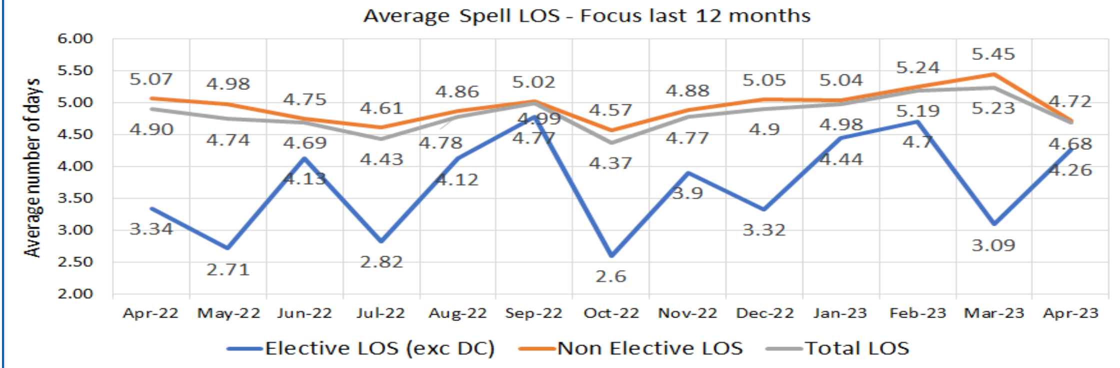
- The average number of patients in hospital with 21+ days LOS is currently showing special cause variation (concern). An increase since June 2022 is observed but in the current calendar year 2023 this has improved.

Background

- An expectation that the daily average number of patients staying 21+ days would not exceed 59. The ECIST existing target of 59 is subject to either pass or fail based on common cause variation.
- The number of LLOS patients again decreased slightly in April to 88.8 from 90.6 in March. This is the 4th month in a row that has seen a reduction, following the peak in December.
- The number of patients in the hospital with spells of more than 7+ days has continued to reduce, each month since January.
- In April there was a daily average 230.7 patients in the hospital with a spell of 7+ days, a 1.5% reduction from 234.1 in March.
- A daily average of 139.6 patients in the hospital with a spell of 14+ days, a 0.3% reduction from 140.0 in March.
- A daily average of 88.8 patients in the hospital with a spell of 21+ days, a 2.0% reduction from 90.6 in March.
- Trust monthly data shows average length of stay of elective patients (excluding day cases) fluctuates each month, in the latest month increased, having reduced in March. In April the figure stood at 4.26 from 3.09 in March.
- Both total LOS and non elective LOS reduced for the first time since October 2022.
- Total LOS reduced to 4.68 from 5.23 in March, the lowest since November 22. While non elective LOS reduced from to 5.45, to 4.72 also the lowest its been since November.

Recommendation

- Review as part of discharge workstream under the Urgent and Emergency Care Board.

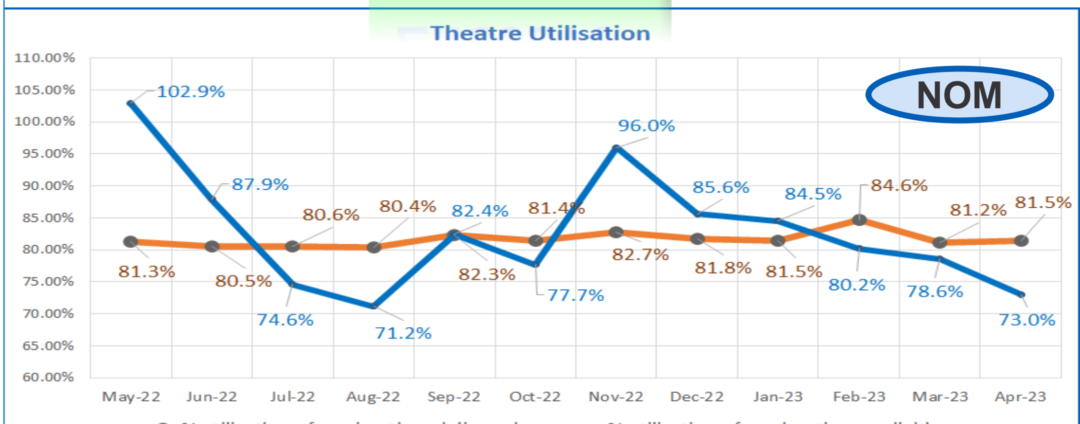


Efficiency and Productivity – Theatres

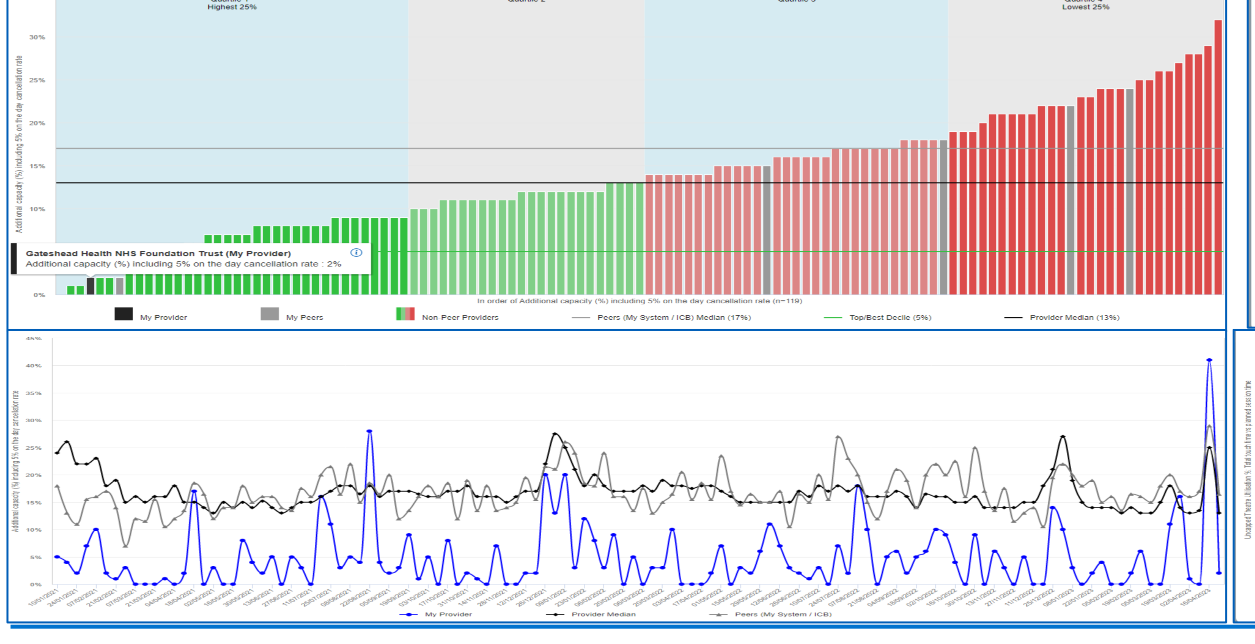
Effective

Improving theatre productivity to drive elective activity plays a crucial role in reducing our patient waiting times and eradicating our backlogs.

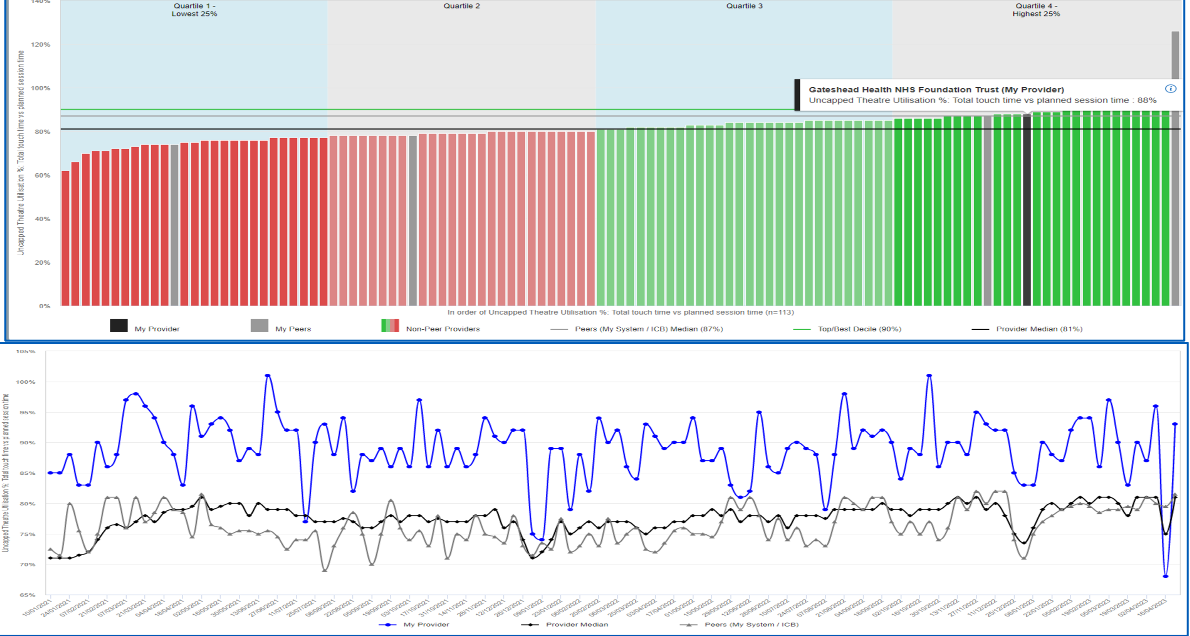
- Maximise our running theatre sessions > =85% with appropriate volumes of cases per list. At the end of April the Trust below the threshold at 81.5%, similar to March at 81.2%.
- Maximising the use of the theatre session time available is an area of improvement. The chart right, has been revised this factor in funded capacity. This has changed the trend in relation to monthly performance outturns , and show some significant peaks across the year. However, since a high of 96.0% in November the overall monthly trend has been one of steady reduction month on month to 73.0% in April.
- National data shows Uncapped theatre utilisation rate of 88% for touch time/planned which is higher then latest peer average (87%) and national average (81%). With Capped theatre utilisation rate of 86% for touch time/planned again higher then latest peer average (81%) and national average (76%).
- National data also benchmarks well in relation to additional capacity (%) including 5% on the day cancellation rate which stands at 1%, an in the best performing quartile, lower than the latest peer average (16%) and national average (12%).



Additional capacity (%) including 5% on the day cancellation rate - Benchmarking



Uncapped Theatre Utilisation %: Total touch time vs planned session time - benchmarking



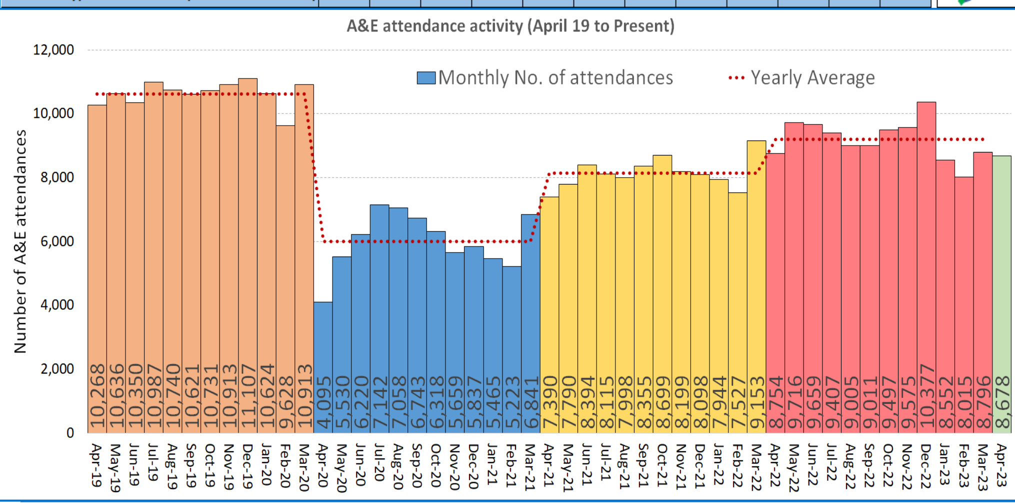
UEC Measures

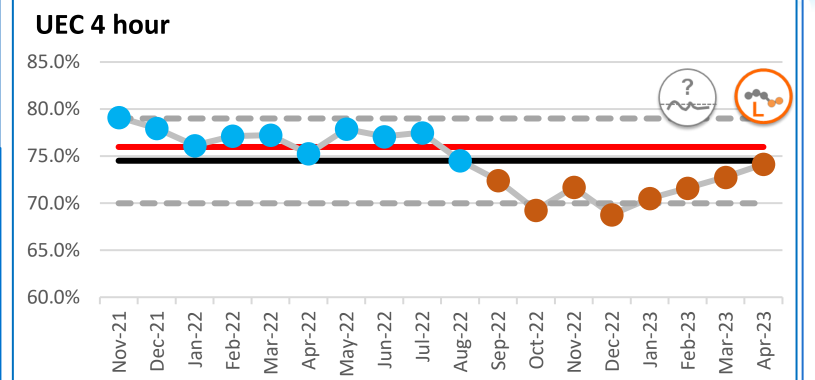
Responsive

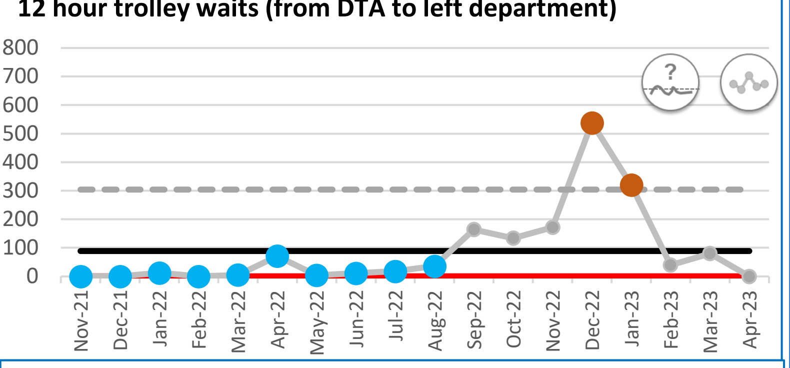
NHSI SOF Operational Performance & National Operational Standards

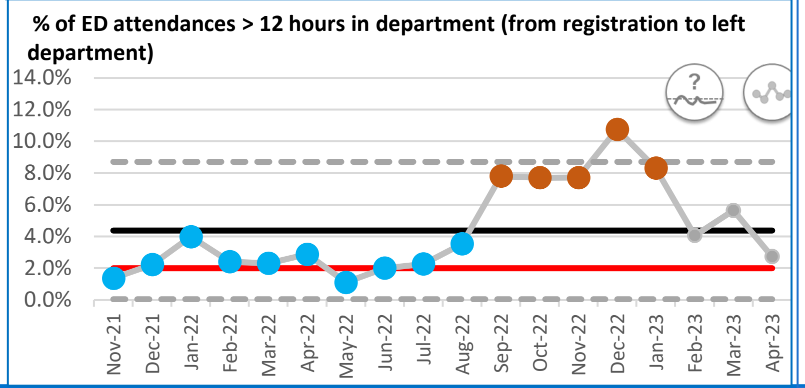
1. % of patients who spend 4 hours or less in A&E (target 95% 22/23 76% 23/24 onwards)
2. National rank 4-hr performance our of all trusts
3. No. of attendances
4. No of waits in department > 12 hours
5. No of waits in department waiting longer than 12 hours for a bed

A&E Indicators	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	Monthly Trend
Attendances: Type 1	6091	6034	5950	5579	5796	6254	6220	7012	5500	5255	5940	5843	
Attendances: Type 3	3625	3625	3457	3427	3215	3243	3355	3365	3052	2760	2856	2835	
Total Attendances	9716	9659	9407	9006	9011	9497	9575	10377	8552	8015	8726	8678	
Total Breaches	2148	2212	2116	2292	2484	2918	2709	3237	2522	2275	2395	2243	
Trust Total - % seen in 4 hours	77.9%	77.1%	77.5%	74.6%	72.4%	69.3%	71.7%	68.8%	70.5%	71.6%	72.6%	74.2%	
National Rank (Accute trusts - Lower is better)	20	19	16	29	33	38	31	25	50	47	37	43	
12 hour trolley waits (DTA breaches)	4	11	18	36	164	134	172	538	320	40	80	0	
Volume in department > 12hours	108	193	213	318	703	731	738	1116	710	325	496	237	
A&E >12hour waits (target <2%)	1.11%	2.00%	2.26%	3.53%	7.80%	7.70%	7.71%	10.75%	8.30%	4.05%	5.68%	2.73%	
Average bed occupancy	92.8%	94.4%	95.1%	96.0%	96.8%	96.7%	96.5%	96.6%	95.4%	94.4%	94.6%	94.9%	
Peadiatric Type 1 Attendances (number)	1101	1109	1107	749	886	1070	1388	2030	977	946	1103	1003	
Peadiatric Type 1 Attendances (% of all attendances)	11.3%	11.5%	11.8%	8.3%	9.8%	11.3%	14.5%	19.6%	11.4%	11.8%	12.6%	11.6%	









Situation

- Attendances decreased in April to 8,678 from 8,797 in March, daily attendances averaged 3 per day less than April 2022 (representing a decrease of 0.9%).
- 4hr performance improved to 74.2% the highest monthly outturn since August 2022 and moving closer to the new 76% target for 2023/24.
- At 74.2% the Trust ranked 43rd nationally, a decline from 37 in March.
- Overall time in the department has reduced but remains high, (non-admitted 2 hours 43 minutes, admitted 7 hours 8 minutes).
- The target for 12 hr dept times of no more than 2% of all attendances has not been met since June 22, however in April 2.73% of attendances (237) were in the dept more than 12 hours, down from 5.68% in March and the first time the figure has been below 3% since July 2022.
- There were no 12 hr DTAs in April, down from 80 in March. This is the first time in the past 12 months the Trust reported no DTA breaches.
- Bed occupancy levels remained consistent with the previous month, averaging 94.9% in April (compare with 94.6% in March), with a daily peak of 97.9% on the 30th April.

Context:

- Urgent and Emergency Care remains under pressure however in all key areas April has seen improved performance.
- Challenges remain however as a result of high bed occupancy, pressures on social care discharges, IPC bed closures other challenges in the managing and placing of patients
- The trust has been at OPEL 2 through out the whole of April, with exception of April 9th when we moved to OPEL3, but returned to OPEL2 the next day.

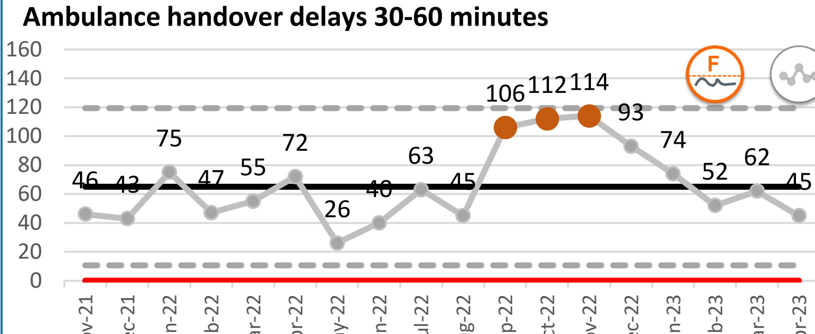
UEC Measures - Ambulance Handover Delays

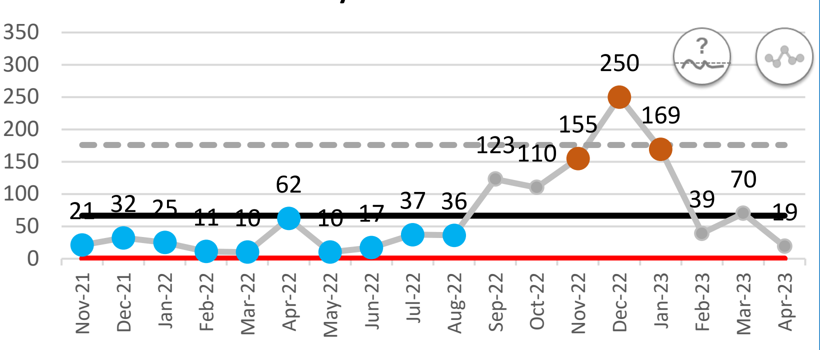
Responsive

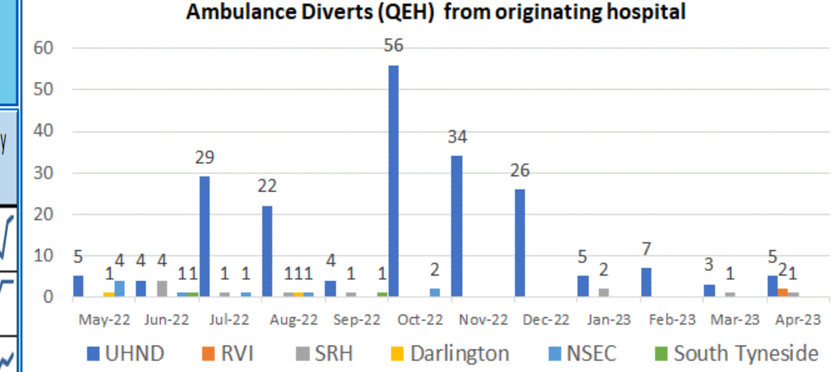
NHSI SOF Operational Performance & National Operational Standards

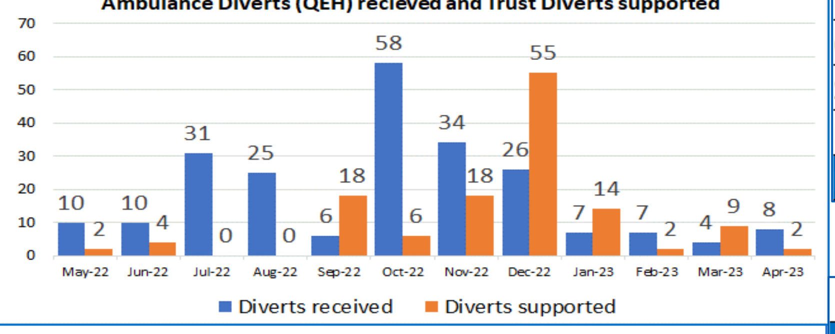
1. No. of ambulance delays
2. No. of ambulance diverts

Ambulance Arrivals and handover delays	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	Monthly Trend
No. Patients arriving by Ambulance	1803	1733	1748	1760	1753	1708	1679	1563	1629	1597	1778	1809	
% of handovers <15 Minutes	46.7%	45.1%	42.5%	45.8%	38.2%	34.7%	33.6%	24.7%	39.5%	48.6%	48.0%	48.0%	
% of handovers 30-60 Minutes	98.4%	97.3%	95.9%	97.1%	93.0%	92.9%	92.2%	93.4%	94.9%	96.3%	95.9%	97.1%	





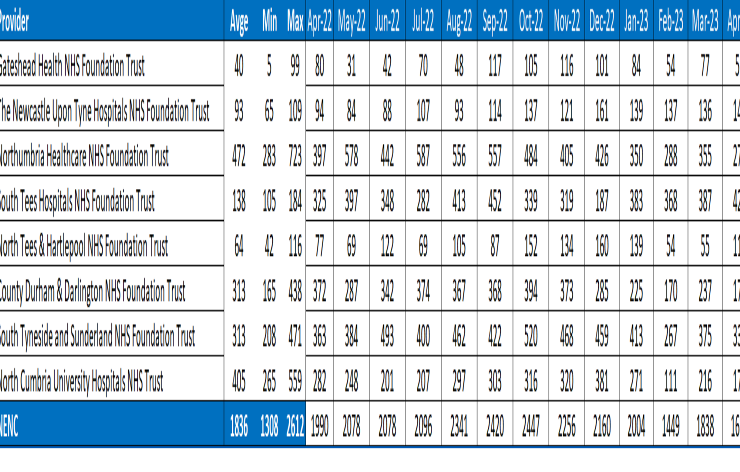




Situation

- April saw the highest number of Ambulance attendances in the past 12 months, 1809.
- However positively both ambulance handover metrics are currently displaying common cause variation, and reduced in the latest month.
- In April 23, there were 45 30-60 minute delays reported and 19 60+ minutes delays, a reduction from 62 and 70 respectively in March.
- April was the thirdd month in a row when the 95% target of patients arriving by ambulance waiting between 30-60 minutes for handover was met.
- In April the Trust was top performing Trust in the (ICS) region for 30-60m Ambulance hand-over times, and 2nd for 60+ minute delays.
- Ambulance diverts received increased to 8 in April, from 4 in March. Diverts from the Trust that were supported fell from 9 to 2.

Handover Delays – 30-60 minutes



	2019/20															
Provider	Avge	Min	Max	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
Gateshead Health NHS Foundation Trust	40	5	99	80	31	42	70	48	117	105	116	101	84	54	77	51
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	93	65	109	94	84	88	107	93	114	137	121	161	139	137	136	146
Northumbria Healthcare NHS Foundation Trust	472	283	723	397	578	442	587	556	557	484	405	426	350	288	355	273
South Tees Hospitals NHS Foundation Trust	138	105	184	325	397	348	282	413	452	339	319	187	383	368	387	429
North Tees & Hartlepool NHS Foundation Trust	64	42	116	77	69	122	69	105	87	152	134	160	139	54	55	112
County Durham & Darlington NHS Foundation Trust	313	165	438	372	287	342	374	367	368	394	373	285	225	170	237	171
South Tyneside and Sunderland NHS Foundation Trust	313	208	471	363	384	493	400	462	422	520	468	459	413	267	375	335
North Cumbria University Hospitals NHS Trust	405	265	559	282	248	201	207	297	303	316	320	381	271	111	216	172
NENC	1836	1308	2612	1990	2078	2078	2096	2341	2420	2447	2256	2160	2004	1449	1838	1689

Handover Delays – 60 minutes +

	2019/20															
Provider	Avge	Min	Max	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
Gateshead Health NHS Foundation Trust	21	0	81	63	10	18	44	41	125	132	174	279	170	49	62	20
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	2	0	6	0	2	4	3	3	1	10	8	12	9	7	13	8
Northumbria Healthcare NHS Foundation Trust	79	24	206	84	122	87	110	102	125	171	123	236	90	20	72	27
South Tees Hospitals NHS Foundation Trust	47	10	117	233	203	232	210	200	246	289	278	328	174	202	276	206
North Tees & Hartlepool NHS Foundation Trust	6	1	18	10	7	23	11	30	23	39	40	118	96	4	7	22
County Durham & Darlington NHS Foundation Trust	178	32	404	241	153	273	347	373	425	449	410	526	278	60	83	42
South Tyneside and Sunderland NHS Foundation Trust	117	23	268	133	88	181	126	160	100	270	205	407	281	58	198	111
North Cumbria University Hospitals NHS Trust	72	26	117	85	90	71	100	184	228	209	238	319	165	52	115	33
NENC	522	227	1138	849	675	889	951	1093	1273	1569	1476	2225	1263	452	826	469

Community Waiting List and 2hr Rapid Response

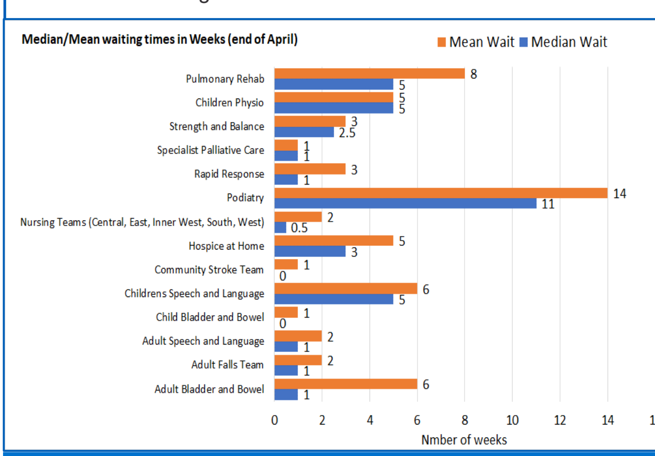
Responsive

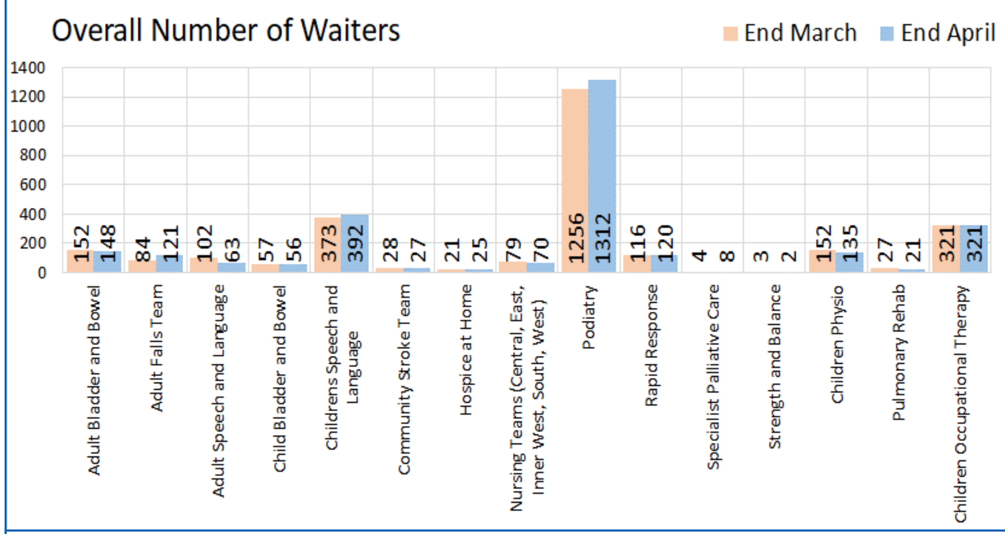
Context
Community waiting list data is now submitted as part of the monthly Community Health Services SITREP. The following data is a summary of the latest submission as the end of April 23.
Note: CYP Occupational Therapy service currently using paper based system so timescale breakdown unavailable at present, plan to move to electronic system in 2023.

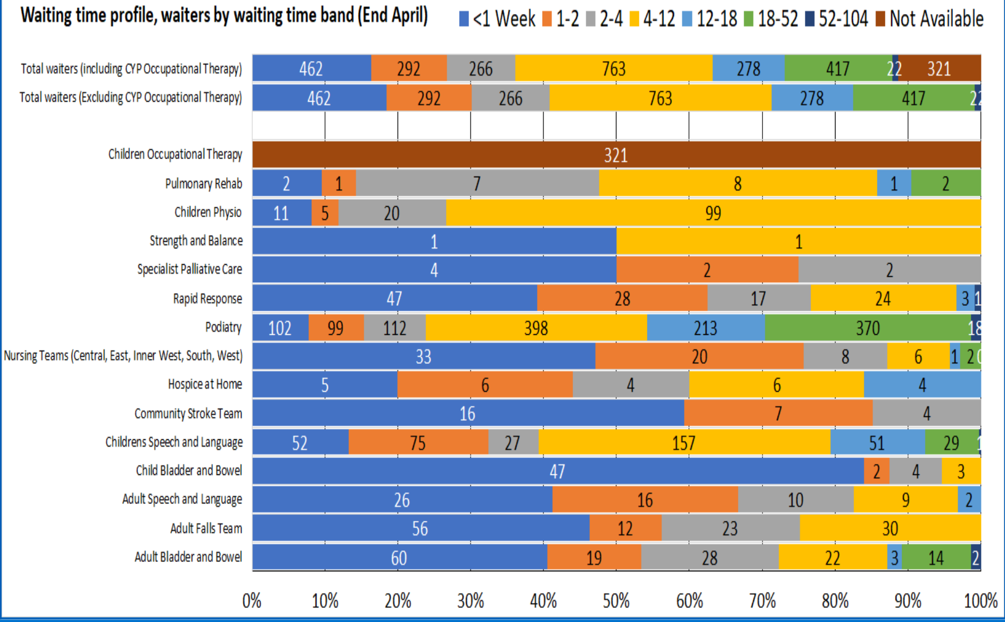
Key points

- At the end of April there were 2821 patients on the waiting list for assessment, a very slight increase from 2775 at the end of March. Nearly half (46.5%) of all those waiting are for Podiatry, with the next largest cohort Children Speech and Language (13.9%) and Childrens Occupational Therapy (11.4%).
- Average median and Mean waiting times vary by service, with the shortest average waits seen in child bladder and bowel and Community Stroke Team both between 0 and 1 weeks. The longest in Adult Podiatry at between 14 and 11 weeks.
- Of the total waiting list (excluding children OT), 82.4% (had been waiting less than 18 weeks), 16.7% between 18 and 52 weeks. 0.9% (22 patients) have been waiting more than 52 weeks with 18 of those in the podiatry service.

Next Steps:
Routine reporting and monitoring of this data mainstreamed into Community performance reporting, and CYP OT move to electronic recording.

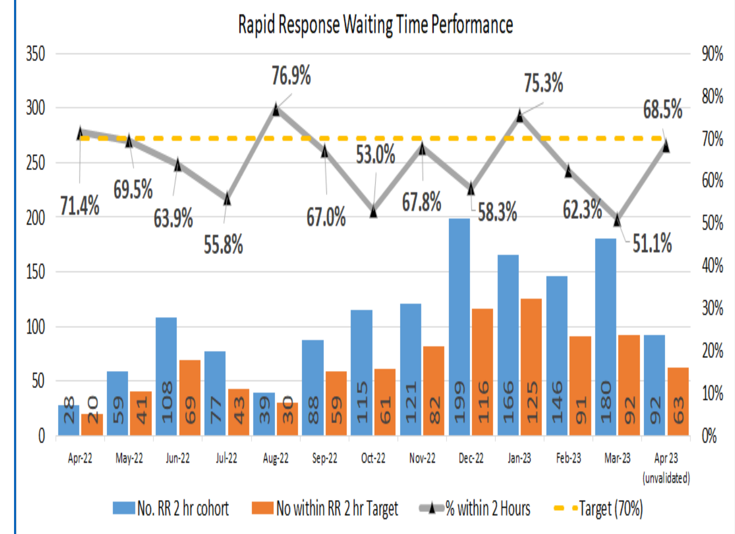






Rapid Response
The Rapid Response team responded to 180 two-hour crisis response referrals in March (an increase from 146 in February), and achieved a validated compliance rate of 51.1% for patients seen within 2 hours, below the 70% target and lowest monthly percentage so far. **Indicative** (currently being validated) performance for April is 92 referrals with a compliance rate of 68.5%, again below the 70% target but only just. Validated performance stands at 62.6% since the end of Q3.

Next Steps:
Following a revision to guidance in April 23, work is ongoing within the Community Business Unit to ensure additional activity which the services undertake, and now fits the criteria for the performance measure, is being captured appropriately in order to be reported and reflect all levels of activity being undertaken within the service.



Elective Care Activity & Recovery

Responsive

The below data tracks performance against planned for levels of activity in 2023/24 as part of the Trusts Operational Plan. For each metric with the exception of (follow-up outpatients) target is to achieve 100% or higher, this would mean planned for levels of activity has been met or exceeded. For follow up outpatients the aim is to achieve 100% or ideally lower as the plan is to look to reduce follow-up up outpatient attendances. The table provides in month figures and then a rolling year to date total.

Elective Activity - % of planned for levels 23/24 achieved	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Monthly Trend	Year To Date
Total - Comined Elective Activity (>100%)	90.4%							90.4%
Daycase (>100%)	85.8%							85.8%
Elective Overnights (>100%)	79.1%							79.1%
Outpatient - New (>100%)	83.9%							83.9%
Outpatient - Followup (Less than <100%)	94.0%							94.0%
Total Outpatient	91.2%							91.2%

April activity is below planed levels with **Combined elective activity 90.4% of planned activity**

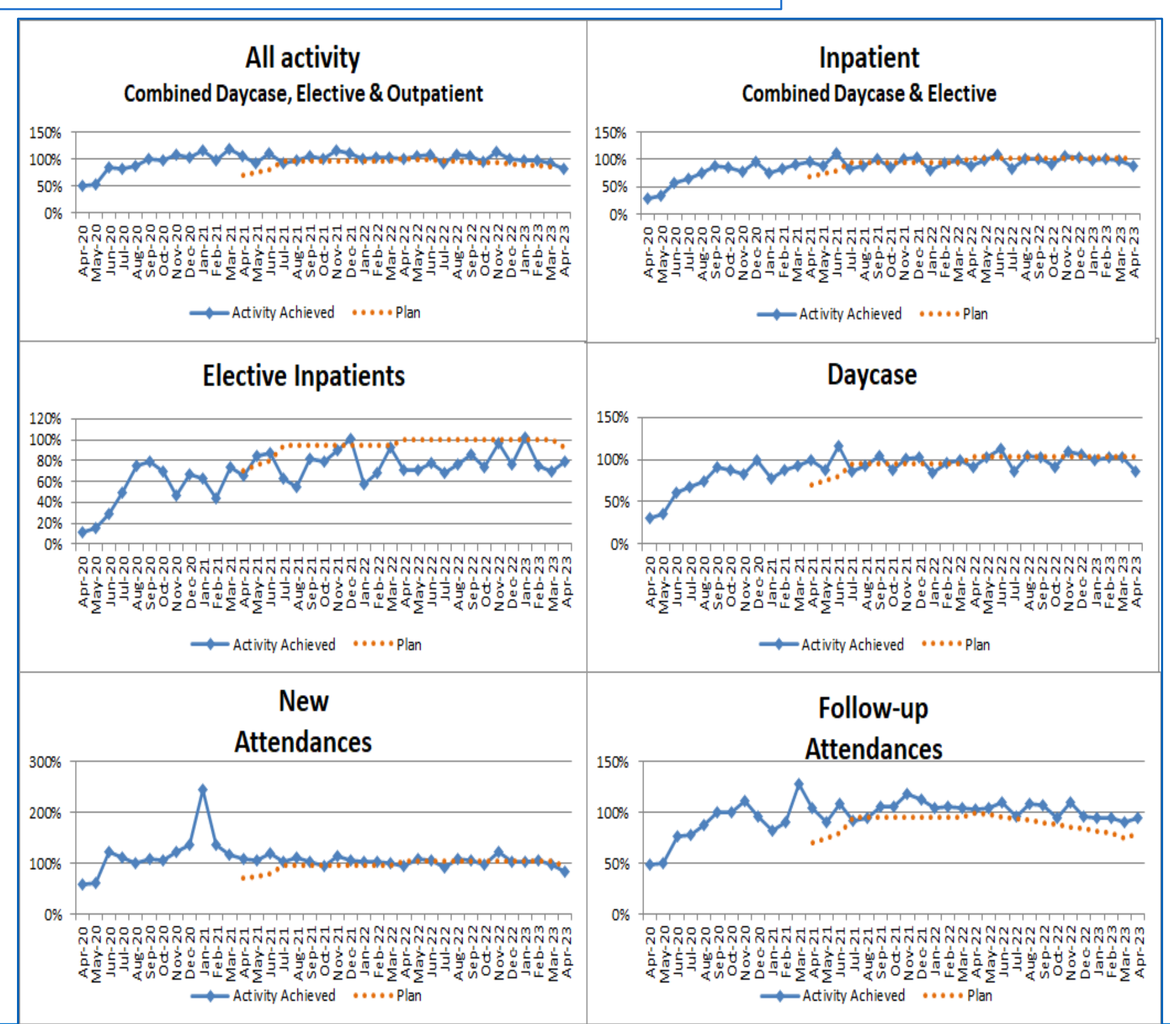
- Day cases was 85.8%%
- Elective inpatients 79.1%
- New Outpatients 83.9%
- FU Outpatients 94.0%

NOM

A combined rolling cumulative year to date figure will be included in the table moving forward, so the Trust is able to identify the overall level of activity achieved as the year moves on as well as individual in month achievement. For this first month however the figures are the same as there is only the first month to include in the data.

Other key requirements in April:

- The Trust is reporting 23.07% of all outpatient attendances conducted remotely, which is slightly below the 25% expectation
- 3.57% of all OP recorded as Patient Initiated Follow-Up – which is below planned levels of 5.0%



Activity & Recovery - Diagnostic

Responsive

The below data tracks performance against planned for levels of diagnostic activity in 2023/24 as part of the Trusts Operational Plan. For each metric the target is to achieve 100% or higher, this would mean planned for levels of activity have been met or exceeded. The table provides in month figures and then a rolling year to date total. By achieving planned for levels of activity, the Trust will achieve the Operational Plan system wide expectations of delivery against increases of activity against the 19/20 baseline.

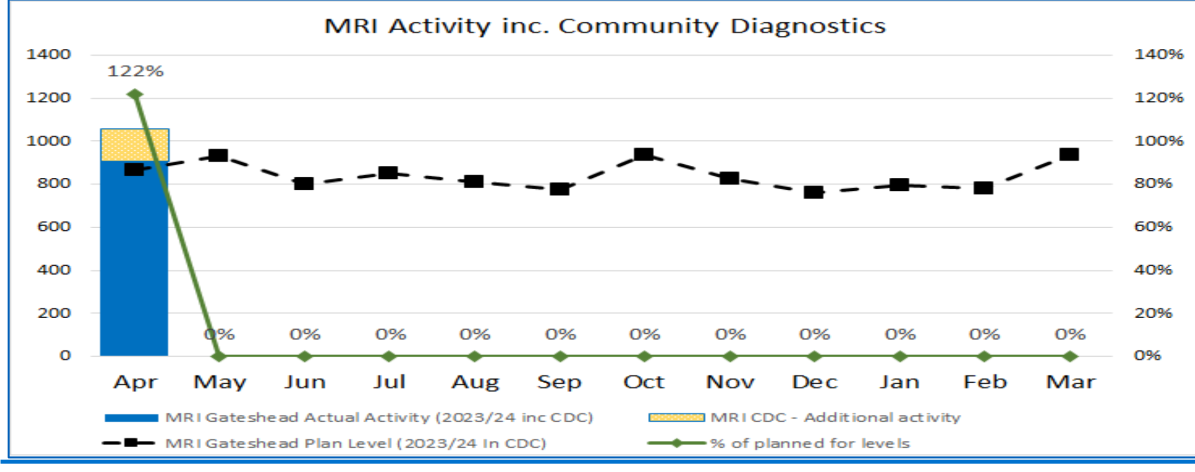
Diagnostic Activity - % of planned for levels 23/24 achieved	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Monthly Trend	Year to date
Total (>100%)	95.4%							95.4%
MRI (>100%)	103.0%							103.0%
CT (>100%)	103.5%							103.5%
Colonoscopy (>100%)	86.7%							86.7%
Non Obs Ultrasound (>100%)	90.2%							90.2%
Flexi Sigmoidoscopy (>100%)	65.6%							65.6%
Gastroscopy (>100%)	72.7%							72.7%
Echo (>100%)	99.4%							99.4%
Endoscopy (>100%)	77.1%							77.1%

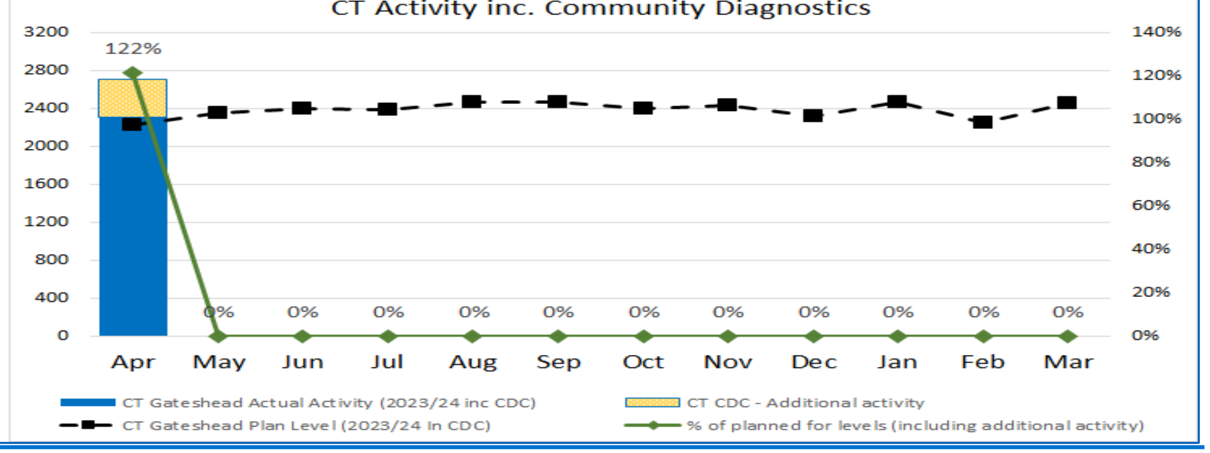
Note: The tests listed on this page are not all diagnostic activity tests undertaken by the Trust, only those that form part of the 23/24 Operational Plan expectations. This page monitors delivered activity against those planned for levels only. Activity in the table right reports on Gateshead only activity, and for MRI and CT this will include activity undertaken for Gateshead at Blaydon CDC also. The graphs at the bottom of the page provides overall levels of MRI and CT activity delivered by Gateshead including the additional non-Gateshead activity delivered at Blaydon CDC for MRI and CT.

Detailed monitoring of Gateshead and non Gateshead Blaydon CDC planned activity is being developed and will be available from month 2.

In April the overall level of diagnostic activity delivered against plan for levels was below target at 95.4%. Both MRI and CT achieved and exceeded their planned for levels of activity, at 103% each. Echo fell only slightly below target at 99.4%. However the other 4 tests fell well short of planned levels with figures ranging from 90.2% for NOUS and but only 65.6% for Flexi SIG. The combined endoscopy tests only achieved 77.1% of planned for levels overall.

In April when adding on non-Gateshead activity the percentages of activity delivered including CDC were 122% for MRI and 122% for CT.





Maximum 6-week wait for diagnostic procedures

Responsive

NHSI SOF Operational Performance & National Operational Standard

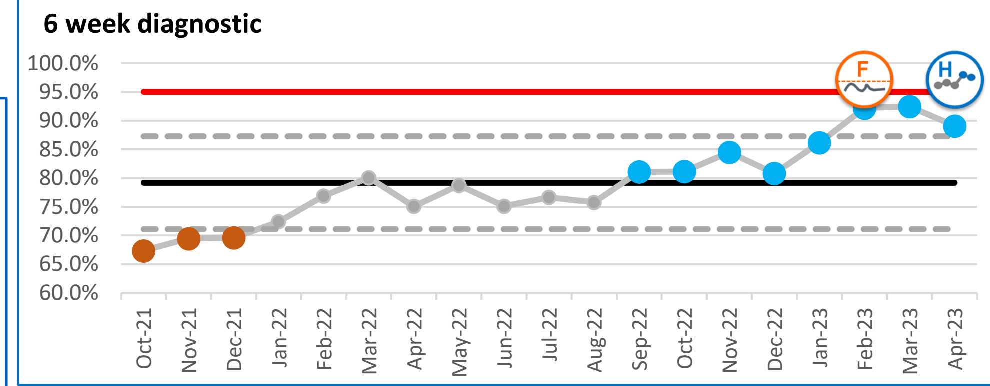
1. Number of patients waiting on a diagnostic WL at month end.
2. Number of patients waiting on a diagnostic WL at month end waiting greater than 6 weeks
3. % patients waiting 6 weeks or more for a diagnostic test at month end (target -1% moving to 5% by March 2023)
4. Number of diagnostic tests/procedures carried out in month

Trust's Diagnostic performance:

- Performance 89.1% in April, a slight reduction from 92.5% in March. Overall Trust performance remains below 95% target. Aprils performance however continues to be above latest NENC average of 84.1% (Mar23) and continues to exceed the latest national average of 75.0% (Mar23).
- Numbers waiting for a diagnostic test increased from decreased from 5449 in March to 5327, however the number of patients waiting >6 weeks increased from 410 to 581, which is what has driven down the performance level achieved this month.
- The increase in >6w waiters was largely focussed in two areas. First in Audiology, where numbers increased by 72 from 262 to 334 (27%), this was the result of long-term staff sickness impacting on activity delivery in April. The other area being the 4 tests that are part of Endoscopy (Colonoscopy, Flexi Sig, Gastroscopy and Cystoscopy) where numbers increased by 69 from 91 to 160 (75%). Pressures around endoscopy capacity have resulted in additional outsourced activity being sought to address the pressures, this is planned to start at the end of May. The 5th Endo room is also expected to go live around this time also providing additional capacity and flexibility.
- Echocardiology has seen significant improvement over the past few months which continues, Echo has achieved its recovery trajectory target for April 23.
- Audiology performance reduced to 51.4% in April, down from 60.1% in March. Audiology is the single largest risk area in achieving the target. As mentioned above, Aprils performance was impacted by staff sickness. Plans are in place now to mitigate for the sickness absence, and the new Band 3 post will be fully operational in the next couple of weeks bringing the extra capacity required to address the waiters. As such the service remains confident of achieving the audiology improvement trajectory (chart bottom right) which plans to achieve the 95% target by late summer 2023.

95 % Standard

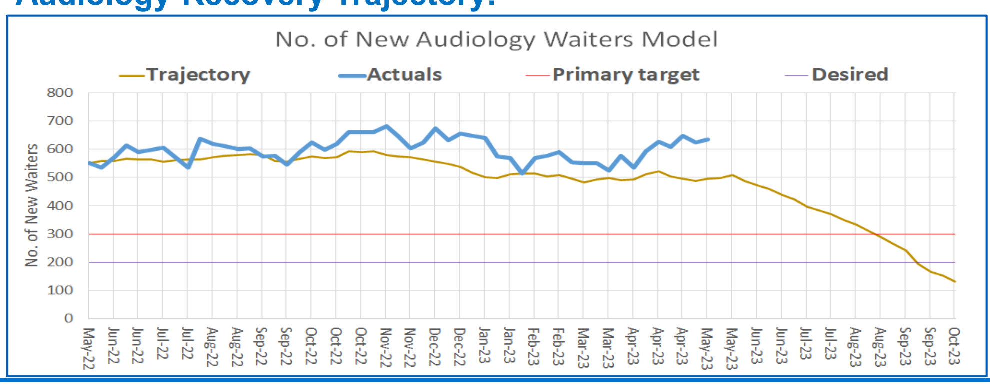
Diagnostic waiters <6 weeks	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	Trend
Trust Total (95%)	78.7%	75.1%	76.6%	75.8%	81.1%	81.2%	84.5%	80.8%	86.2%	92.2%	92.5%	89.1%	
Barium Enema (95%)	100.0%	98.4%	100.0%	96.6%	97.6%	100.0%	100.0%	100.0%	97.8%	100.0%	100.0%	100.0%	
CT (95%)	99.5%	99.0%	99.6%	99.5%	99.8%	99.5%	99.3%	99.0%	99.5%	99.3%	99.2%	99.4%	
MRI (95%)	97.6%	99.6%	99.2%	98.0%	98.9%	99.3%	98.4%	95.4%	97.6%	99.7%	100.0%	99.7%	
Non-Obstetrc Ultrasound (95%)	99.6%	99.0%	99.2%	98.5%	99.3%	99.3%	99.6%	99.6%	99.4%	99.4%	99.5%	99.2%	
Audiology (95%)	57.1%	55.5%	57.2%	57.6%	54.9%	48.9%	52.0%	42.3%	51.1%	65.2%	60.1%	51.4%	
Urodynamics (95%)	90.0%	88.2%	100.0%	100.0%	95.2%	96.0%	97.4%	90.7%	91.2%	100.0%	88.2%	92.6%	
Colonoscopy (95%)	97.7%	98.7%	94.8%	96.2%	96.2%	94.5%	98.2%	93.5%	96.3%	92.1%	86.8%	81.6%	
Flexi-Sig (95%)	93.5%	97.7%	100.0%	98.2%	97.5%	100.0%	98.2%	94.5%	96.4%	93.1%	92.1%	81.2%	
Gastroscopy (95%)	96.8%	98.1%	98.4%	98.2%	98.3%	96.9%	97.5%	95.6%	95.1%	98.7%	95.5%	91.0%	
Dexa (95%)	97.9%	98.8%	99.2%	98.3%	97.7%	98.0%	99.0%	98.5%	99.5%	98.2%	98.7%	97.4%	
Echo Cardiology (95%)	38.4%	30.0%	29.1%	30.1%	39.1%	42.7%	52.1%	42.5%	63.0%	85.3%	93.9%	90.6%	
Cystoscopy (95%)	85.7%	89.6%	94.2%	96.7%	97.8%	100.0%	100.0%	97.0%	93.1%	90.0%	91.3%	87.6%	



Echocardiography 6 Week Performance Recovery Trajectory:

	ECHO	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Trend
Projection	Total waiting List (projection 23/24)	650	600	555	500	500	500	500	
	> 6 weeks	98	60	28	25	25	25	25	
	% within 6 weeks	84.9%	90.0%	95.0%	95.0%	95.0%	95.0%	95.0%	
Actual	Total waiting List	615							
	> 6 weeks	58							
	% within 6 weeks	90.6%							
	Difference to projection (%)	5.6%							
	Met recovery trajectory	Yes							

Audiology Recovery Trajectory:



Referral to Treatment

Responsive

RTT Long Waiters (at month end)

Waiters at month end		May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	Trend
Total Waiters	Actual	11542	11604	11949	12244	12430	12837	12715	12593	12753	12864	12880	13389	
52w waiters	Plan	45	40	35	30	30	20	15	10	5	2	0	100	
	Actual	71	58	77	81	91	89	95	99	84	70	86	98	
General Surgery	Actual	12	8	12	10	17	10	13	16	8	2	8	14	
Gynaecology	Actual	2	1	2	1	2	0	1	0	1	0	4	2	
Trauma & Orthopaedics	Actual	21	25	31	28	31	17	16	16	9	11	8	10	
Urology	Actual	4	1	0	1	1	1	1	1	1	4	2	4	
Paediatrics	Actual	14	12	13	16	17	24	32	30	42	33	45	44	
Cardiology	Actual	0	0	3	5	2	3	1	5	7	7	1	2	
Gastroenterology	Actual	5	3	1	4	4	7	3	5	1	1	1	3	
General Medicine	Actual	0	0	0	0	0	0	0	0	0	0	0	0	
Respiratory Medicine	Actual	4	4	7	3	9	13	14	16	2	2	1	0	
Rheumatology	Actual	0	0	0	0	0	0	0	0	1	0	0	0	
Other	Actual	9	4	8	13	8	14	14	10	12	10	16	19	
65 week waiters	Plan	New Monitoring Measure for 2023/24											59	
	Actual												6	
78 week waiters	Plan	1	0	0	0	0	0	0	0	0	0	0	0	
	Actual	5	2	1	1	5	2	3	2	0	0	0	0	

RTT % Within 18 weeks	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	Monthly Trend
Trust (92%)	75.9%	76.3%	75.8%	75.1%	74.3%	73.4%	72.1%	68.7%	70.2%	70.5%	71.0%	69.9%	
General Surgery (92%)	80.4%	79.0%	75.8%	78.0%	79.8%	79.0%	78.6%	73.0%	71.7%	69.7%	68.9%	67.6%	
Gynaecology (92%)	77.3%	80.8%	80.2%	78.0%	81.7%	80.5%	78.8%	77.2%	72.8%	70.4%	72.5%	68.1%	
Trauma & Orthopaedics (92%)	66.7%	67.0%	66.2%	64.0%	63.2%	62.6%	61.7%	57.6%	58.6%	60.4%	59.3%	55.4%	
Urology (92%)	78.2%	73.3%	74.8%	75.5%	77.5%	76.2%	75.2%	69.9%	68.1%	74.5%	75.4%	70.5%	
Paediatrics (92%)	74.6%	74.8%	73.3%	69.6%	68.5%	69.1%	68.1%	67.1%	67.8%	69.0%	67.8%	65.4%	
Cardiology (92%)	78.7%	76.4%	74.5%	72.0%	69.6%	71.2%	71.6%	70.3%	73.8%	75.7%	75.2%	79.1%	
Gastroenterology (92%)	78.1%	87.7%	90.0%	88.4%	80.8%	77.2%	71.5%	67.1%	72.6%	72.1%	77.4%	79.1%	
General Medicine (92%)	78.1%	75.0%	86.2%	95.0%	76.9%	88.9%	88.9%	81.8%	91.8%	95.5%	94.2%	94.3%	
Geriatric Medicine (92%)	91.2%	95.4%	89.7%	88.6%	89.1%	86.8%	83.4%	78.2%	81.9%	84.0%	79.7%	79.5%	
Respiratory Medicine (92%)	69.1%	66.2%	65.2%	67.8%	64.4%	60.9%	66.8%	65.3%	79.4%	79.1%	76.9%	79.4%	
Rheumatology (92%)	84.3%	80.1%	81.0%	83.6%	82.6%	83.2%	78.9%	75.9%	87.4%	93.3%	91.5%	90.8%	
Other (92%)	73.3%	72.2%	71.9%	70.6%	69.2%	69.2%	67.2%	65.4%	66.8%	67.8%	68.4%	68.1%	

NHSI SOF Operational Performance & National Operational Standard

1. Number of patients waiting on an incomplete RTT pathway at month end
2. Number of patients on an incomplete pathway waiting 18 weeks or more
3. Percentage of patients waiting < 18 weeks on an incomplete pathway (target> 92%)
4. No of patients waiting longer than 52 weeks, 65 weeks and 78 weeks

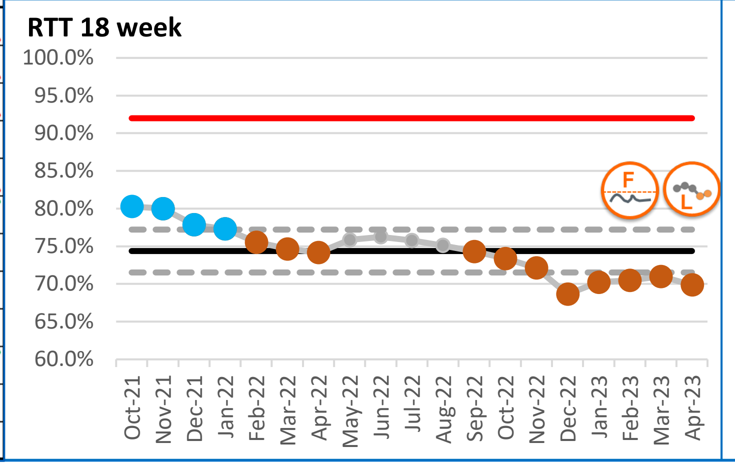
Trust's RTT performance

- April performance 69.9%, reduction from 71.0% in March, below the 92% target.
- At 69.9% Trust performance however continues to exceed latest national average 58.6% (Mar 23), and the ICB average of 69.5% (Mar 23). General Medicine the only speciality to achieve the target, now for the past 3 months. Total waiting list increased from 12,880 to 13,389 in April (increase of 509 or 3.9%).
- The number patients waiting 52 weeks or more increased to 98 in April, just below the 100 planned for. However, the numbers in this cohort are projected to rise again in the coming months. Paediatric waiters accounted for 44 of the 98 (the single largest individual cohort) and Pain Patients 17 of the 48. There continues to be 0 patients waiting more than 78 weeks in April. The Trust had 6 65week waiters, below planned for levels of 59 in April.

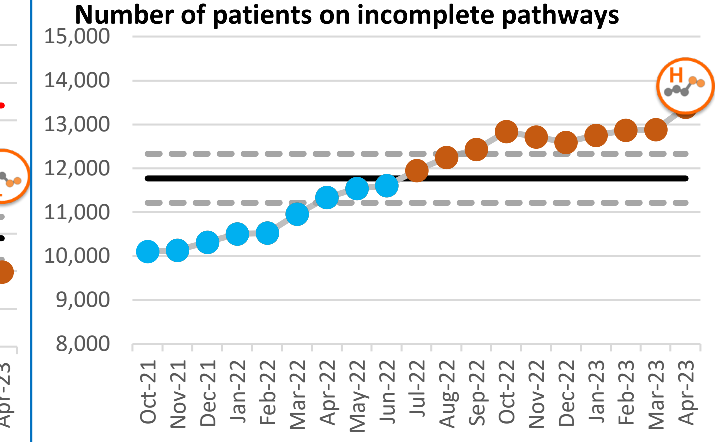
Main Risks – increasing 52w+ waiters

- **Paediatric long waiters** – pressures continue and are increasing in Paediatric long waiters, projections based on current cohort indicate by the end of June there will be circa 81 over 52 week waiters up from 44 end of April, of which 9 will be over 65 weeks. Options to address the demand and capacity challenges to address this being considered by the service. Paediatric long waiters are exclusively children aged 0-4 awaiting an autism assessment.
- **Pain long waiters** – 3 new staff start in September which will provide sufficient capacity, and work to address backlog. Locum cover being sourced in the meantime. projections based on current cohort indicate by the end of June there will be circa 45 over 52 week waiters up from 17 end of April, of which 6 will be over 65 weeks.

RTT 18 week



Number of patients on incomplete pathways

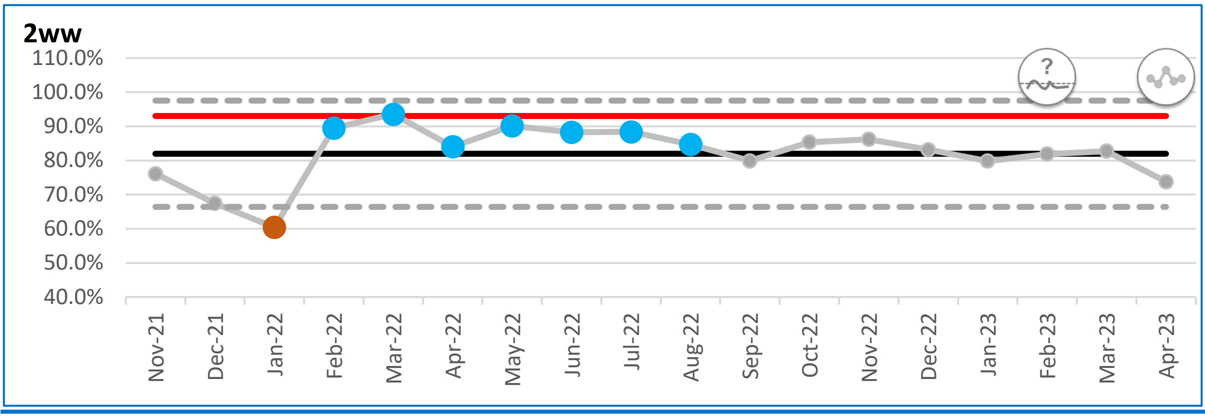


Cancer Standards - 2 Week Waits

NHSI SOF Operational Performance & National Operational Standard

1. No. of urgent GP referrals for suspected cancer
2. Number of patients seen after more than 2 weeks
3. % patients seen within 2 weeks

2ww performance	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	Monthly Trend
Trust (93%)	89.4%	88.8%	89.1%	84.7%	79.9%	85.1%	86.6%	83.3%	79.8%	82.3%	82.7%	74.4%	
Breast (93%)	97.4%	94.9%	97.0%	96.8%	93.2%	93.2%	94.8%	88.0%	94.4%	96.7%	94.9%	90.3%	
Gynae (93%)	95.5%	89.8%	82.4%	86.4%	73.6%	85.9%	79.4%	93.7%	90.9%	91.1%	90.7%	70.2%	
Lower GI (93%)	80.0%	82.8%	67.6%	45.8%	36.4%	42.4%	40.2%	44.9%	37.5%	25.5%	35.6%	26.4%	
Testicular (93%)	85.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	83.3%	100.0%	100.0%	100.0%	75.0%	
Urology (93%)	79.0%	71.2%	83.2%	84.4%	94.2%	93.7%	94.1%	86.5%	69.0%	86.0%	82.5%	71.4%	
Haematology (93%)	100.0%	88.9%	100.0%	92.3%	86.7%	100.0%	100.0%	100.0%	85.7%	91.7%	100.0%	75.0%	
Lung (93%)	43.1%	65.7%	77.4%	74.6%	47.2%	81.8%	88.6%	90.0%	90.8%	91.3%	79.3%	88.3%	
Upper GI (93%)	82.1%	79.5%	86.5%	84.8%	74.6%	76.3%	88.9%	85.5%	45.5%	62.0%	73.1%	45.6%	
												Indicative	
Symptomatic Breast (93%)	97.8%	93.6%	94.4%	95.0%	90.3%	100.0%	89.7%	95.7%	100.0%	100.0%	97.2%	91.2%	
												Indicative	



Trust's 2 week wait Cancer performance

- Trust's validated performance for March 82.7% against the 93% target
- 82.7% is slightly below the latest England average at 83.9% (Mar 23) and NENC average which is 86.9%
- The 2 week wait performance has not achieved the expected target in any month of the year.
- Indicative performance for April stands at 74.4%

Tumour Update:

- Using validated final data for March, Breast, Testicular and Haematology exceeding the 93% target, haematology for the first time. Indicative figures for April would indicated this position has not continued, with no site meeting the standard
- Consistent pressure in all months for Lower GI, Lung and Upper GI.
- Activity volumes for most tumour sites higher than 19/20 levels, with the exception of some individual months. However no tumour site has consistent not met activity levels for longer periods recently

Risks

- Referral pathway management: pro-forma review, choice delays and timely capacity release
- Capacity / summer holidays and shared pathways (urology/lung)
- Outpatient capacity
- Workforce pressures across tumour groups (lung)

Volumes as a % of 2019/20 Activity	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
Trust (100%)	121%	125%	104%	141%	112%	119%	121%	113%	121%	122%	146%	103%
Breast (100%)	122%	151%	126%	141%	121%	124%	128%	113%	119%	128%	155%	115%
Gynae (100%)	141%	152%	129%	173%	163%	196%	155%	151%	134%	135%	139%	113%
Lower GI (100%)	114%	89%	60%	122%	85%	70%	83%	85%	96%	107%	153%	92%
Testicular (100%)	88%	38%	40%	138%	100%	100%	20%	150%	140%	67%	50%	160%
Urology (100%)	132%	96%	117%	163%	132%	123%	128%	150%	155%	131%	106%	65%
Haematology (100%)	144%	129%	100%	186%	136%	88%	140%	100%	100%	240%	89%	300%
Lung (100%)	138%	108%	63%	156%	89%	153%	175%	113%	224%	157%	208%	117%
Upper GI (100%)	100%	106%	84%	119%	79%	108%	103%	96%	98%	90%	120%	76%
												Indicativ

Cancer Standards – 28 day Faster Diagnosis

Responsive

Trust's 28 day Faster Diagnosis performance:

- Trust has achieved 75% target most months since June 22, only narrowly missing in September at 74.9%
- Latest Trust final figure for March 78.5% continued to exceed the latest national average 74.2% (Mar 23) but slightly below the latest NENC average 79.7% (Mar 23). In February for the first time, both the NENC and national average achieved the 75% target. However in March the England average was below target once again.
- Indicative performance for April stands at 76.0%, a slight fall from 78.5% in March
- This measure will replace the 2 Week wait in future.

Tumour Update:

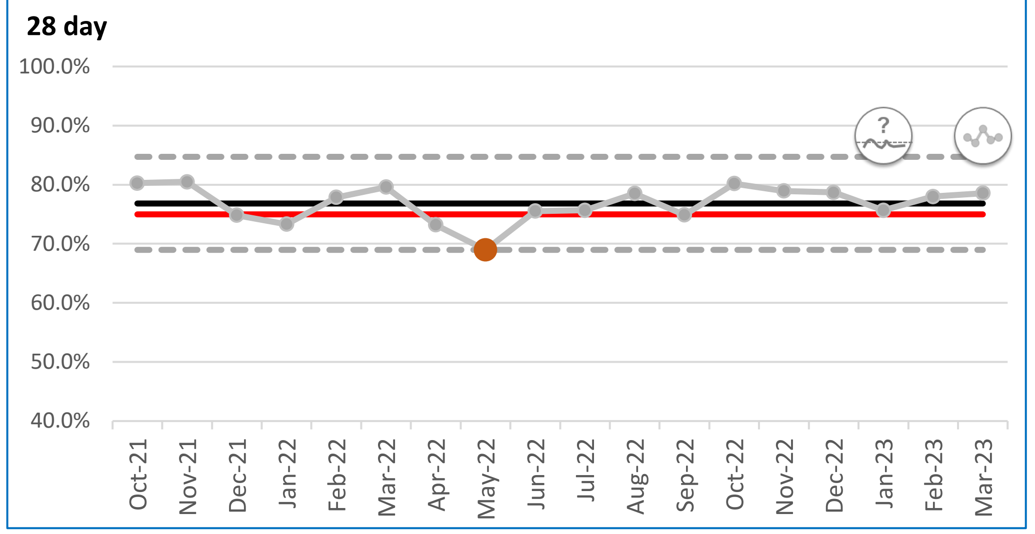
- While Trust wide performance achieves the standard, performance risks continue across most specialties - Particular consistently challenged specialties Gynae, Lower GI, Urology and Upper GI
- Breast and Symptomatic Breast sites exceeding the 75% target in each of the last 12 months
- Testicular and Lung noted month on month improvement between September and January, and have continued to achieve the target consistently
- Lung are the first to go-live with Best Practice Timed Pathways, Implementation of BPTP in the remaining tumour groups is underway

Risks

- Capacity, Endoscopy capacity, Shared pathways, TP biopsy capacity (urology)

NHSI SOF Operational Performance & National Operational Standard

1. No. of patients receiving diagnosis of cancer or ruling out cancer
2. No of patients receiving communication more than 28 days after referral
3. % of patients receiving communication within 28 days of referral (target 75%)

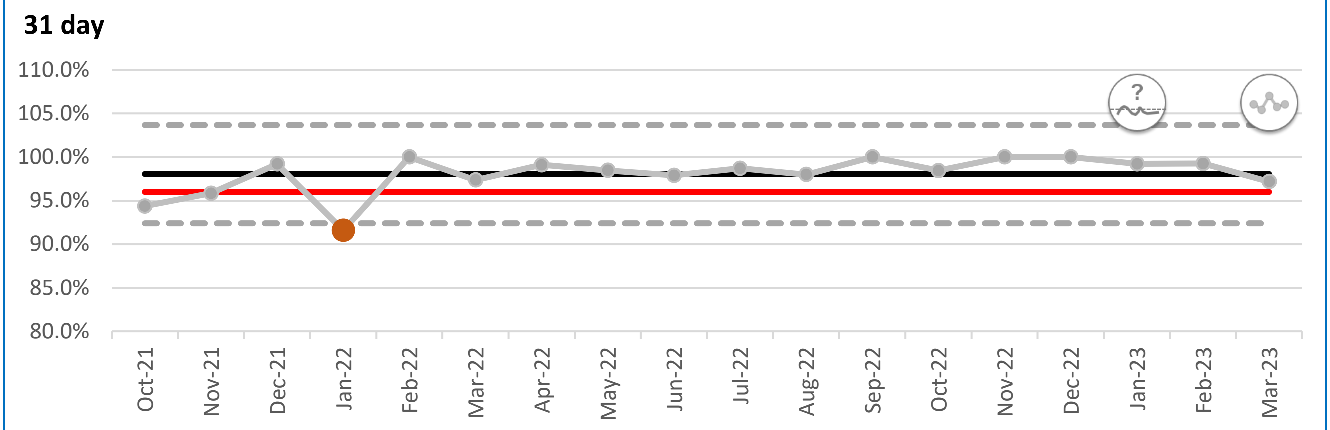


Faster Diagnosis Standard	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	Monthly Trend
Trust (75%)	69.0%	75.5%	75.7%	78.5%	74.9%	80.1%	79.0%	78.6%	75.7%	78.1%	78.5%	76.0%	
Breast (75%)	96.6%	97.0%	97.5%	97.8%	96.9%	95.4%	96.5%	98.1%	94.7%	96.6%	97.5%	97.3%	
Gynae (75%)	46.0%	59.1%	65.0%	69.7%	68.0%	61.7%	50.8%	44.6%	51.0%	49.6%	65.2%	57.1%	
Lower GI (75%)	36.1%	42.7%	44.4%	49.7%	52.3%	54.1%	51.6%	57.7%	38.1%	47.3%	34.4%	30.6%	
Testicular (75%)	100.0%	66.7%	100.0%	100.0%	66.7%	75.0%	100.0%	100.0%	100.0%	75.0%	83.3%	100.0%	
Urology (75%)	27.0%	30.4%	44.4%	50.6%	65.2%	62.4%	64.5%	66.3%	50.6%	67.6%	57.7%	34.5%	
Haematology (75%)	100.0%	87.5%	57.1%	62.5%	68.8%	28.6%	45.5%	71.4%	20.0%	66.7%	60.0%	77.8%	
Lung (75%)	38.1%	74.5%	62.1%	80.8%	53.8%	75.0%	84.1%	67.9%	80.7%	79.0%	85.7%	81.5%	
Upper GI (75%)	51.5%	52.5%	51.2%	53.8%	41.7%	55.6%	52.0%	56.4%	55.7%	54.7%	57.5%	54.9%	
												Indicative	
Symptomatic Breast (75%)	100.0%	100.0%	100.0%	97.5%	100.0%	96.6%	100.0%	95.5%	100.0%	96.0%	97.2%	100.0%	
												Indicative	

Cancer Standards - 31 Day Waits

NHSI SOF Operational Performance & National Operational Standard

1. No. of patients receiving 1st definitive treatment following a cancer diagnosis
2. No, of patients receiving fist definitive treatment more than 1 month pf a decision to treat following a cancer diagnosis
3. % of patients receiving 1st definitive treatment within 1 month of a DTT following a cancer diagnosis > 96%
4. Patients receiving surgery (94%) or drug treatment for cancer within 31 days (98%)



Trust's 31 day cancer performance:

- The Trust continues to exceed the 31 day standard, as it has for more than a year now
- Trust's validated performance for March 97.2% against the 31 Day standard, with both the Surgery subsequent treatment and Drug above target
- 97.2% continues to well exceed the latest national average of 91.9% (Mar 23) and the NENC average 91.7% (Mar 23)
- Aprils indicative position is 98.9% overall a slight increase, with only Haematology failing to meet the standard in April
- Volume of 31 day activity is consistently below 19/20 baselines for all tumour sites for the past 2 months

Tumour Update:

- Typically all tumour sites achieve the standard each month, and in fact exceed the 96% threshold. In some months there are short term fails, for example only Haematology failing to meet the standard in April

Risks

- Capacity / shared pathways, Theatre workforce pressures

31 day performance	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	Monthly Trend
Trust (96%)	99.1%	97.9%	98.7%	98.0%	100.0%	98.5%	100.0%	100.0%	99.2%	99.3%	97.2%	98.9%	
Breast (96%)	100.0%	100.0%	100.0%	98.6%	100.0%	100.0%	100.0%	100.0%	98.2%	100.0%	98.4%	100.0%	
Gynae (96%)	92.6%	90.0%	91.4%	95.5%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	90.6%	100.0%	
Lower GI (96%)	100.0%	100.0%	100.0%	91.7%	100.0%	88.2%	100.0%	100.0%	100.0%	90.0%	100.0%	100.0%	
Urology (96%)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Haematology (96%)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	80.0%	
Lung (96%)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	NA	100.0%	100.0%	
Upper GI (96%)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
												Indicative	
Surgery (94%)	100.0%	100.0%	93.8%	100.0%	96.4%	97.1%	100.0%	100.0%	95.5%	100.0%	100.0%	95.5%	
Drug (98%)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
												Indicative	

Volumes as a % of 2019/20 Activity	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
Trust (100%)	100.8%	124.3%	106.9%	119.2%	100.8%	87.7%	125.4%	103.3%	95.5%	141.9%	65.2%	62.0%
Breast (100%)	94.0%	126.8%	113.7%	147.9%	89.8%	82.8%	125.9%	101.7%	100.0%	190.6%	76.7%	61.0%
Gynae (100%)	112.5%	116.7%	100.0%	78.6%	91.7%	96.3%	147.4%	133.3%	129.4%	100.0%	92.0%	44.0%
Lower GI (100%)	55.6%	115.4%	114.3%	92.3%	107.1%	94.1%	125.0%	122.2%	45.0%	88.9%	18.2%	86.0%
Urology (100%)	190.9%	158.3%	138.5%	175.0%	160.0%	200.0%	233.3%	216.7%	111.8%	166.7%	75.0%	189.0%
Haematology (100%)	85.7%	66.7%	66.7%	80.0%	71.4%	100.0%	180.0%	166.7%	80.0%	225.0%	38.5%	29.0%
Lung (100%)	140.0%	141.7%	87.5%	50.0%	91.7%	50.0%	92.3%	13.3%	42.9%	70.0%	50.0%	53.0%
Upper GI (100%)	50.0%	166.7%	116.7%	333.3%	300.0%	40.0%	27.3%	116.7%	225.0%	166.7%	42.9%	11.0%
												Indicative

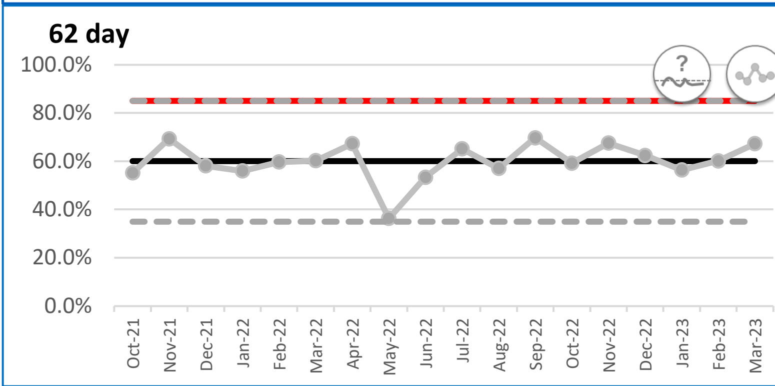
Cancer Standards - 62 Day Waits

Trust's 62 day cancer performance

- Final performance for March at 65.2% was slightly above the latest national average 63.5% (Mar 23) and NENC average 63.9% (Mar 23).
- Performance has improved in April (indicative) to 69.9%
- **The Trust reported 64 patients waiting over 62 days on a 2ww classic pathway (8.8% of the total waiters on a 62 day 2ww classic pathway) (89 on all pathways, 9.7% of total waiters)).**
- Within the operational guidance 'Systems are being asked to plan to restore >62-day backlogs to the relative backlog using urgent suspected cancer referral volumes seen in Q3 2019/20 compared to the overall national backlog for the w/e 16th February'; for Gateshead this was a position of 55 however due to the pressures supporting the ICS the Trust submitted a plan of 65 at April 2023, reporting 64 for the month, **the plan has been met**.
- The number of long waits (>104 days) on a 62 day (2ww) pathway at the end of April had increased to 11 patients (1.5% of total waiters on a 62 day 2ww classic pathway) (18 on all pathways, 2.0% of total waiters).

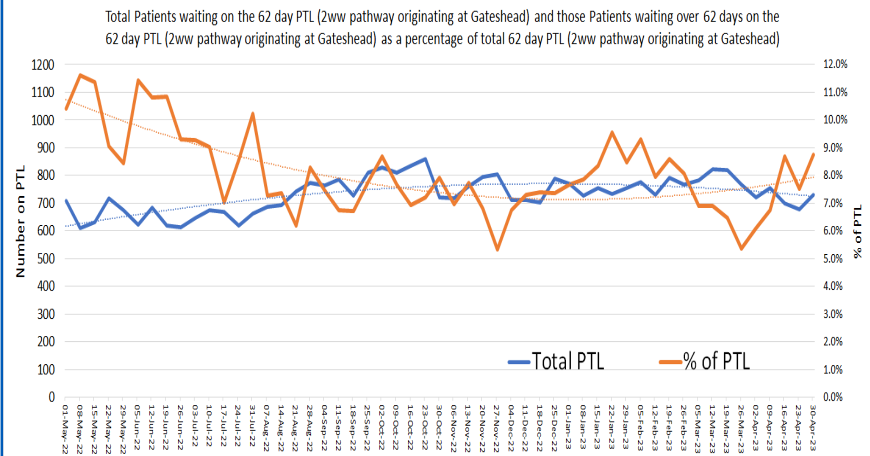
Tumour Update:

- Performance Risks across the majority of specialties to achieve 85%. Monthly positions are variable but consistently challenged specialties continue to be Gynae, Lower GI, Urology, with challenges noted consistently in Lung since December and Upper Gi since January 23.



NHSI SOF Operational Performance & National Operational Standard

1. No. of patients receiving 1st definitive treatment for cancer following an urgent referral for suspected cancer/NHS Screening/Consultant upgrade
2. No of patients receiving 1st definitive treatment for cancer 62 days or more following an urgent GP referral for suspected cancer/NHS Screening/Consultant upgrade
3. % of patients receiving 1st definitive treatment for cancer within 62 days following an urgent GP referral for suspected cancer (target 85%)
4. No. of patients receiving 1st definitive treatment 104 days or more



62 day performance	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	Monthly Trend
Trust (85%)	34.5%	53.6%	63.2%	56.7%	70.5%	58.2%	67.1%	60.4%	53.5%	62.6%	65.2%	69.9%	
Breast (85%)	91.7%	81.1%	96.6%	78.7%	85.7%	81.1%	80.0%	76.0%	73.7%	93.2%	94.1%	100.0%	
Gynae (85%)	4.2%	20.0%	54.2%	50.0%	53.8%	36.8%	52.4%	58.8%	31.3%	27.8%	56.3%	70.0%	
Lower GI (85%)	0.0%	53.3%	16.7%	50.0%	46.2%	40.0%	20.0%	0.0%	33.3%	66.7%	40.0%	66.7%	
Urology (85%)	20.0%	22.2%	21.4%	32.6%	53.3%	45.8%	62.2%	34.8%	42.1%	25.0%	15.4%	57.1%	
Haematology (85%)	66.7%	75.0%	NA	100.0%	0.0%	57.1%	90.9%	NA	100.0%	60.0%	100.0%	50.0%	
Lung (85%)	30.0%	40.0%	42.9%	61.5%	88.2%	80.0%	85.7%	60.0%	66.7%	0.0%	55.0%	50.0%	
Sarcoma (85%)	NA	100.0%	0.0%	NA	NA	0.0%	0.0%	NA	NA	NA	NA	NA	
Upper GI (85%)	NA	100.0%	57.1%	0.0%	60.0%	66.7%	0.0%	100.0%	28.6%	25.0%	28.6%	0.0%	
Other (85%)	NA	100.0%	100.0%	100.0%	100.0%	100.0%	NA	0.0%	100.0%	42.9%	NA	NA	

Indicative

Patients waiting >62 days against plan

	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
Actual number >62 day patients	57	59	67	64	72	57	43	59	64	62	44	64

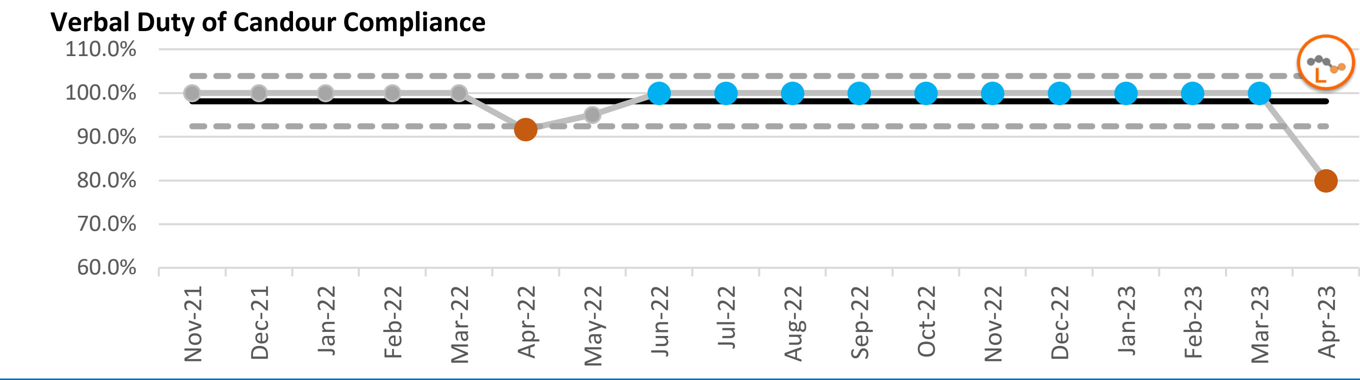
Planned number >62 day patients

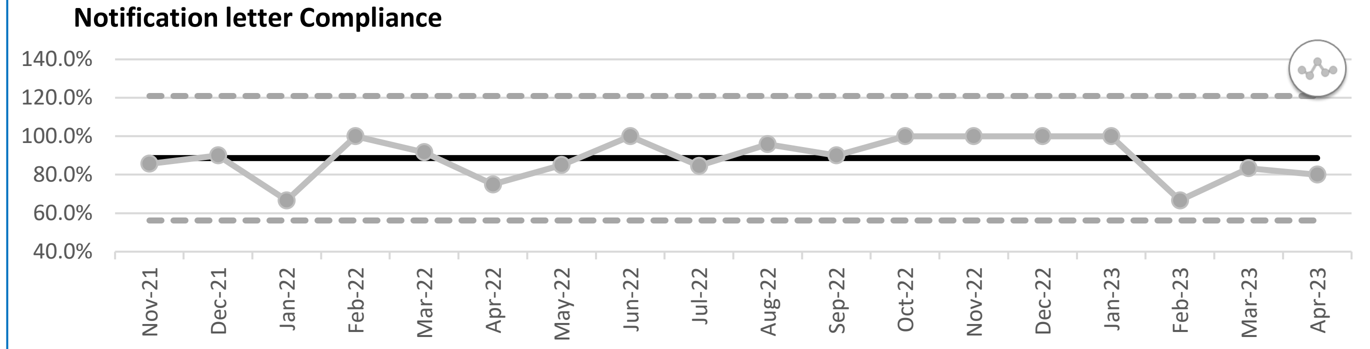
Cancer - Patients waiting more than 62 days

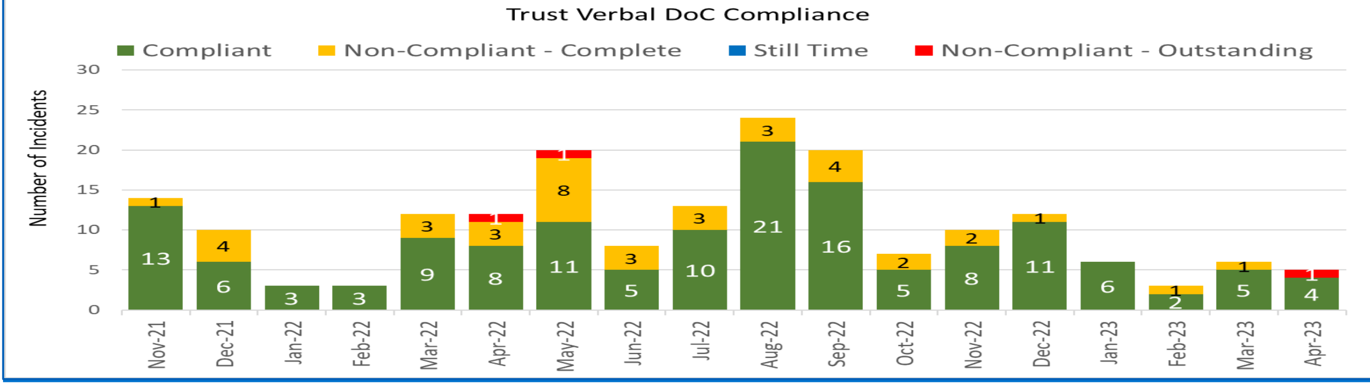
63 to 104 days	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr
Breast	2	1	7	4	2	4	2	3	4	3	2	2
Gynaecology	4	11	5	11	17	14	12	17	18	9	5	13
Haematology	4	1	3	0	2	2	1	0	0	0	1	1
Lower Gastrointestinal	3	6	6	8	12	3	5	7	5	11	10	9
Lung	6	1	3	4	2	8	5	4	6	2	3	3
Upper Gastrointestinal	8	6	11	16	12	9	5	8	7	12	10	14
Urological	17	26	15	12	11	6	4	8	12	15	6	11
Other	1	0	0	0	0	0	0	1	0	1	0	0
63 to 104 days total	45	52	50	55	58	46	34	48	52	53	37	53
Over 104 days	**May**	**June**	**July**	**July**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**
Breast	1	0	0	1	1	0	0	0	0	0	0	0
Gynaecology	3	1	3	1	4	3	3	2	3	3	0	1
Haematology	2	0	1	0	0	1	0	1	0	0	0	0
Lower Gastrointestinal	1	0	1	1	1	3	1	2	5	2	2	5
Lung	1	1	1	1	1	0	3	0	1	1	0	0
Upper Gastrointestinal	0	1	1	4	7	1	1	4	2	1	2	2
Urological	3	3	9	1	0	3	1	2	1	2	3	2
Other	1	1	1	0	0	0	0	0	0	0	0	1
Over 104 day total	12	7	17	9	14	11	9	11	12	9	7	11

Report by exception: Responsive – Duty of Candour Compliance

Detail on this measure is included as special cause variation (low) is identified in December 2022







Situation

- Verbal Duty of Candour compliance is special common causevariation for concern for April 2023
- Notification letter compliance is displaying common cause variation for April 2023

Background

- Duty of Candour (DoC) is governed by the Health and Social Care act 2008 (Regulated Activities) Regulations 2014: Regulation 20.
- Verbal Duty of Candour (stage 1): Regulation 20 and underpinning statute, stipulates that an individual (or other appropriate person) must be notified “as soon as reasonably practicable” after a notifiable patient safety incident has occurred. Notifiable is further defined as requiring three criteria to be met in the reasonable opinion of a health care professional. Once determined as notifiable, the enactment should occur verbally within 10 working days. Current Trust processes for DoC require review to ensure consistent compliance with defining notifiable patient safety incidents, as within the current process there is potential for enacting DoC on non-notifiable incidents which should be managed under ‘Being Open’ professional duty only.

Assessment

- Duty of Candour depicted here shows compliance with the DoC section completion in the DATIX system. Compliance with the 10 day timeframe for verbal DoC is be 80%. This dip in compliance related to a case being opened from a complaint and Doc should have been enacted by 12.5.2023- this has been followed up.
- Similarly, in relation to compliance for Notification letters, with four letters outstanding from the last quarter. These letters have been followed up by the legal team with the incident handlers.

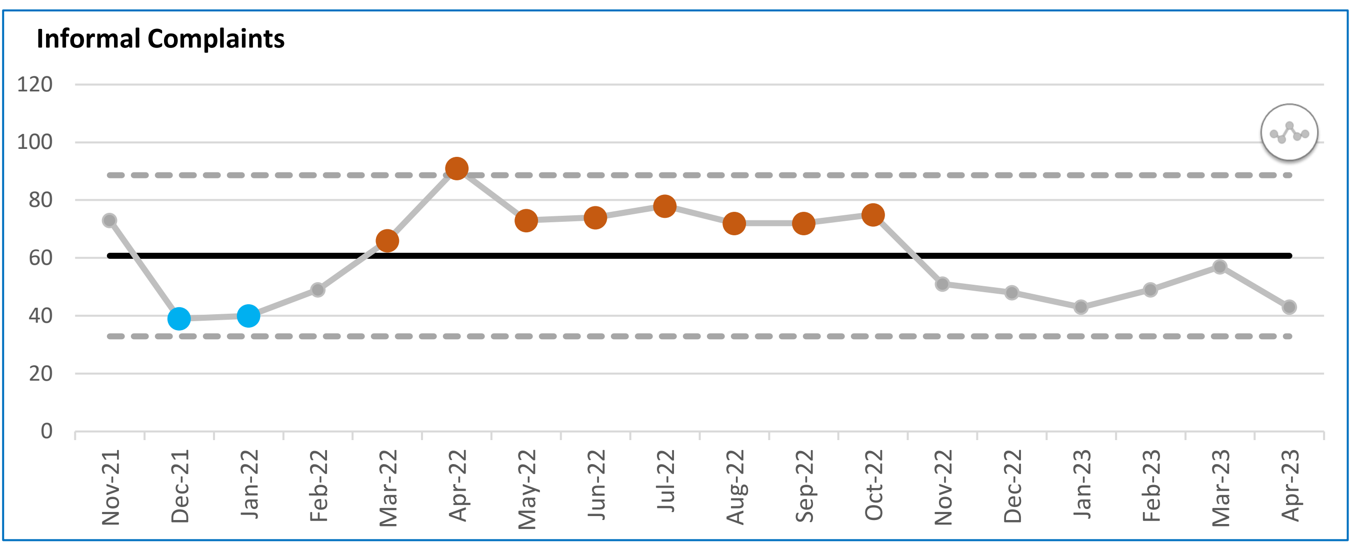
Actions

- The DoC allocation responsibility within the DATIX system often sits with Matrons and SLM’s and not the attending clinicians or those involved with the incident.
- There are some identified themes in relation to the overdue notifications which are being addressed.

Report by exception: Informal Complaints

This indicator is included as a request for thematic analysis of complaints in recent months

Responsive



Analysis:
Even though slightly increasing in the past couple of months, the number of informal complaints continues to achieve common cause variation and is below numbers seen earlier in the year. Analysis of recent informal complaints (November 2022 to January 2023 baseline) and Feb-Apr 23 highlights the two main subjects for complaints are *Communication* and *facilities* mostly linked to Car parking issues. The tables (right) provide a breakdown of the most common issues for both themes, for the previous quarter and latest there months to identify if issues remain consistent.

Communication complaints - The is no patten observed regarding specially / location for poor communication. Telephone waits feature the highest in ENT / Audiology but numbers are generally quite low. Postponed, cancelled, or delays in treatments, patient property, and Staff behaviours also stand out but again numbers individually are small for each category.

Facilities complaints - Car parking issues continue to be the most significant issue, however the number of these type of complaints halved in April compared with March. Complaints relating to parking charge notices have reduced to 0 in the past 2 months, complaints around inconsiderate parking in the local neighbourhood continue to be received with 2 in April, 5 in total between February and April.

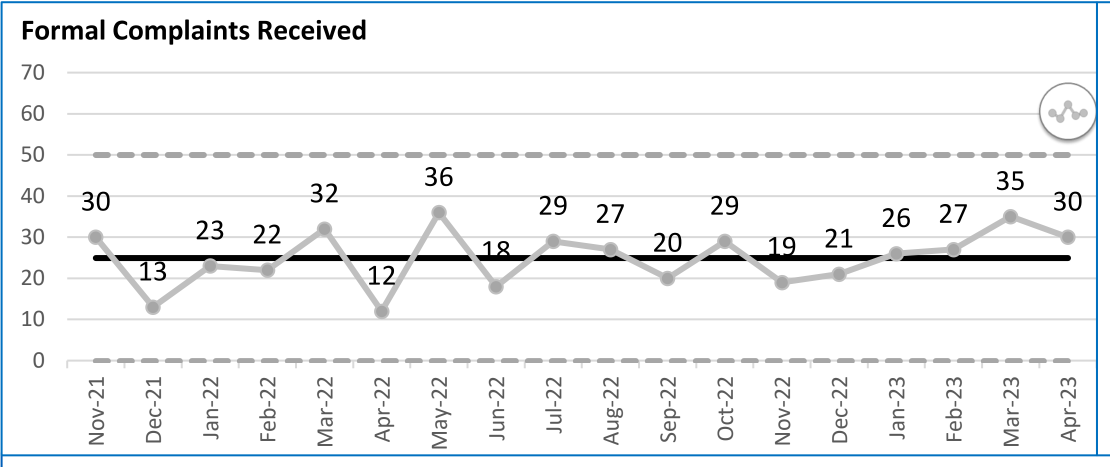
Communications complaints by volume	Nov22 to Jan23	Feb-23	Mar-23	Apr-23
Electronic - Length of wait (telephone)	15	4	4	7
Verbal - Poor communication	14	5	6	6
Written - Incorrect information	4	3		2
Written - Poor communication	4	3	2	3
Verbal - Delay in diagnosis	3			
Verbal - Poor staff attitude	2	1		
Written - Breach of confidentiality	2			
Verbal - Premature discharge	1			
Written - Poor / incorrect signposting	1			
Verbal - Incorrect diagnosis	1			
Verbal - Delay in Treatment	1	2	2	
Electronic - Poor communication	1			
General - Interpreter not available	1	1	1	
Verbal - Lack of community service communications	1			
Verbal - Misunderstanding	1			
Verbal - proceedure / process error	0		1	
General - Lost Mail				1
Grand Total	**52**	**19**	**16**	**19**

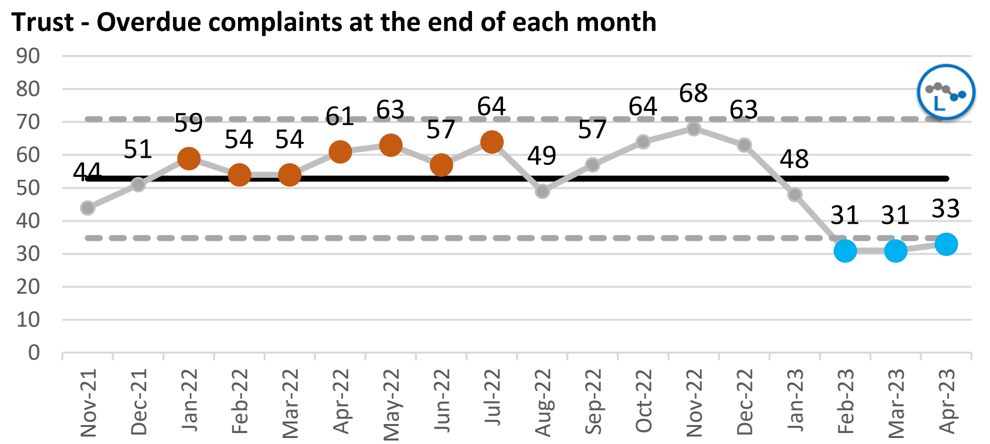
Facilities complaints by volume	Nov22 to Jan23	Feb-23	Mar-23	Apr-23
General - Car parking	15	1	4	
Car Parking - Parking Charge Notice (PCN)	8	7		
Car parking - Issues with blue badge registration	5		1	1
Car parking - inconsiderate parking (neighbourhood)		2	1	2
Lack of resources - No ward bed (Not ITU/CCU/HDU)	1			
Facilities - Incomplete maintenance works	1			
General - Lack of adequate facilities/equiptment		1		
Grand Total	**30**	**11**	**6**	**3**

Report by exception: Formal Complaints

This indicator is included as a request for thematic analysis of complaints in recent months

Responsive





Analysis:

Having increased month on month since November 22, the number of formal complaints received fell in April to 30, from 35 in March. The number of overdue complaints at the end of March is triggering special cause for improvement, and has more than halved since the high of November, however there was a slight increase to 33 in April from 31 in March. Analysis of recent formal complaints received between November 2022 to March April continues to highlight two main subjects as below:

- **Verbal complaints -** All formal complaints relating to communication were listed as issues with verbal communication. UEC teams received the most complaints (important to note they also deal with the largest volume of patients). However the graphic (bottom right) shows that verbal communication complaints were spread across a range of areas of the hospital.
- **Clinical Treatment complaints - Actions not carried out complaints are the largest category and** also featured strongly again with UEC receiving the highest number of complaints. These complaints tend to link to people's perceptions that something should have taken place such as an x-ray and links back to communications around rationales for care plans. The graphic (top right) also shows that other clinical Treatment complaints were spread in small numbers across a range of areas of the hospital.

Friends and family test results - identify the following themes for patients whose experience was rated as 'Poor' or Very Poor'

- Long waits
- Staff attitude
- Business of staff and perceived lack of attention and responsiveness to the needs of the patient

Overdue Complaints

There were 33 overdue complaints remaining open at the end of April, 18 were within the Surgery Business Unit, 13 Medicine Business Unit. The remaining 2 were 1 in CSS and 1 in QEF Facilities out patient Pharmacy.

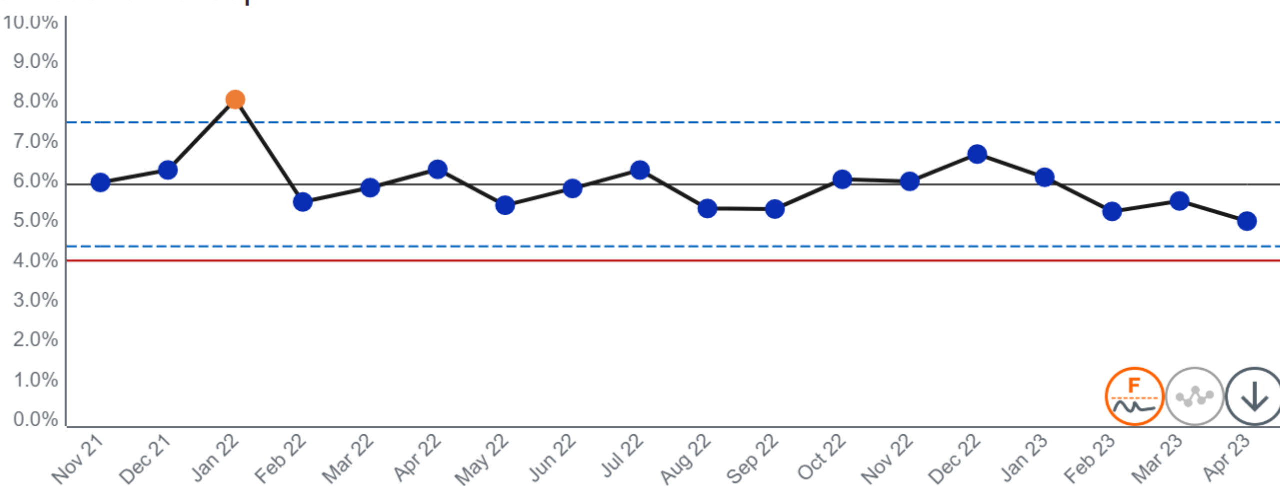
Clinical Treatment Complaints - by location (Nov-22 to Apr 23)

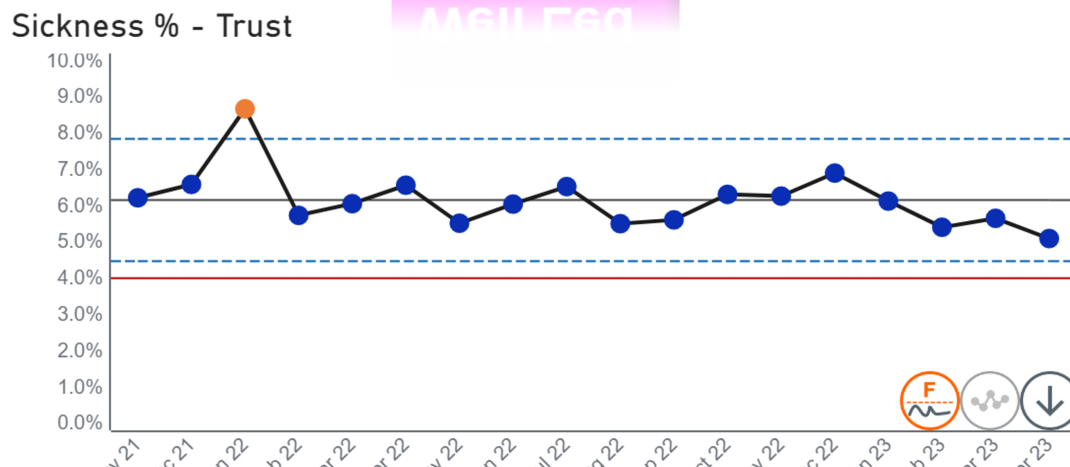
	Accident and Emergency	Same Day Emergency Care (SDEC)	Ward 2 - EAU	Ward 8 (Cardiology)	Ward 9 (Respiratory)	Ward 10 (Respiratory)	Ward 11 (Gastroenterology)	Ward 12	Ward 14a (Trauma and Orthodpeadics)	Ward 21 Escalation	Ward 22 (Care of the Elderly)	Ward 23 (Care of the Elderly)	Ward 25 (Care of the Elderly)	T27 (General Surgery)	Trauman and Orthopedics	Blaydon Urgent Treatment Centre	Gastroentorlogy - No specific Dept	General Surgery	Gynaecology	Delivery Suite (Maternity)	Cardiology (Specialty of) - No specific dept	CT (Radiology)	Obstetrics	Paediatrics (outpatient)	PeaPod (Paediatric Emergency Assessment)	PIU Day Unit	Grand Total
Actions - Actions not carried out	23	2	1													1			1	1			1	1	2		33
General - Inadequate/Inappropriate nursing care			1		1	2	4	2	1	1	2	1	2	4												1	22
General - Inadequate/Inappropriate medical care				1	1	1								1	3		1	1	1		3	1			1		15
Total	23	2	2	1	2	3	4	2	1	1	2	1	2	5	3	1	1	1	2	1	3	1	1	1	3	1	70

Verbal Complaints - by location (Nov-22 to Apr 23)

	Accident and Emergency	Same Day Emergency Care (SDEC)	Emergency Admissions Unit	Ward 1 - Emergency Admission Unit	Ward 9 (Respiratory)	Ward 12	Ward 14a (Trauma and Orthopaedics)	T27 (General Surgery)	General Surgery (Medical)	Gastroentorology	Pain Clinic	Children's Community Nursing	Breast Screening	Discharge Liason Team	Pregnancy Assesment Unit	Outpatients	Community Stroke	Grand Total
Grand Total	5	1	1	1	1	1	2	1	2	1	1	1	2	1	1	2	1	25

Sickness Absence



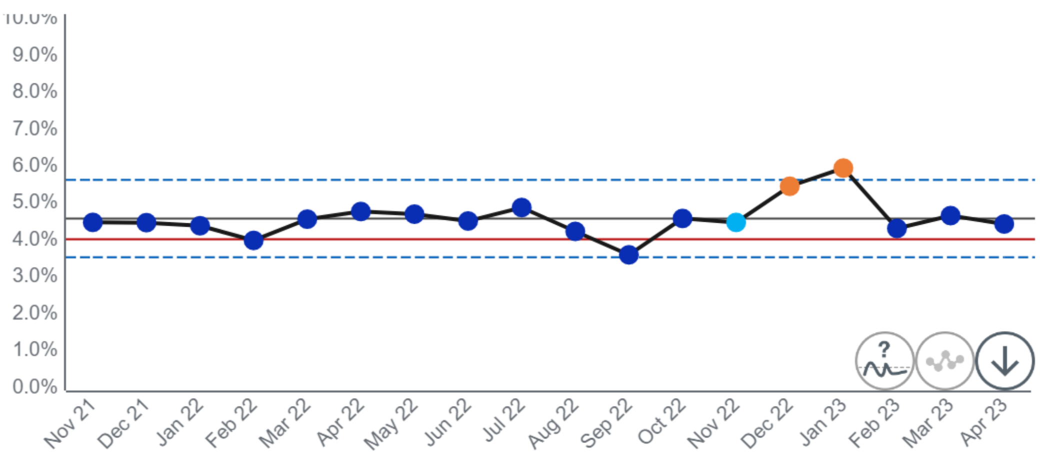


What is the data telling us?

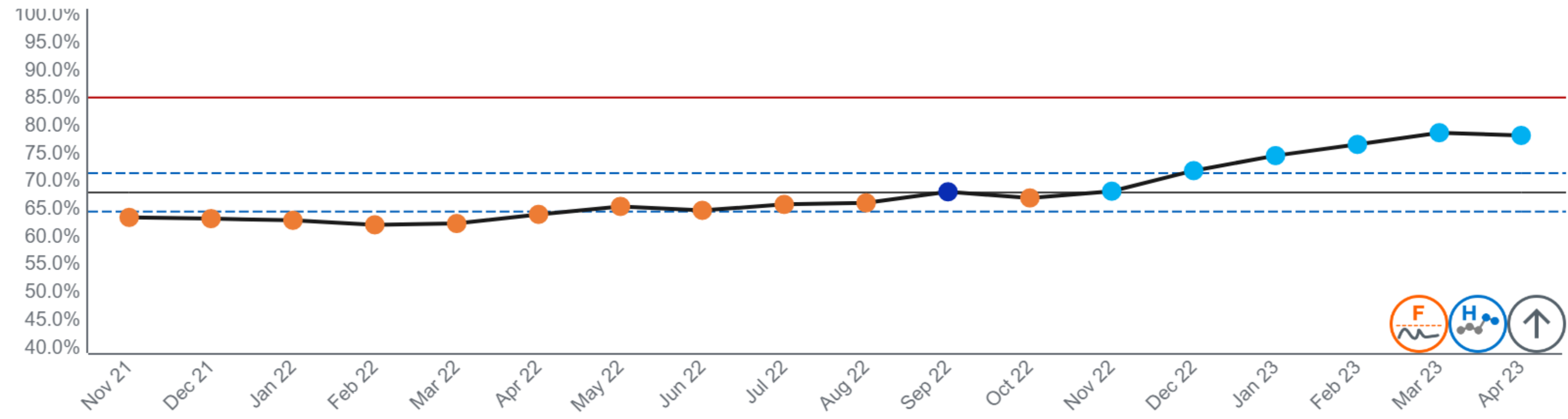
- The data continues to show a reduction in absence rates across the Group, Trust and QEF achieving the Trust Target of 5%

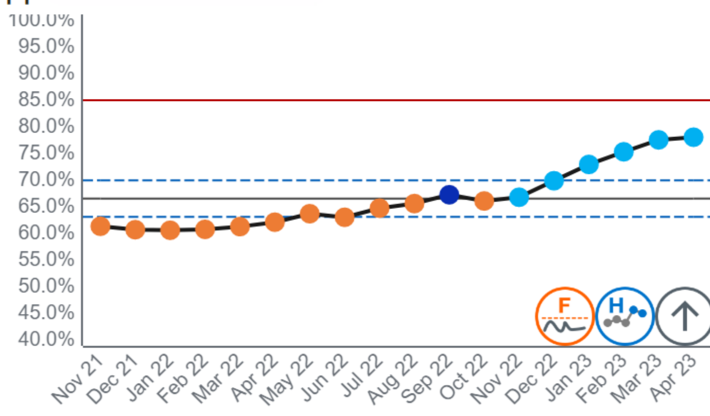
What is our plan and expected impact?

- The collective approach to managing absence continues with positive reductions in absence variances across the Business Units.
- The focused piece of work on Absence Management was measured from 1st November 2022 – 31st January 2023 and reviewed in February/March 2023. There was a collective approach from the management teams of the Business Units and POD. The absence management work continues and an impact review of the collective approach was presented at SMT on the 16th March 2023. This report was well received and supported by our SMT. It was agreed to have a further 6 month focus on Absence Management.
- Monthly sickness absence reporting continues and is shared with the Business Units. POD are continuing to support managers to engage with the refocused collective leadership approach.
- Monthly LTS clinics within the Business Units are now set up for a 12 month period and working successfully. The Trust SMT continue to fully support the new approach to absence management.
- Professional Absence Management training continues to be provided by Capsticks we have training sessions for our managers are to be commissioned for the new financial year.
- The bespoke training session for our SLM's, Matrons and Business Managers has now been delivered and a further session is to be agreed.



Appraisals



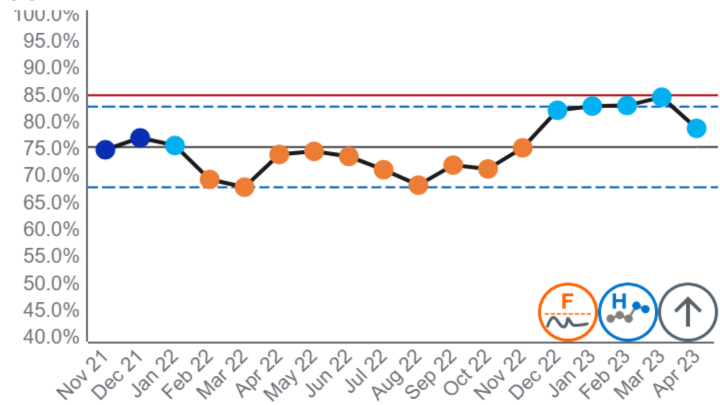


What is the data telling us?

- The target of 85% is consistently not being achieved. The data shows that there has been a slight decrease to 78.2% for the group. There has been a sustained improvement since May 2022 prior this slight decrease. The Trust has seen increases in compliance this month with the trust sitting at 78.1% however QEF has decreased by 5.8% to 78.8% which has impacted the group position.
- There remain a number of areas of concern, with varying numbers of staff requiring an appraisal. There are areas of concern with regards to appraisal compliance, and a new way of inputting into ESR has been launched which will support managers.

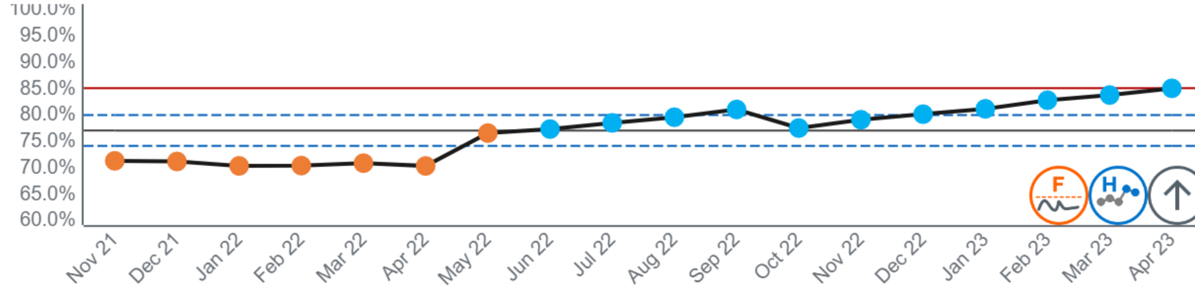
What is our plan and expected impact?

- The People and OD (POD) Leads are working with each business unit, directorates and teams to identify actions required to reach the required compliance levels. Additional training is being provided in areas as requested, for new appraisers and refresher training to ensure people are comfortable with the current process. The quarterly oversight reviews are making sure that appraisal compliance remains high on the agenda, and our colleagues in POD are supporting in any way possible.
- The teams in POD have supported with inputting appraisals in areas requesting support to ensure we have the most accurate data possible, and the new manager portal which links directly with ESR will make this process much simpler for managers. The matrix teams are working with the business units to ensure all appraisals are booked in.
- Group appraisal has been scoped with a process available however there has been limited uptake so far. Support is available as and when people want to explore this option.

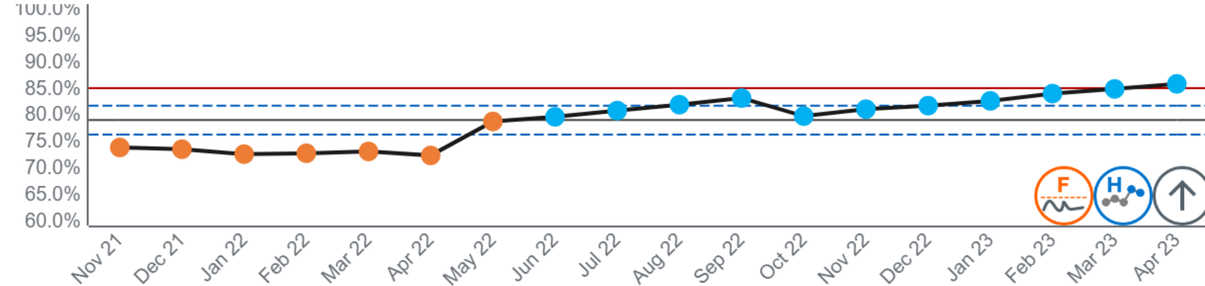


Core Training

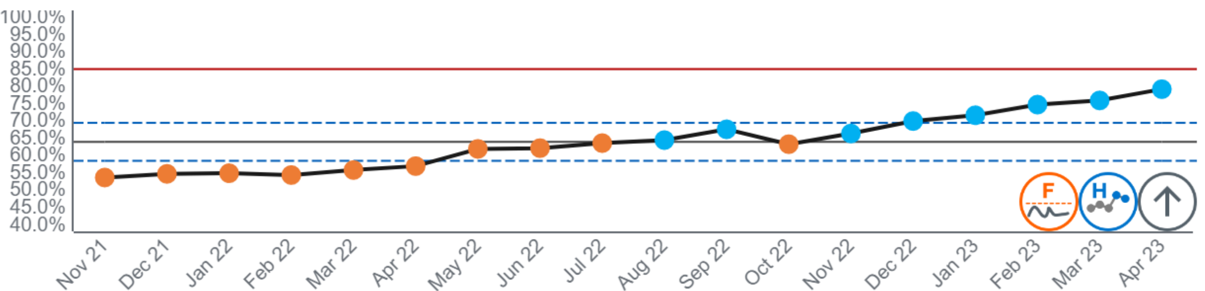
Core Skills % - Group



Core Skills % - Trust



Core Skills % - QEF



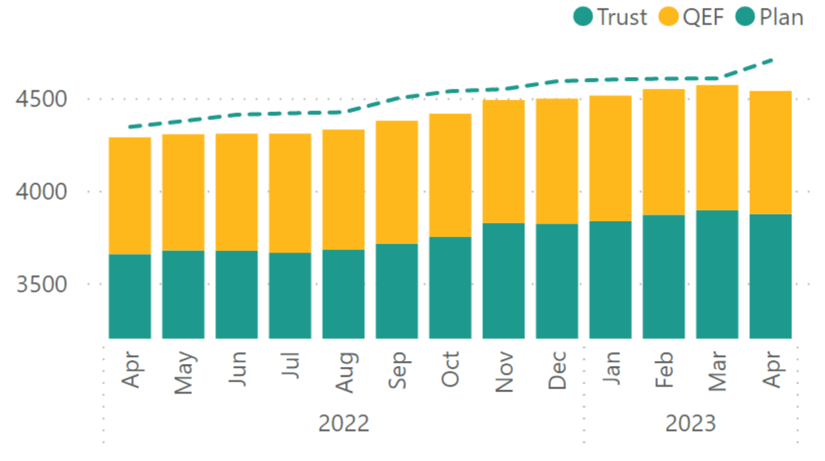
What is the data telling us?

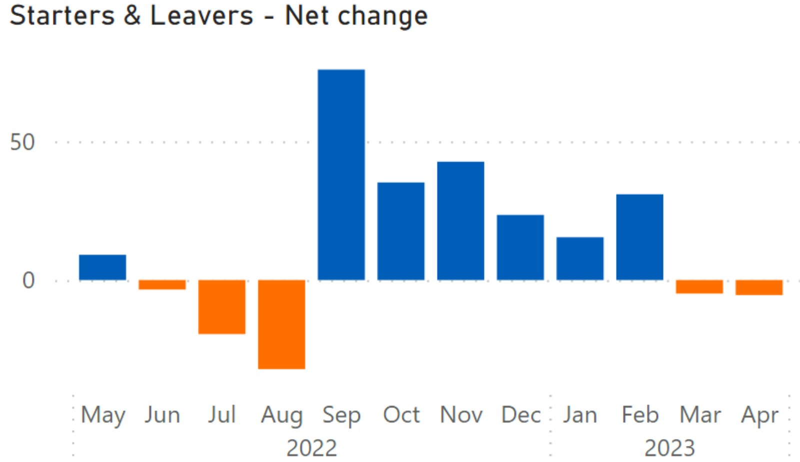
- Another increase in compliance with a whole group compliance figure of 85% against an 85% target, meaning the target has been met for the first time.
- QEF currently have a compliance level of 79.2% against the 85% target, which is a further 5% increase on the last metrics report. Managers are aware that significant work is required to improve that position, however this is another positive improvement since the last report. The additional space for QEF staff for training is available and this continues to see an increase compliance.
- The Trust has increased to 85.8 against an 85% target, meaning the target has been met for the first time
- The topics that remain under compliance targets and provide a level of risk are-Moving and handling level 2, Level 2 and 3 PMVA, Safeguarding level 3 topics and Information Governance. Work on-going with the SME's for these topics to increase compliance. These remain a risk within the overall compliance target.
- PMVA training will remain a risk until further staff have completed the training. Dates have now been made available and staff are booking on to attend so there should continue to be sustained increases in compliance with this topic. Work is on-going through the violence and aggression task and finish group to manage mapping of these topics.

What is our plan and expected impact?

- Core skills compliance has been discussed at SMT, escalated to Executive Team and discussed at recent oversight meetings with business units. The addition of a couple of the topics will see an initial reduction in overall compliance, until the staff complete the training.
- Reporting has altered to ensure business units receive detailed information about their areas of concern, with all core and position topics being reported by business unit and SLM. This will also flow through SMT on a monthly basis to ensure visibility of the topics at risk.
- A full remap of core skills will be undertaken with professional leads and subject matter experts to ensure appropriate mapping. Additional topics are also being considered due to national statutory mandates.
- If Information Governance training does not meet the required standard, there is a risk the Trust will fail the Information Governance Toolkit. The Information Governance team provide regular training sessions, and reminders for staff with regards to completing their training. Training is also available as soon as people join the organisation and can be completed prior to their attendance at corporate induction.

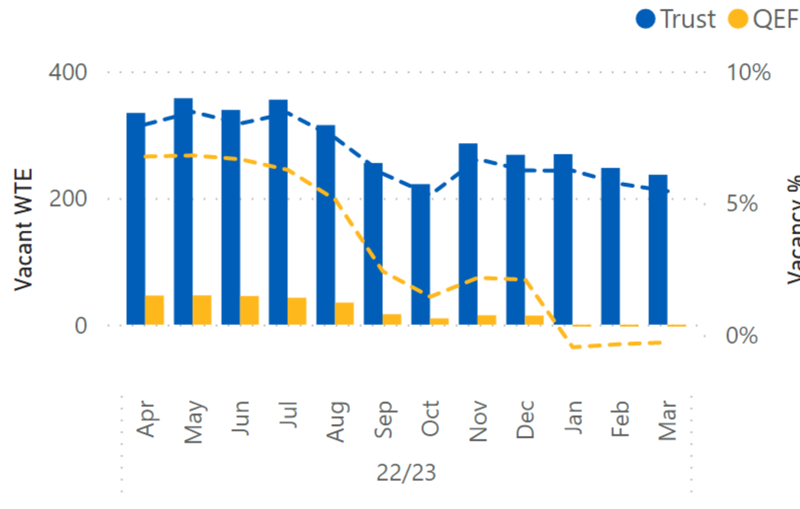
SIP, Vacancies

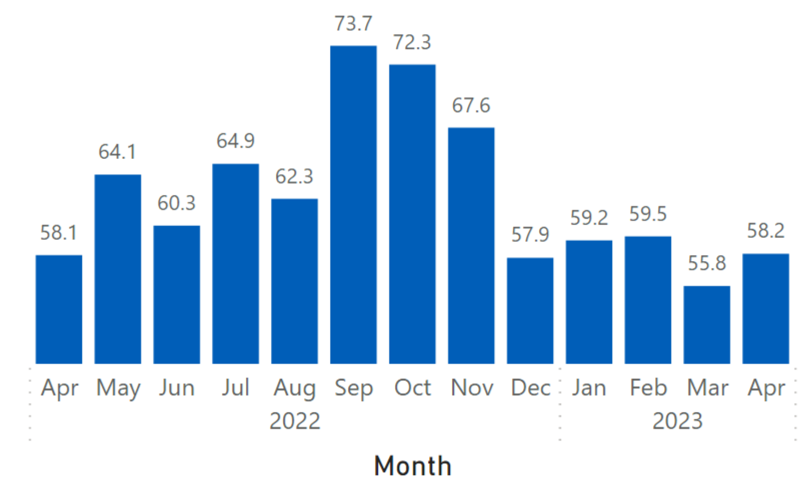




What is the data telling us?

- The Time to hire metric used by the Trust is Advertising Start Date to Starting Letter (T19 report). The time to hire metric continues to show a decreasing trend since September 2022 although has increased slightly in April. The data covers all posts that are being processed by the recruitment team, including Medical posts, Non-medical posts, Volunteers and Bank staff. The only staff not included in the data are those who have been recruited by Yeovil Hospital. There has been increased activity in Medical recruitment which has impacted on the overall time to hire metric.



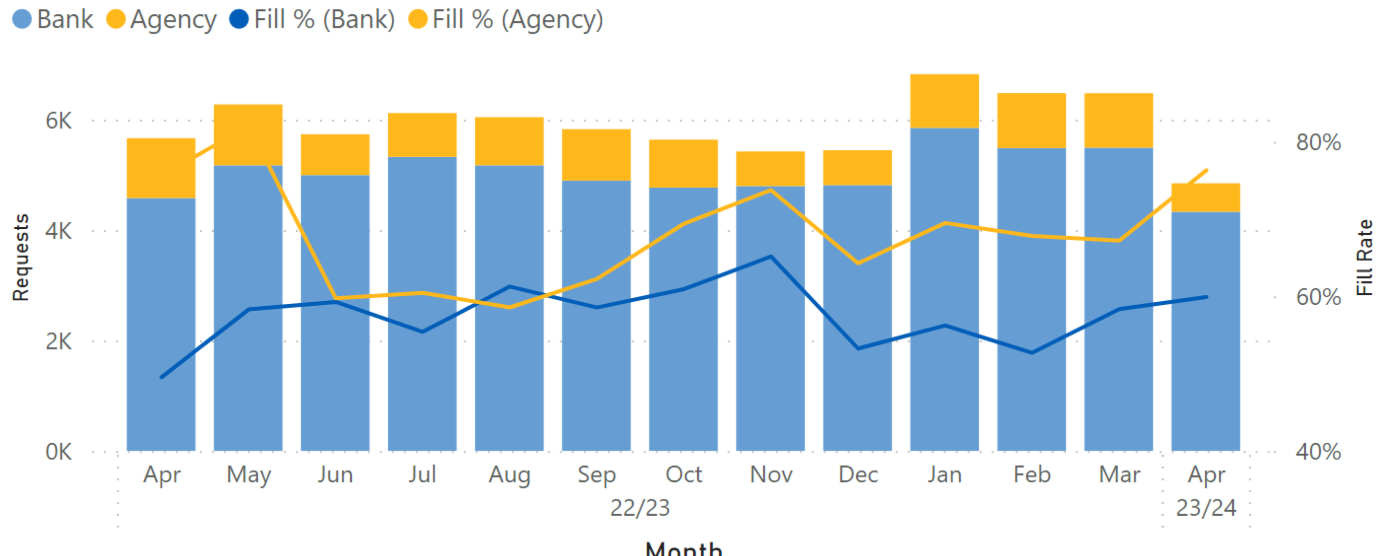


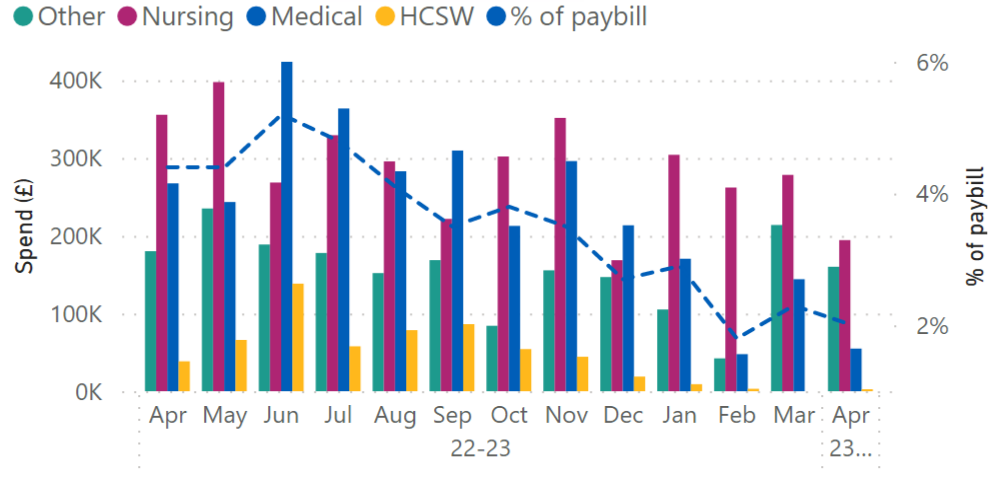
What is our plan and expected impact?

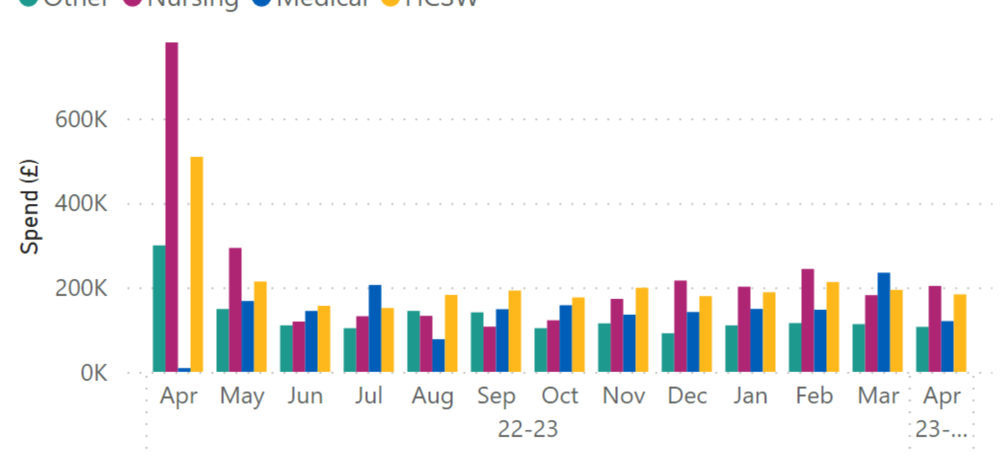
- Given the variety of posts included, there are factors that can impact on this metric for various roles. For example, Medical posts are advertised for 4 weeks, which is longer than non-medical posts which typically are advertised for 1-2 weeks. This metric does not include the time taken to authorise the vacancies on Trac, nor does it include the time from starting letter (Checks complete) to when someone starts employment with the Trust.
- The Recruitment performance is monitored weekly by the Head of People Services and the Recruitment Manager. The performance metrics are then shared fortnightly with our SMT for information. We aim to reduce our time to hire metric and keep focused on this vision.

NOTE: Due to timing of committee and subsequent report deadlines, budget/establishment information is not available in time to produce vacant WTE & Vacancy % figure and supporting narrative for April to include in this page.

Agency and Bank Spend







What is the data telling us? *Bank requests include all requests via Health Roster

- Total Agency spend continues to demonstrate a reduction since peak spend in June 22. There is a noticeable reduction of Medical and Nursing agency spend in April 23. Total bank spend has remained relatively consistent since May 22 for all workforce groups included.

What is our plan and expected impact?

- Ongoing agency control procedures remain in place, requiring divisional manager sign off for all agency shifts and escalation for 'break glass' requirements. Clinical work is ongoing to work with 'hotspot' areas demonstrating increased bank and agency spend on effective rostering practice. The intended impact of this work is to reduce unrequired nursing agency use.

Report Cover Sheet Agenda Item: 15i

<table>
<tr><td>Report Title:</td><td colspan="4">Nursing Staffing Exception Report</td></tr>
<tr><td>Name of Meeting:</td><td colspan="4">Board of Directors in Public</td></tr>
<tr><td>Date of Meeting:</td><td colspan="4">24th May 2023</td></tr>
<tr><td>Author:</td><td colspan="4">Andrew Rayner, Deputy Chief Nurse
Laura Edgar, People Data and Information Lead</td></tr>
<tr><td>Executive Sponsor:</td><td colspan="4">Gillian Findley, Chief Nurse and Professional Lead for Midwifery and AHP’s</td></tr>
<tr><td>Report presented by:</td><td colspan="4">Gillian Findley, Chief Nurse and Professional Lead for Midwifery and AHP’s</td></tr>
<tr><td rowspan="2">Purpose of Report
Briefly describe why this report is being presented at this meeting</td><td>Decision:
☐</td><td>Discussion:
☐</td><td>Assurance:
☒</td><td>Information:
☒</td></tr>
<tr><td colspan="4">This report is to provide assurance to the Board that staffing establishments are being monitored on a shift-to-shift basis.</td></tr>
<tr><td>Proposed level of assurance – <u>to be completed by paper sponsor</u>:</td><td>Fully assured
☐
No gaps in assurance</td><td>Partially assured
☐
Some gaps identified</td><td>Not assured
☐
Significant assurance gaps</td><td>Not applicable
☐</td></tr>
<tr><td>Paper previously considered by:
State where this paper (or a version of it) has been considered prior to this point if applicable</td><td colspan="4"></td></tr>
<tr><td>Key issues:
Briefly outline what the top 3-5 key points are from the paper in bullet point format

Consider key implications e.g.
• Finance
• Patient outcomes / experience
• Quality and safety
• People and organisational development
• Governance and legal
• Equality, diversity and inclusion</td><td colspan="4">This report provides information relating to ward staffing levels (funded against actual) and details of the actions taken to address any shortfalls within the month of April 2023.

April continued with ongoing staffing challenges relating to vacancies and short term sickness absence. Within April we continued to experience periods of increased patient activity with surge pressure resulting in escalation areas alongside managing delays in transfers of care. This has impacted on staffing resource and the clinical operating model, which is supportive of maintaining elective recovery. There is continued focused work around the recruitment and retention of staff and managing staff attendance.

Wards where staffing fell below 75% of the funded establishment are shown within the paper. Detailed context and actions taken to mitigate risk are documented. A staffing escalation protocol is now in operation across all areas within the organisation and</td></tr>
</table>

<table>
<tr><td></td><td colspan="5">assurance of this operating as expected, is provided by the number of staffing incident reports raised through the incident reporting system.</td></tr>
<tr><td>Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper</td><td colspan="5">The Board are asked to:
• receive the report for assurance
• note the work being undertaken to address the shortfalls in staffing</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:</td><td>Aim 1 ☒</td><td colspan="4">We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>Aim 2 ☒</td><td colspan="4">We will be a great organisation with a highly engaged workforce</td></tr>
<tr><td>Aim 3 ☒</td><td colspan="4">We will enhance our productivity and efficiency to make the best use of resources</td></tr>
<tr><td>Aim 4 ☐</td><td colspan="4">We will be an effective partner and be ambitious in our commitment to improving health outcomes</td></tr>
<tr><td>Aim 5 ☐</td><td colspan="4">We will develop and expand our services within and beyond Gateshead</td></tr>
<tr><td>Trust corporate objectives that the report relates to:</td><td colspan="5"></td></tr>
<tr><td>Links to CQC KLOE</td><td>Caring ☒</td><td>Responsive ☒</td><td>Well-led ☐</td><td>Effective ☒</td><td>Safe ☒</td></tr>
<tr><td colspan="6">Risks / implications from this report (positive or negative):</td></tr>
<tr><td>Links to risks (identify significant risks and DATIX reference)</td><td colspan="5">There were 4 staffing incidences raised via datix throughout the month of April of which there was no moderate harm incident identified.</td></tr>
<tr><td>Has a Quality and Equality Impact Assessment (QEIA) been completed?</td><td>Yes ☐</td><td colspan="2">No ☐</td><td colspan="2">Not applicable ☒</td></tr>
</table>

Gateshead Health NHS Foundation trust
Nursing and Midwifery Staffing Exception Report
April 2023

1. Introduction

This report details the staffing exceptions for Gateshead Health NHS Foundation Trust during the month of April 2023. The staffing establishments are set by use of the Safer Nursing Care staffing tool (SNCT). This is a recognised, nationally used tool that matches the acuity of patients with the staffing requirements for acute medical and surgical wards. Maternity use the Birth Rate Plus tool and this has been reported to Quality Governance Committee and the Trust Board separately.

2. Staffing

The actual ward staffing against the budgeted establishments from April are presented in Table 1. Whole Trust wards staffing are presented within this report in appendix 1, broken down into each ward areas staffing. In addition, the Trust submit monthly care hours per patient day (CHPPD) as a national requirement to NHS Digital.

Table 1: Whole Trust wards staffing April 2023

Day	Day	Night	Night
Average fill rate - registered nurses/midwives (%)	**Average fill rate - care staff (%)**	**Average fill rate - registered nurses/midwives (%)**	**Average fill rate - care staff (%)**
85.3%	122.5%	89.6%	96.1%

The Trust is required to present information on funded establishments (planned) against actual nurses on duty. The above figures are average fill rates and thus do not reflect the daily challenges experienced during Covid-19 and operational pressures to maintain adequate staffing levels.

Exceptions:

The guidance on safe staffing requires that the Board will be advised of those wards where staffing capacity and capability frequently falls short of what is planned, the reasons why, any impact on quality and the actions taken to address gaps in staffing. In terms of exception reporting, Gateshead Health NHS Foundation Trust reports to the Board if the planned staffing in any area drops below 75%.

Safer Nursing Care Tool (SNCT) data collection is completed bi-annually in January and July each year. Patient acuity and dependency data is triangulated with key performance indicators and professional judgement templates in line with the Developing Workforce Safeguards and Safe Staffing Recommendations (NHSi 2018).

The Community Business Unit implemented the Mental Health Optimal Staffing Tool (MHOST) from October and have now aligned with the data collection schedule as above.

Contextual information and actions taken

Cragside Court have 3 WTE Registered nursing staff due to start in May, which will take them to full establishment. Sunniside and Cragside provide supportive staffing cover across both areas. Ward 21 elective orthopaedics continue with a reduced bed capacity therefore have been able to support other ward areas across the Trust during April, with 47 redeployments made in April.
Ward 24 have 5.7 WTE registered nurse vacancies currently. Recruitment is ongoing to fill these vacancies.

There has been episodes of over rostering, predominantly with Healthcare support worker day shift, displayed in appendix 1. This is in response to increased levels of enhanced care and complex care needs, increased acuity and dependency of patients within our care and due to supernumery periods of time for staff joining the Trust.

The exceptions to report for April are as below:

April 2023	
Registered Nurse Days	**%**
Cragside Court	74.0%
Ward 21 Elective Ortho	64.0%
Ward 24	72.4%
Registered Nurse Nights	**%**
N/a	
Healthcare Support Worker Days	**%**
Ward 21 elective ortho	67.7%
Healthcare Support Worker Nights	**%**
Ward 21 Elective Ortho	56.1%

In April, the Trust worked to the agreed clinical operational model, which meant at times some wards listed above had lower patient occupancy and staff were redeployed appropriately to areas with the greatest clinical need. Throughout April, areas of deficit were escalated as per staffing policy and mitigations were put in place by the Matron teams using professional judgement as to the acuity and demand in each area, which included:

- Redeployments of Registered Nurses and HealthCare assistants on a daily and at times hourly basis between wards according to patient acuity and demand.
- Concentrated support from the Matrons and the People and Organisational Development team to address the sickness absence levels within the divisions and to recruit to vacant posts.

3. Care Hours Per Patient Day (CHPPD)

Following the Lord Carter Cole report, it was recommended that all trusts start to report on CHPPD this is to provide a single consistent way of recording and reporting deployment of staff working on inpatient wards/units. It is calculated by adding the hours of registered nurses to the hours of support workers and dividing the total by every 24 hours of inpatient admissions. CHPPD is relatively stable month on month, but they can show variation due to a number of factors including:

- Patient acuity and dependency
- Patients required enhanced care and support
- Bed occupancy (activity)

Ward level CHPPD is outlined in Appendix 1. For the month of April, the Trust total CHPPD was 9.1. This compares very well when benchmarked with other peer-reviewed hospitals and when compared with the same month last year.

4. Monitoring Nurse Staffing via Incident Reporting system

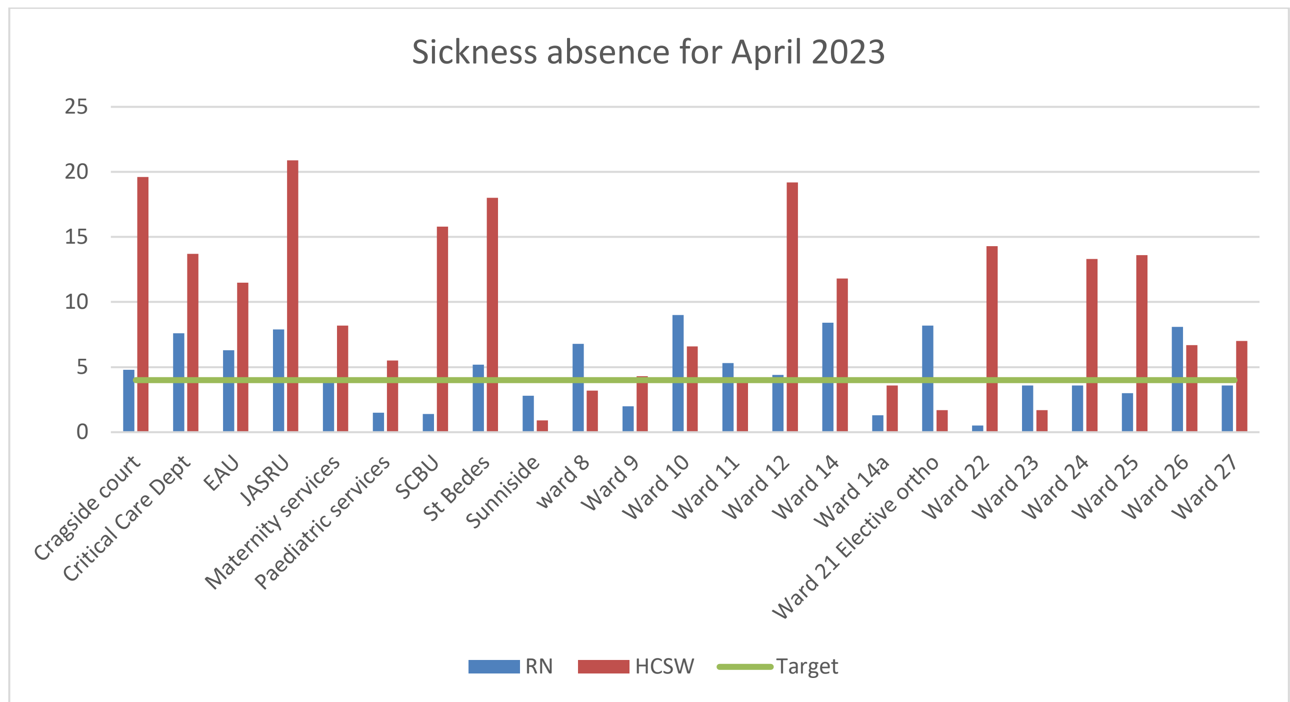
The Trust has an escalation process in place for addressing staffing shortages with identified actions to be taken. Further discussion is to take place to scope the potential for identifying thresholds that trigger when a staffing related incident should be submitted to provide reporting consistency. In addition to this the ongoing work to triangulate fill rates and care hours against reported staffing and patient safety incidents, has highlighted that the subcategories available to the reporter within the incident reporting system requires review to streamline and enable an increased understanding of the causes of the shortages, e.g., short notice sickness, staff moves or inability to fill the rota.

A task and finish group to streamline data capture and explore these potential emerging themes is being set up, alongside reviewing the potential to triangulate this data against a number of potential care quality measures to truly explore any impacts of staffing challenges on patient care, and to enable targeted support for staff.

A report of staffing concern related incidents is generated monthly and discussed at the Nursing Professional Forum. There were 4 staffing incidents raised via the incident reporting system, one of those was identified within an area included within this paper. All incidents were reported as no and low harm.

5. Attendance of Nursing workforce

The below table displays the percentage of sickness absence per staff group for April. This includes Covid-19 Sickness absence. Data extracted from Health Roster.



6. Governance

Actual staff on duty on a shift-to-shift basis compared to planned staffing is demonstrated within the Safe care Live system. Staff are required to enter twice-daily acuity and

dependency levels for actual patients within their areas/department, to support a robust risk assessment of staff redeployment.

7. Conclusion

This paper provides an exception report for nursing and midwifery staffing in April 2023 and provides assurance of ongoing work to triangulate workforce metrics against staffing and care hours.

8. Recommendations

The Board is asked to receive this report for assurance.

Dr Gill Findley
Chief Nurse and Professional Lead for Midwifery and AHP's

Appendix 1- Table 3: Ward by Ward staffing April 2023

	Day		Night		Care Hours Per Patient Per Day (CHPPD)			
Ward	**Average fill rate - registered nurses/midwives (%)**	**Average fill rate - care staff (%)**	**Average fill rate - registered nurses/midwives (%)**	**Average fill rate - care staff (%)**	**Cumulative patient count over the month**	**Registered midwives / nurses**	**Care Staff**	**Overall**
Cragside Court	74.0%	136.9%	93.5%	68.9%	150	10.6	13.0	23.6
Critical Care Dept	83.5%	120.6%	88.6%	77.1%	181	39.2	7.7	46.9
Emergency Care Centre - EAU	80.6%	118.2%	76.1%	126.7%	1324	5.7	4.3	10.0
JASRU	76.9%	95.9%	102.9%	143.8%	542	3.3	5.1	8.4
Maternity Unit	145.3%	173.7%	107.9%	90.1%	535	15.6	6.0	21.6
Paediatrics	149.9%	134.9%	109.1%		49	55.0	15.1	70.1
Special Care Baby Unit	89.9%	103.4%	100.2%	100.0%	157	10.5	3.9	14.4
St. Bedes	87.5%	203.3%	102.2%	95.1%	280	5.1	5.9	11.0
Sunniside Unit	77.7%	199.9%	115.6%	101.9%	184	7.9	8.3	16.2
Ward 08	107.6%	175.2%	103.5%	121.3%	577	3.9	4.8	8.6
Ward 09	77.3%	156.5%	100.1%	104.3%	748	2.4	3.3	5.6
Ward 10	80.6%	139.6%	104.8%	105.4%	693	2.7	3.2	5.9

	Day		Night		Care Hours Per Patient Per Day (CHPPD)			
Ward	**Average fill rate - nurses/midwives (%)**	**Average fill rate - care staff (%)**	**Average fill rate - nurses/midwives (%)**	**Average fill rate - care staff (%)**	**Cumulative patient count over the month**	**Registered midwives / nurses**	**Care Staff**	**Overall**
Ward 11	94.8%	143.7%	104.0%	137.2%	708	2.9	4.0	6.9
Ward 12	98.1%	108.0%	102.0%	128.3%	759	2.7	3.0	5.8
Ward 14 Medicine	106.8%	115.5%	106.1%	109.4%	621	3.6	3.4	7.0
Ward 14A Trauma	86.9%	146.7%	105.6%	110.0%	734	2.7	4.1	6.8
Ward 21 Elective Ortho	64.0%	67.7%	76.5%	30.3%	118	10.3	7.2	17.5
Ward 22	75.8%	125.1%	103.8%	101.5%	871	2.2	3.6	5.8
Ward 23	83.2%	156.7%	106.0%	105.5%	699	2.5	4.5	6.9
Ward 24	72.4%	121.0%	114.7%	102.7%	843	2.3	3.7	6.0
Ward 25	86.6%	131.7%	122.2%	105.3%	900	2.5	3.6	6.1
Ward 26	95.5%	130.6%	108.0%	111.1%	737	3.2	3.9	7.1
Ward 27	84.9%	112.2%	115.9%	104.9%	634	3.5	4.0	7.5
QUEEN ELIZABETH HOSPITAL - RR7EN	85.3%	122.5%	89.6%	96.1%	13044	4.7	4.4	9.1

Report Cover Sheet   Agenda Item: 15ii

<table>
<tr><td>Report Title:</td><td colspan="4">Inpatient Safer Nursing Care Staffing Bi-Annual Report</td></tr>
<tr><td>Name of Meeting:</td><td colspan="4">Board of Directors</td></tr>
<tr><td>Date of Meeting:</td><td colspan="4">Wednesday 24th May 2023</td></tr>
<tr><td>Author:</td><td colspan="4">Drew Rayner, Deputy Chief Nurse</td></tr>
<tr><td>Executive Sponsor:</td><td colspan="4">Dr Gillian Findley, Chief Nurse</td></tr>
<tr><td>Report presented by:</td><td colspan="4">Drew Rayner, Deputy Chief Nurse</td></tr>
<tr><td rowspan="2">Purpose of Report
Briefly describe why this report is being presented at this meeting</td><td>Decision:
☐</td><td>Discussion:
☒</td><td>Assurance:
☒</td><td>Information:
☐</td></tr>
<tr><td colspan="4">This paper provides an overview of the Safe Staffing Nursing review undertaken at Gateshead Health in January 2023.
The purpose of this paper is to provide the board with continual assurance that the nursing workforce at the Gateshead Health is safe, competent, and compliant with National Institute for Clinical Excellence (NICE), National Quality Board (NQB) and NHSI Safer Staffing guidelines and standards at a time when nationally nursing is facing the greatest recruitment and retention challenges</td></tr>
<tr><td>Proposed level of assurance – <u>to be completed by paper sponsor</u>:</td><td>Fully assured
☐
No gaps in assurance</td><td>Partially assured
☐
Some gaps identified</td><td>Not assured
☐
Significant assurance gaps</td><td>Not applicable
☐</td></tr>
<tr><td>Paper previously considered by:
State where this paper (or a version of it) has been considered prior to this point if applicable</td><td colspan="4">Discussed at EMT</td></tr>
<tr><td>Key issues:
Briefly outline what the top 3-5 key points are from the paper in bullet point format

Consider key implications e.g.
• Finance
• Patient outcomes / experience
• Quality and safety
• People and organisational development
• Governance and legal
• Equality, diversity and inclusion</td><td colspan="4">Bi-annual review of staff staffing using Safer Nursing Care Tool (SNCT) in line with national recommendations.

The SNCT is a recognised, evidence-based tool approved by the national institute of health and care Excellence for calculating staffing establishments.

The paper highlights current challenges across the nursing workforce and mitigations on how we are monitoring and working to provide safe, effective patient care.</td></tr>
</table>

<table>
<tr><td colspan="1">Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper</td><td colspan="5">

- Recommendation to support the realignment of registered nurses' establishment to enable safe staffing numbers for night shifts across inpatient ward areas.
- Recommendation to support the uplift of Registered nurses to support a supervisory 1.0WTE for each clinical area.
- Recruitment of both Registered and HCA remain challenging in line with the national and global picture. Gateshead Health has a high reliance on International Recruitment.
- There continues to be a high level of temporary staff usage to cover vacancies, absences and high level of temporary staffing required for increased acuity and specialising.
- Ongoing monitoring of acuity and occupancy over next 6 months to determine whether establishment modifications are required in line with the current increasing acuity.
- Matrons to support inpatient and day unit areas to raise red flags to ensure these are being accurately recorded.
- Workforce and CN Office and POD to implement retention strategies with a focus on:
  - Nurses leaving within 3 years.
  - Flexible working.
  - Rewards and benefits.
  - Sustainable accommodation and travel.
  - Leadership programmes to support new leaders.

</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:</td><td>Aim 1 ☒</td><td colspan="4">We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>Aim 2 ☒</td><td colspan="4">We will be a great organisation with a highly engaged workforce</td></tr>
<tr><td>Aim 3 ☐</td><td colspan="4">We will enhance our productivity and efficiency to make the best use of resources</td></tr>
<tr><td>Aim 4 ☒</td><td colspan="4">We will be an effective partner and be ambitious in our commitment to improving health outcomes</td></tr>
<tr><td>Aim 5 ☐</td><td colspan="4">We will develop and expand our services within and beyond Gateshead</td></tr>
<tr><td>Trust corporate objectives that the report relates to:</td><td colspan="5">Supports the majority of objectives</td></tr>
<tr><td>Links to CQC KLOE</td><td>Caring
☒</td><td>Responsive
☒</td><td>Well-led
☒</td><td>Effective
☒</td><td>Safe
☒</td></tr>
<tr><td colspan="6">Risks / implications from this report (positive or negative):</td></tr>
</table>

<table>
<tr><td>Links to risks (identify significant risks and DATIX reference)</td><td colspan="3">No risks link directly to this paper.</td></tr>
<tr><td>Has a Quality and Equality Impact Assessment (QEIA) been completed?</td><td>Yes
☐</td><td>No
☐</td><td>Not applicable
☒</td></tr>
</table>

Safe Staffing – Bi Annual

Inpatient Safer Nursing Care Staffing Report

May 2023

Nursing, Midwifery & Quality
Published: May 2023
© Gateshead Health NHS Foundation Trust

Contents

1. Safe Staffing Nursing
2. Introduction
3. National Context
4. Analysis of Gateshead Health Safe Nursing reviews January 2023
5. Evidence based tools
6. Right staff
7. Right skills
8. Right Place and time
9. Recommendations
10. References
11. Appendix

© Gateshead Health NHS Foundation Trust

Introduction

The need to recruit and retain a suitable health workforce has been described as the greatest challenge currently facing the NHS. Care Quality Commission's State of Care report for 2018/19 stated that workforce problems are having a direct impact on care. Having the right number of nurses, with the right mix of skills and experience is essential if organisations are to provide safe, high-quality care for patients.

The purpose of this paper is to provide the board with continual assurance that the nursing workforce at Gateshead Health is safe, competent, and compliant with National Institute for Clinical Excellence (NICE), National Quality Board (NQB) and NHSI Safer Staffing guidelines and standards at a time when nationally nursing is facing the greatest recruitment and retention challenges.

This paper provides an overview of the Safer Nursing Staffing review undertaken in January 2023. Key observations, mitigations, and where appropriate establishment recommendations are also highlighted.

National context

Nursing continues to face significant challenges with recruiting and retaining nurses, with a reported 46,000 vacant nursing posts in England in January 2023 and a significant increase in nurses leaving the NHS, with two thirds of these being under the age of 45.

Ensuring that we continue to have the right number of nurses, with the right mix of skills and experience is essential. This is increasingly important with the changing needs of patients, and treatment advances meaning that those admitted to hospital tend to have more complex care needs than in the past.
The Government has also made several pledges relating to the nursing workforce, including an additional 50,000 nurses in the NHS by 2024/2025, introducing a nursing grant and devising a fast-track visa for NHS workers including nurses. The NHS continues to look outside the European Union to try and replace the number of European nurses who left due to Brexit. International recruitment has been made increasingly difficult since the pandemic, which is delaying recruitment pipelines.

Analysis of Gateshead Health Safer Staffing Nursing Review January 2023

As recommended by NHSI (2018), Gateshead Health uses a triangulated approach when reviewing the nursing workforce (refer to Figure 1 below). This includes using evidence-based tools where available including Safer Nursing Care tool (SNCT) Care Hours per Patient Day (CHPPD) together with quality and safety metrics linked to nursing care. Together with professional judgment these measures support nurse leaders to make staffing decisions to ensure that Gateshead Health continues to deliver safe, high-quality care based on patients' acuity and dependency. This bi-annual approach supports workforce planning and ensures effective utilisation of staff to ensure we continue to have the right person in the right place with the right skills.

Throughout January – March 2023, the safer staffing review process has been held led by Deputy Chief Nurse alongside the Safe Staffing Nurse Lead and senior representatives from workforce and finance who met with every Ward Manager, Matron, Chief Matron, Service Line Manage of inpatient, day units, Emergency Department and Mental Health Inpatient Units across Gateshead Health.

© Gateshead Health NHS Foundation Trust

Figure 1. Triangulated approach used to ensure safe staffing.

Evidence based tools

Safer Nursing Care tool (SNCT) – All inpatient wards use the SNCT to record patient acuity and dependency, The tool is easy to use by frontline nursing staff but must be applied correctly and consistently for data to be valid, and to allow benchmarking against agreed standards. It should be combined with nurses' professional judgement and account for local factors.

Mental Health Optimal Staffing Tool (MHOST) – In 2022, Gateshead health used the MHOST tool for the first time to review acuity and dependency across our inpatient mental health services. Like SNCT The development of the MHOST was commissioned and funded by Health Education England (HEE). The tool is based on five acuity and dependency levels for each mental health inpatient specialty. Each acuity and dependency level has an associated descriptor to enable clinical staff to score patients receiving care in their ward.

The MHOST embraces all the principles that should be considered when evaluating/implementing decision support tools described in 'Safe, sustainable, and productive staffing: An improvement resource for mental health (NHSI, 2018)

- How acuity and dependency are measured in mental health settings
- How to ensure that accurate data can be collected.
- What quality metrics should be allied to acuity and dependency measurement to enhance staffing decision making
- How to use staffing multipliers to support professional judgement in reviewing and setting clinical workforce establishments

To Note both SNCT and MHOST as designed to record acuity and dependency for inpatient units with a bed base greater then 16 beds. Therefore, further consideration for professional judgement is required for units with a smaller inpatient bed base.

Emergency Department Safe Nursing Care Tool (EDSNCT) - The Emergency Department Safer Nursing Care Tool (EDSNCT) calculates nurse staffing requirements for emergency departments based on patients' needs acuity and dependency. Together with professional judgement, the tool looks at numbers and the acuity of patients at a specific point in the day for a 24-hour period covering the whole day. Gateshead health Introduced the tool in 2022 having now completed 2 data collections, allowing us to now be able to review the data and make recommendations.

© Gateshead Health NHS Foundation Trust

SNCT Audit – The SNCT audit is required to be presented Bi – annually to board. Due to changes in the nursing structure at Gateshead health during the period of audit, the SNCT report for July 2023 was not reported. It has been embedded into this review to ensure board are sited.

Across all inpatient wards patient acuity remains high, alongside 7% increased occupancy across most units. As identified in previous reviews, the ongoing increase in acuity of unwell/unstable patients (classified as 1a) continues with a 15% increase noted since Q3 and Q4 2021/2022. In addition, we continue to see a 3% increase in patients that are stable but have more complex care needs (classified as 1b). This includes some wards seeing an increase in palliative patients and patient with complex mental health needs awaiting appropriate accommodation and support.

Care Hours per Patient Day (CHPPD)
CHPPD is the recognised standard of measure for calculating staffing requirement on inpatient wards. It does not reflect patient acuity, staff skills or size of the ward. The Trust CHPPD (target range 10-12) remains at 9.1 in April 2023 compared with 7.9 in April 2022. Although reduced Gateshead health remains comparable with other regional trusts with NCL (12.5) CDDFT (11.1) and NUH (10.4).

Monthly Fill Rates
Each month the Senior leadership team and Board are presented with The Nursing Staffing Exception report. This report highlights the monthly fill rates broken down by ward area in line with Safer staffing. Overall fill varies depending on vacancies, gaps in rosters and number of patients. Between April 2022 and April 2023 Gateshead health has averaged 83.55% fill rate for registered nursing and 119% fill rate for HCA's. The increased fill rate for HCAs is largely attributable to the over recruitment which is noted and the need for enhanced patient care. This is comparable to regional trusts who also see a similar ratio of fill rate for registered nurses vs health care assistants.

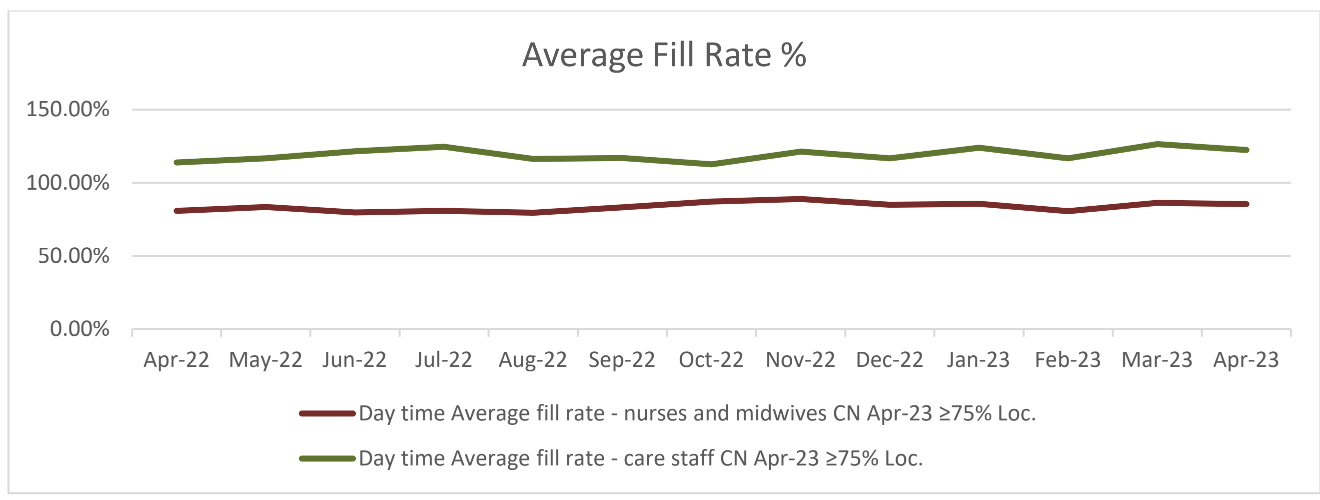


Figure 2: monthly fill rate

© Gateshead Health NHS Foundation Trust

Red Flags
Reg flags are logged using the safer staffing tool, these are used by staff when staffing levels have been identified as impacting safety on the ward either by reduced staff numbers, skill shortfall or delay to care. Between January 2023 – April 2023 the main key themes recorded are:

- Missing Intentional rounding (21)
- Shortfall in registered nursing time (37)
- Unplanned omission in providing medication (18)

It is important to note that whilst red flag reporting has implemented, it needs further work with the ward teams to empower usage, low reporting is likely linked to staff being too busy to raise a red flag. Matrons will now be working with areas to support red flag reporting to ensure accurate documentation.

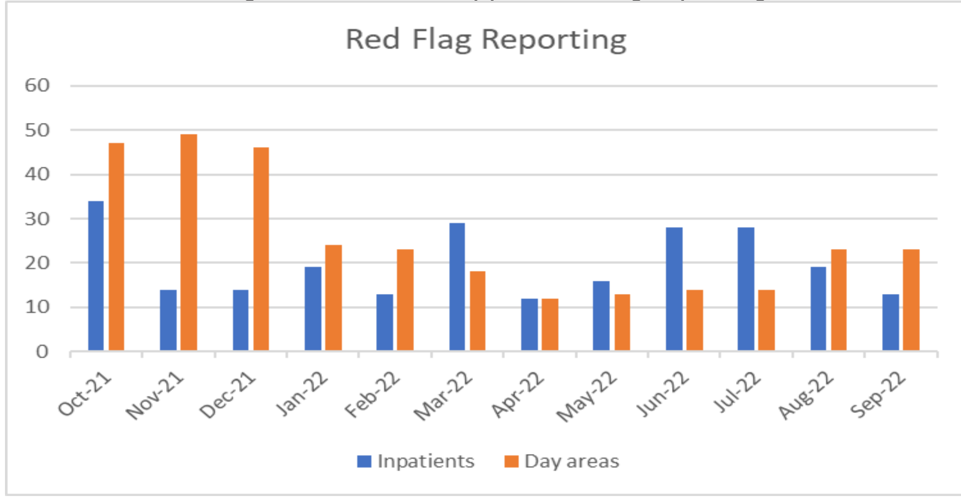


Figure 3: Red Flags

Right staff

Recruitment and retention
Recruitment and retention remain a key priority for Gateshead Health, with a current vacancy rate of 7.9% for nursing against the Trust target of 8%; the lowest vacancy rate the Trust has seen over past 12 months. However, this figure increases to 15.2% for band 5 registered nurses, although this number remains high it is still the lowest vacancy rate for this staffing group over the past 12 months. Rolling recruitment campaigns continue to focus on attracting newly qualified nurses alongside specialist areas such as Critical Care unit (CCU) and Paediatrics. The recruitment and retention group are working with the marketing team to review and refresh the nurse recruitment and looking at how it uses social media in a more targeted way.

© Gateshead Health NHS Foundation Trust

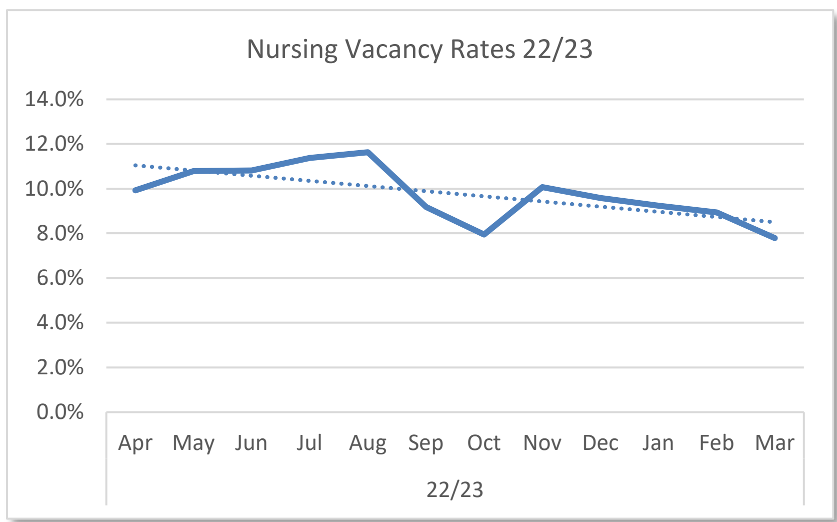


Figure 4: Trust nursing vacancy rate%

International recruitment
Gateshead continues to proactively recruit internationally with 44 nursing recruits having passed their Objective Structured Clinical Examination (OSCE) since January 2022. A further 9 are currently working through the OSCE at present and we continue to work with Yeovil for prospective applicants with a further 69 due to start before December 2023. Through the international recruitment process we have been able to recruit some experienced nurses with a variation of skills and knowledge, over coming months following consolidation we will working with our Practice Development team to commence career progression discussions to support further recognition of there skills and experience.

Gateshead Health has also agreed to be part of cohort 6 supporting NHS England's Refugee programme, with 4 places for nurses who require refuge in the UK being identified. Once recruited they will be working clinically on the wards as healthcare support workers (HCSW) with planned study days to support them with English language preparation to enable them to take the Occupational English Language test (OET). Prior to then commencing on the OSCE.

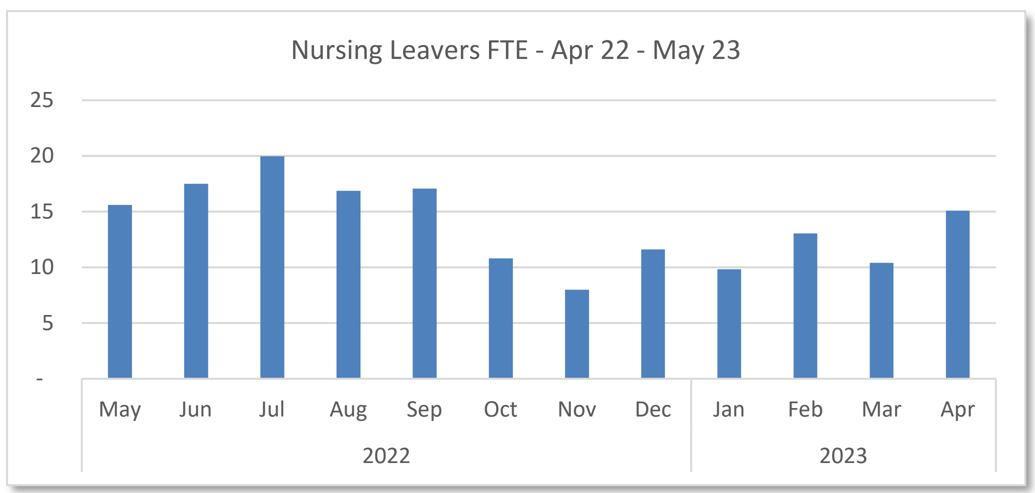
Despite the success of this pipeline to date, it is important to note that it has become increasingly challenging to recruit internationally educated nurses as the UK demand outweighs the supply. Consideration of sustainable domestic pipelines, including growing our own Nursing Degree Apprenticeships will be key.

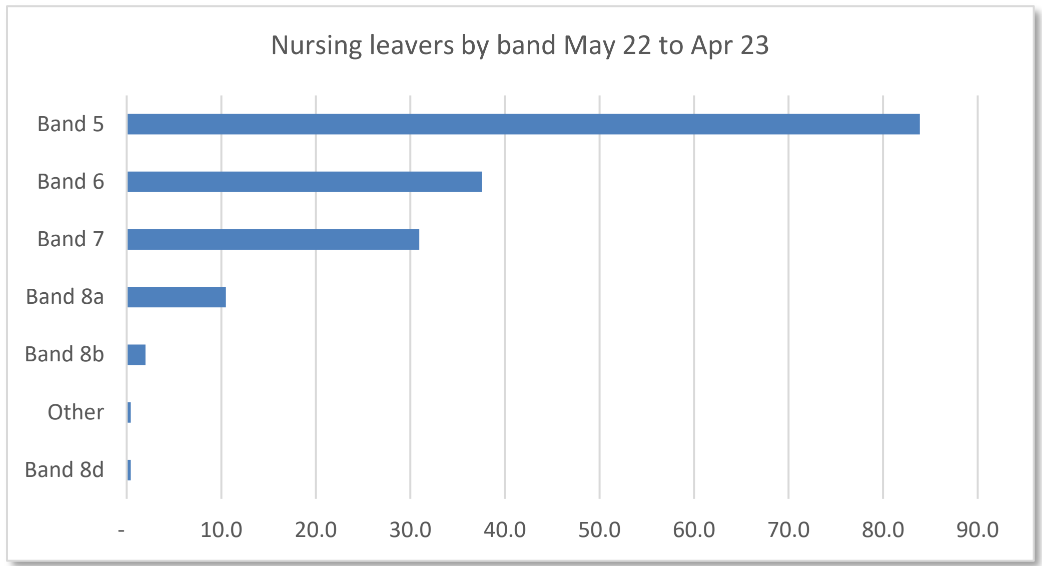
Nursing Turnover

Regionally, Gateshead has been highlighted as having one of the highest nursing turnover rates including those leaving the NHS, with this increasing to 13.7 in January 2023. There were 166 nurse leavers from May 2022 to April 2023, which equates to 13% of registered nursing workforce (total RNs = 1266 WTE).

A deep dive into registered nurses leaving the trust showed that 17% (n= 28) of all leavers retired from the health services. 5% (n = 10) left the NHS to work in the private sector. 18% (n = 32) relocated outside of the north east and Yorkshire ICB and 16% (N = 27) left to do a promotion or development opportunity. Band 5 remains the highest band to leave the trust during this period.

© Gateshead Health NHS Foundation Trust





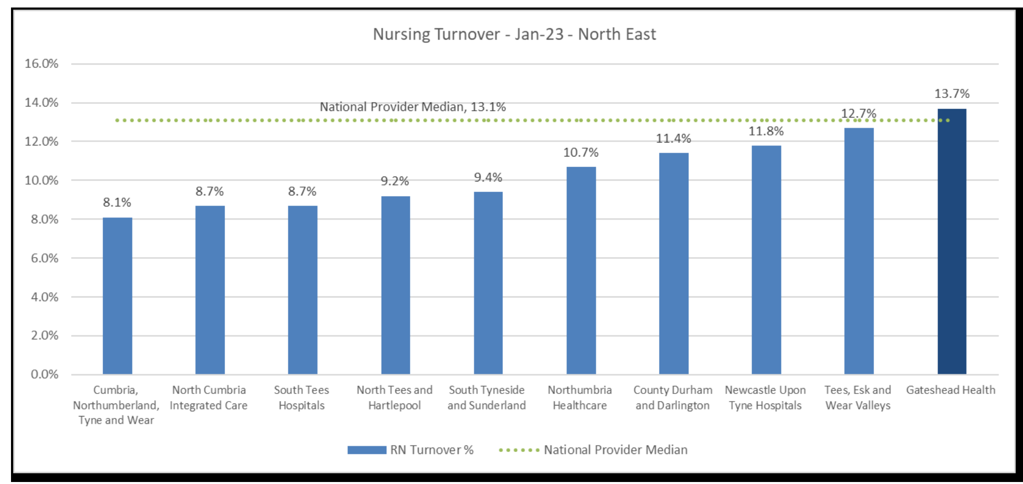


Figure 5,6,7: Regional Turnover position and trust Nurse leaver

© Gateshead Health NHS Foundation Trust

NHSE in collaboration with Gateshead Health are due to commence a review of our workforce reporting structures and services.

Unavailability – sickness/staff absence
Sickness levels within nursing remain high and above the NHS target of 3% however, throughout the year there has been an overall decrease in % absence, averaging at 6.3% in March (vs 7% average in December). Work continues with POD to review sickness and absence reasons and work with staff to support them to return to work safely.

Unavailability - Annual leave
Annual leave remains to be monitored monthly by the Matron team, Ward managers have worked hard trying to facilitate 25% of leave for the workforce per quarter while balancing vacancies and ensuring safe staffing levels on the wards to ensure that staff will be able to attend training and be available to be clinical shifts.

Right skills

Mandatory training (MT): across the workforce MT is compliant at 86.52% in April 2023. Business units are working together with ward teams to facilitate time for staff to complete all mandatory training.
With several new recruits and nurses there are shifts with the right staff numbers; however, may be missing key nursing skills. Where these occur, the senior nursing team are supporting clinical areas and staff may be redeployed to ensure care is not compromised. All new starters are being supported by ward teams and practice educators to obtain key skills applicable to their clinical area and care of the deteriorating patient.

Leadership: There have been several appointments into ward manager and matron leadership roles within the organisation, through both internal promotion and external appointments. Currently at Gateshead health ward leaders are not budgeted for allocated management time or clinical supervisory time to support ward staff. In line with national guidance, throughout December – February, wards 25 and 26 have been trialling a period of 100% supervisory time for ward mangers to facilitate time to improve ward metrics, ensure Mandatory training compliance is monitored and provide clinical supervisory support for the ward team and patients.
This trial has been successful in seeing a marked improvement in ward metrics as well as seeing improved staff rostering compliance and a reduction in bank and agency spend during this period. The Matrons are due to present the outcome of the trial to the trust's senior management time.

Supervisory B7
Presentation April 2(

Healthcare support workers (HCA): National guidance around the differentiation between band 2 and 3 HCA and skills requires Gateshead Health to review this role and each clinical area requirement, which may require re-banding of some posts in the coming months. This work is underway. In 2022 due to increased registered nursing vacancies the trust approved over recruitment into HCA posts to backfill support to clinical areas currently we remain with an overall increased number of HCAs across the trust with 36.3WTE above funded establishments across the trust. As the resisted nursing vacancy position has improved work is underway to review placement of each of the over established HCAs to ensure pipeline recruitment is levelled off across the trust.

© Gateshead Health NHS Foundation Trust

Right place, right time

Bed Closures: Due to operational pressures, bed closures have only taken place due to IPC requirement and are reviewed daily by the site resilience team and the IPC team. Due to winter pressures additional beds during the winder period were opened and factored into the winter plan. The Executive team have worked with the medicine business unit to agree the future bed base and escalation opportunities during times of surge.

Redeployment: Staffing is reviewed daily by the senior nursing team and staff are redeployed to the areas of greatest need whilst maintaining patient safety throughout the Trust. Providing oversight and supporting the decision-making process is the use of safe care, which provides a live update of staffing and acuity levels on the ward. Staff continue to be flexible and supportive of being redeployed; however, this has led to increase in anxiety and concerns over the frequency it can occur especially on nights. Notably, redeployment from staff from EAU and theatres has been particularly challenging for staff in those areas, both of which are specialist areas being moved to support surgical and medical wards.

Shift status- Fill %: A RAG rating system is being introduced to assist with the redeployment of staff throughout both inpatients and day areas. The RAG rating is:

- Green: Rostered staff hours are greater than or up to 5% less than required hours. Skills on shift meet the needs of the current patient mix.
- Amber: Rostered staff hours 5-15% shortfall from required hours and/or missing key skills
- Red: Rostered staff hours are 15% or less than required for the current requirements and/or missing key skills.

Headroom
Gateshead Health headroom is currently calculated at 21%, which is broken down by annual leave 15%, Study leave & training 6%. This is less than the national recommended headroom of 22%. It is recognised that some clinical areas will have a requirement for additional training and study leave which is not factored into budgeted establishments. Areas such as Critical Care or theatres have additional training needs before being competent to complete the role independently.

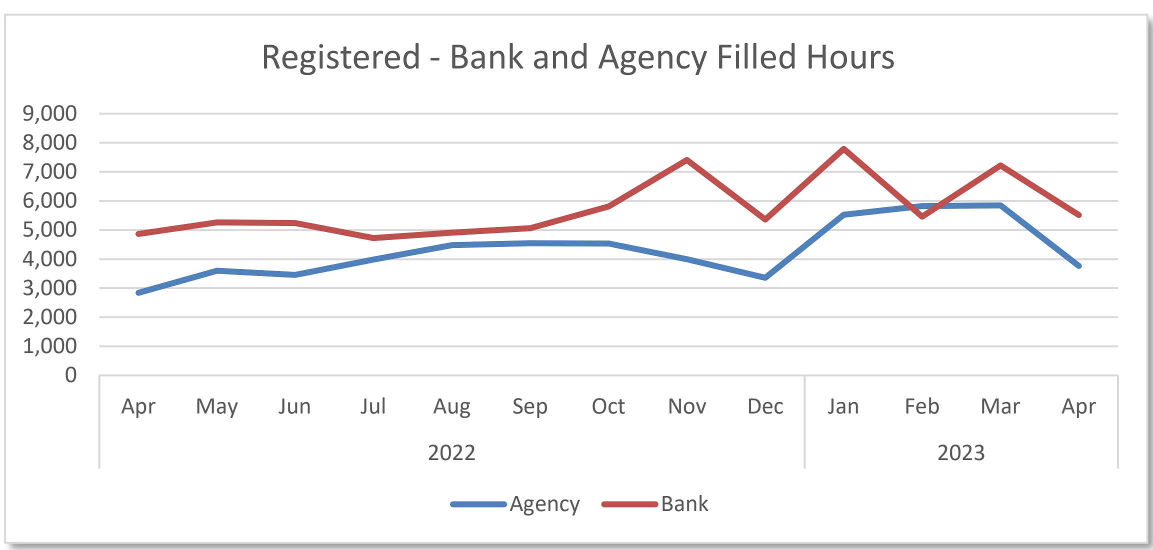
Bank/agency use: There continues to be an ongoing reliance on bank and an ongoing need for nurses via agencies over the past 6 months; including the need to cover shifts using high-cost agencies. The use of enhanced care (1:1s) continues to rise. Gateshead has managed to secure some agency nurses working lines of work and has been able to be upskill them, which allows them to support day units and administration of intravenous medications; however, it has been challenging to incentivise the agency nurses to join the nurse bank pool due to the inability to meet the current benefits they receive via the agency. The Senior management team has commissioned a Agency review group that is looking at overall agency spend and rationalisation across all staff groups. The Deputy Chief Nurse and the Workforce lead are working with Pulse to scope out a master vendor relationship to reduce the need to use high cost off framework agencies and improve patient safety.

Whilst increasing numbers of Gateshead health staff are working bank, on many occasions this is using enhanced rates. Furthermore, it has been increasingly challenging to fill HCA shifts on day shifts in week using bank, in part thought to be attributable to the rising cost of living, incentivising HCAs to opt for unsocial hours.

© Gateshead Health NHS Foundation Trust

Though November 2022 – April 2023, the Trust approved an enhanced payment rate for registered nurses working bank shifts at time + 70%. This was monitored and saw an initial improvement in the uptake of bank shifts, resulting in a reduction in agency spend but as months progressed this initial uptake reduced. This incentive was stopped in April 2023 with little impact on uptake of bank shifts noted.

Gateshead health spent £295,995 more on temporary staffing expenditure between April 2022 – April 2023, with circa £72,257k on agency staff (table 1).



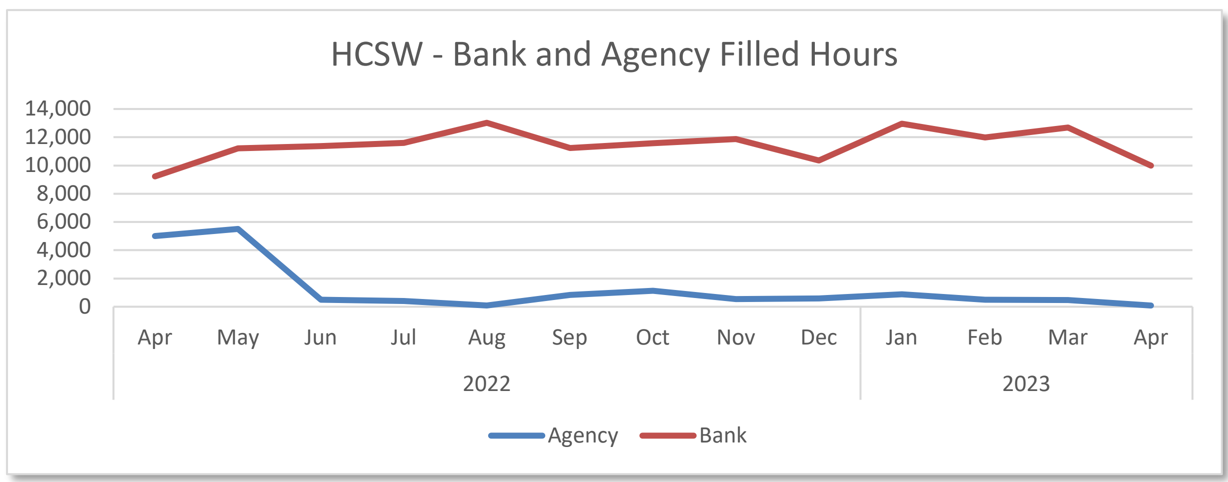


Figure 8,9: Bank and Agency usage in 2022/23.

Temporary staff	April 22 – Dec 22	Jan 23 – April 23	Grand Total
Agency expenditure £	£49,343	£22,914	£72,257
Bank expenditure £	£150,120	£73,578	£223,698
Grand Total £	**£199,463**	**£96,492**	**£295,955**

Table 1: Temporary staff expenditure

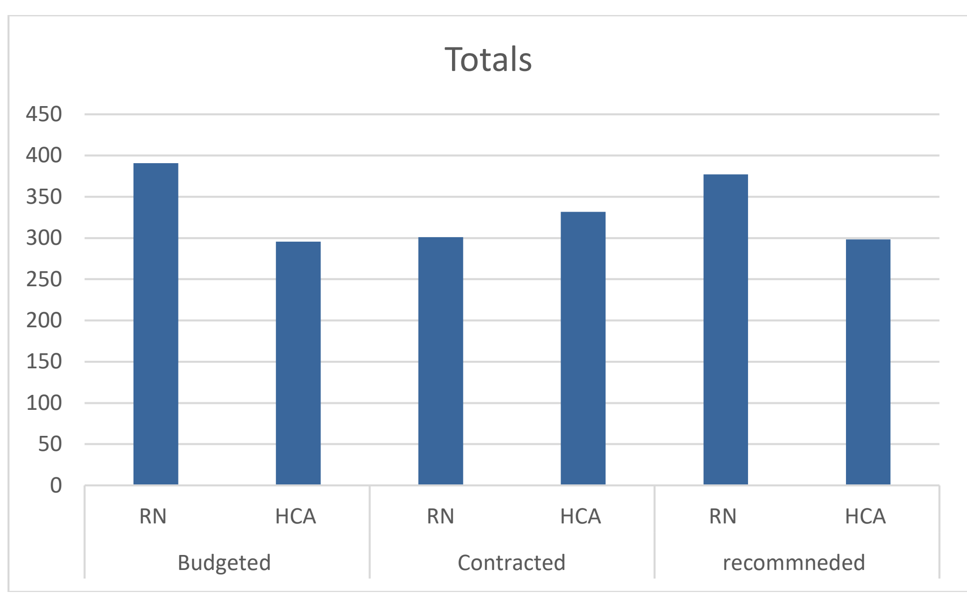
© Gateshead Health NHS Foundation Trust

SNCT Staffing Review Results:

RN & HCA funded establishment WTD against actual WTE in post against SNCT recommended WTE (excluding ED)

The financial ledger for 2022/23 month 10 was used to identify both the funded and actual establishments across the audited areas.

The comparison includes a recommended supervisor post 1.0WTE for each inpatient area and an uplift to RN numbers to comply with safe staffing on a night shift. Current practice in Gateshead health is to staff ward areas with 2 registered nurses. This is outside of the recommended guidance for 1 registered healthcare per 10 patients at night, therefore the recommended registered nursing numbers includes an uplift in areas to accommodation the additional staff required to work at night.



Variance of funded vs. ratio recommendation			
	Total	Registered Nurses	Healthcare Support Workers
Emergency Department	31.1		
Emergency Assessment unit	4.38		
Ward 8	-1.08	-0.63	-0.45
Ward 9	-2.55	-4.82	2.26
Ward 10	2.92	3.37	-0.45
Ward 11	2.92	3.37	-0.45
Ward 12	5.4	3.37	2.26
Ward 14	8.27	0.58	7.68
Ward 22	0.37	0.58	0.22
Ward 23	4.74	4.87	-0.14
Ward 24	0.37	0.58	-0.22
Ward 25	0.37	0.58	-0.22
JASRU	2.85	3.37	-1.1
St Bedes	3.78	2.79	0.99

© Gateshead Health NHS Foundation Trust

Ward 14a	1.25	-0.27	1.53
Ward 21/28	-5.19	-0.32	-4.87
Critical Care Department	6.52		
Ward 26	2.25	0.27	1.97
Ward 27	3.23	1.27	1.97
Cragside	3.83	0.35	3.47
Sunniside	4.19	-1.76	5.95

Conclusion and Recommendations:

- Recommendation to support the realignment of registered nurses' establishment to enable safe staffing numbers for night shifts across inpatient ward areas.
- Recommendation to support the uplift of Registered nurses to support a supervisory 1.0WTE for each clinical area.
- Recruitment of both Registered and HCA remain challenging in line with the national and global picture. Gateshead Health has a high reliance on International Recruitment.
- There continues to be a high level of temporary staff usage to cover vacancies, absences and high level of temporary staffing required for increased acuity and specialising.
- Ongoing monitoring of acuity and occupancy over next 6 months to determine whether establishment modifications are required in line with the current increasing acuity.
- Matrons to support inpatient and day unit areas to raise red flags to ensure these are being accurately recorded.
- Workforce and CN Office and POD to implement retention strategies with a focus on:
    - Nurses leaving within 3 years.
    - Flexible working.
    - Rewards and benefits.
    - Sustainable accommodation and travel.
    - Leadership programmes to support new leaders.

The Trust continues to closely monitor staffing levels and comply with National recommendations on safer staffing. However, it must be acknowledged that sustained demand and capacity issues presents significant challenges with regards to ensuring safe staffing across all areas. Consideration should be given to the overall global shortage of healthcare workforce and the strategies that Gateshead Health will require to build a sustainable nursing workforce model that provides competent and skilled staff to meet the needs of all our patients. There is no magic bullet for addressing workforce shortages, it requires consistent and concerted effort across all areas of pay, training, retention, and job security.

References

NHSI: (2018) Developing workforce safeguards.
NQB: (2016) Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time.
The Kings Fund (2022) The NHS nursing workforce – have the flood guards opened.
Shelford Group: (2014) Safer Nursing Care Tool.

© Gateshead Health NHS Foundation Trust

Appendix 1: SNCT Data Analysis:

Medical Service Line 1
Emergency Department

Accident and Emergency	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Average (6 months)
Observations on time	-	-	-	-	-	-	-
Hand Hygiene	98.0%	100.0%	100.0%	92.9%	100.0%	100.0%	98.5%
Falls	9	5	9	6	8	8	7.5
Falls with harm	2	1	3	0	1	3	1.7
FFT	86.8%	81.9%	70.4%	80.6%	76.5%	87.9%	80.7%
Staffing incidents	0	0	0	0	0	0	0.00
Medication incidents	11	6	10	13	9	15	10.7
Trust acquired pressure damage (all categories)	0	0	1	0	0	0	0.2

Average Beds	Current Funded Establishment (wte)			Current Contracted staff (wte)			SNCT Recommendations (wte)			Nurse:Patient ratio Recommendation (wte)			Variance Funded V. SNCT (wte)			Variance Funded V. recommendation		
	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW
	59.7	47.9	11.8	83.3	54.4	28.9	65.7	56.6	9.1	90.8			6	8.7	-2.7	31.1		

Comments:

© Gateshead Health NHS Foundation Trust

EAU

Average Beds	Current Funded Establishment (wte)			Current Contracted staff (wte)			SNCT Recommendations (wte)			Nurse:Patient ratio Recommendation (wte)			Variance Funded V. SNCT (wte)			Variance Funded V. ratio recommendation (wte)		
	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW
48	108.4	75.5	32.8	96.3	53.7	37.1	68.0	47.4	20.6	112.78			-40.4	-28.1	-12.2	4.38		

Comments:

	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Average (6 months)
Obsevations on time	74.90%	73.50%	71.6%	73.8%	72.3%	74.6%	73.4%
Hand Hygiene				100.0%	93.8%		96.9%
Falls	16	13	18	20	22	19	18.0
Falls with harm	4	2	2	2	8	4	3.7
FFT	100.0%	80.0%	75.0%	85.7%	71.4%	100.0%	83.8%
Staffing incidents	0	0	1	0	0	1	0.3
Medication incidents	21	14	13	15	6	6	12.5
Trust acquired pressure damage (all categories)	2	1	0	1	1	1	1.00

© Gateshead Health NHS Foundation Trust

Medicine Service Line 2
Ward 8

Average Beds	Current Funded Establishment (wte)			Current Contracted staff (wte)			SNCT Recommendations (wte)			Nurse:Patient ratio Recommendation (wte)			Variance Funded V. SNCT (wte)			Variance Funded V. ratio recommendation (wte)		
	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW
21	34.6	20.6	14.0	39.2	19.7	19.8	26.5	15.8	10.7	33.52	19.97	13.55	-8.1	-4.8	-3.3	-1.08	-0.63	-0.45

Comments: WTE Staff include specialist nurses and cover catheter lab and chest pain assessment services including 24hour cardiac arrest bleep cover. There has been some skill mixing to provide a chest pain assessment nurse. The work delivered by this group is not measured as part of the SNCT therefore funded establishment is based on clinical judgement including this group. There is a strong band 6 staff base, with a focus on band 5 development. The observations on time data is nuanced by the many patients on frequent observations as their normal parameters skew the compliance figures. Bed occupancy for July 96.6%. Vacancy 1.18 RN and .71wte unregistered.

	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Average (6 months)
Obsevations on time	74.6%	79.6%	75,4%	75.4%	68.7%	71.9%	74.0%
Hand Hygiene	100.0%	100.0%	100.0%	100.0%	-	100.0%	100.0%
Falls	0	2	2	7	4	2	2.8
Falls with harm	0	1	0	3	1	1	1.0
FFT	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Staffing incidents	0	0	0	0	0	0	0
Medication incidents	0	3	1	0	1	0	0.8
Trust aquired pressure damage (all categories)	0	0	0	1	0	0	0

© Gateshead Health NHS Foundation Trust

Ward 9

Average Beds	Current Funded Establishment (wte)			Current Contracted staff (wte)			SNCT Recommendations (wte)			Nurse:Patient ratio Recommendation (wte)			Variance Funded V. SNCT (wte)			Variance Funded V. ratio recommendation (wte)		
	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW
29(24)	41.5	27.5	14.0	41.3	20.9	18.8	34.4	22.2	12.2	38.95	22.68	16.26	-7.1	- 5.3	-1.8	- 2.55	- 4.82	2.26

Comments: Worked value is in line with the current establishment, the ward has been escalated in July to 29 beds. Vacancy 7.45wte RN and slightly over on unregistered. Bed occupancy July 97.4%. The ward team are focused on trying to protect the NIV service; a recent NIV audit supports protecting the NIV service as any reduction can compromise patient care, recommending protection of nurse resource and cubicle particularly in the out of hours period.

50.0
40.0
30.0
20.0
10.0
0.0

	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6
SNCT Establishments 21% uplift	39.3	38.2	40.3	38.0		
Funded Establishments (WTE care staff)	35.7	35.7	35.7	35.7	35.7	35.7
Level 0	13.0	10.2	9.2	15.0	0.0	0.0
Level 1a	5.2	9.2	8.2	5.0	0.0	0.0
Level 1b	11.4	9.0	11.8	9.7	0.0	0.0
Level 2	0.0	0.2	0.0	0.0	0.0	0.0
Level 3	0.0	0.0	0.0	0.0	0.0	0.0

Level 0
Level 1a
Level 1b
Level 2
Level 3
Funded Establishments (WTE care staff)
Worked (Care Staff) Monthly figure Jan 2023
SNCT Establishments 21% uplift

Ward 9 (Respiratory)	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Average (6 months)
Observations on time	89.1%	90.5%	91.7%	88.0%	89.0%	87.9%	89.4%
Hand Hygiene	89.3%	100.0%	94.6%	95.8%	100.0%	100.0%	96.6%
Falls	6	14	15	6	4	5	8.3
Falls with harm	0	3	6	1	1	0	1.8
FFT	100%	100%	-	100%	100%	100%	100.0%
Staffing incidents	0	0	0	0	0	0	0.0
Medication incidents	5	0	2	1	4	2	2.3
Trust acquired pressure damage (all categories)	1	0	0	3	1	3	1.3

© Gateshead Health NHS Foundation Trust

Ward 10

Average Beds	Current Funded Establishment (wte)			Current Contracted staff (wte)			SNCT Recommendations (wte)			Nurse:Patient ratio Recommendation (wte)			Variance Funded V. SNCT (wte)			Variance Funded V. ratio recommendation (wte)		
	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW
29(24)	30.6	16.6	14.0	31.2	16.8	14.4	37.2	20.2	17.0	33.52	19.97	13.55	6.6	3.6	3.0	2.92	3.37	-0.45

Comments:

	Level 0	Level 1a	Level 1b	Level 2	Level 3	Funded Establishments (WTE care staff)	Worked (Care Staff) Monthly figure Jan 2023	SNCT Establishments 21% uplift
Week 1	13.0	5.2	11.4	0.0	0.0	35.7		39.3
Week 2	10.2	9.2	9.0	0.2	0.0	35.7		38.2
Week 3	9.2	8.2	11.8	0.0	0.0	35.7		40.3
Week 4	15.0	5.0	9.7	0.0	0.0	35.7		38.0
Week 5	0.0	0.0	0.0	0.0	0.0	35.7		
Week 6	0.0	0.0	0.0	0.0	0.0	35.7		

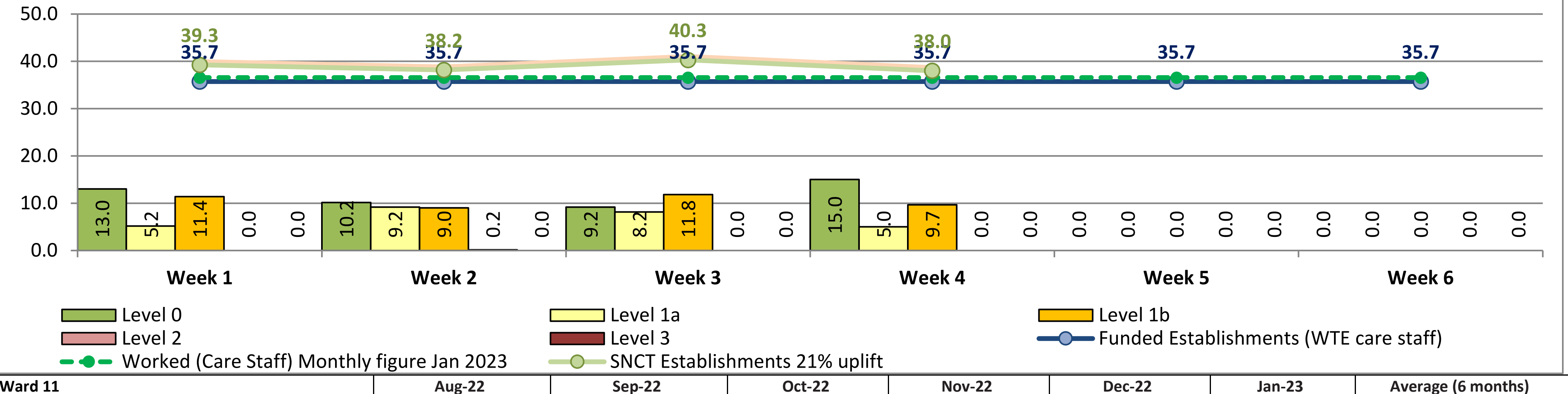
Ward 10 (Respiratory)	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Average (6 months)
Observations on time	90.7%	88.1%	87.3%	84.7%	85.1%	84.2%	86.7%
Hand Hygiene	-	-	-	94.4%	100.0%	100.0%	98.1%
Falls	12	6	14	10	8	11	10.2
Falls with harm	3	2	2	1	4	`	2.4
FFT	100.0%	33.3%	-	100.0%	-	100.0%	66.7%
Staffing incidents	1	1	0	1	0	0	0.5
Medication incidents	0	0	2	2	0	2	1
Trust acquired pressure damage (all categories)	0	0	1	3	0	1	0.8

© Gateshead Health NHS Foundation Trust

Ward 11

Average Beds	Current Funded Establishment (wte)			Current Contracted staff (wte)			SNCT Recommendations (wte)			Nurse:Patient ratio Recommendation (wte)			Variance Funded V. SNCT (wte)			Variance Funded V. ratio recommendation (wte)		
	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW
25(24)	30.6	16.6	14.0	35.5	15.1	20.4	28.1	15.3	12.9	33.52	19.97	13.55	-2.5	-1.3	-1.1	2.92	3.37	-0.45

Comments: Comments: Acute gastro ward with a fast turnover of patients and in general gastro patients tend to have higher acuity requiring increased IV's and blood transfusions. The ward manager noted the increased enhanced care requirement in January, indicative of the patient group.



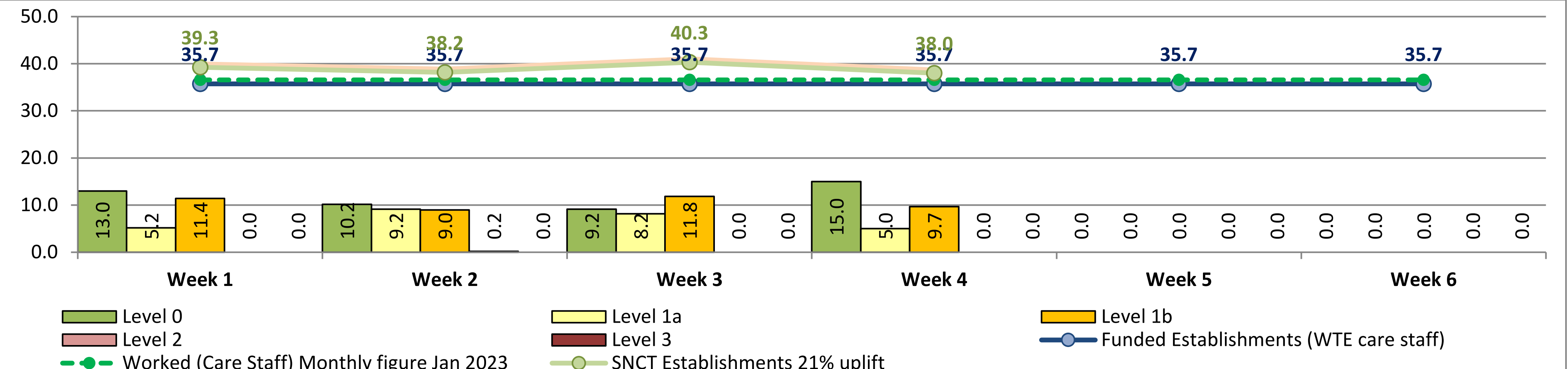
Ward 11	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Average (6 months)
Observations on time	72.7%	80.1%	81.4%	80.4%	79.7%	78.0%	78.7%
Hand Hygiene	100.0%	-	-	-	-	100.0%	100.0%
Falls	5	8	6	5	6	7	6.2
Falls with harm	3	2	0	1	1	1	1.3
FFT	50.0%	66.7%	100.0%	100.0%	66.7%	100.0%	76.9%
Staffing incidents	0	1	0	1	1	0	0.5
Medication incidents	0	0	2	0	1	0	0.5
Trust acquired pressure damage (all categories)	0	0	0	0	1	1	0.3

© Gateshead Health NHS Foundation Trust

Ward 12

Average Beds	Current Funded Establishment (wte)			Current Contracted staff (wte)			SNCT Recommendations (wte)			Nurse:Patient ratio Recommendation (wte)			Variance Funded V. SNCT (wte)			Variance Funded V. ratio recommendation (wte)		
	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW
25	30.6	16.6	14.0	31.3	13.6	17.6	33.8	18.3	15.4	36.24	19.97	16.26	3.2	1.7	1.4	5.64	3.37	2.26

Comments: Mixed group of patients, acuity split between 0 and 1b patients, The ward has continued to be heavily reliant on bank and agency usage. Ward managing promoting open reporting culture to support capturing staffing incidents.



Ward 12	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Average (6 months)
Observations on time	80.3%	66.3%	70.3%	75.0%	71.0%	71.1%	72.3%
Hand Hygiene	-	-	-	-	-	-	-
Falls	0	3	5	4	8	2	3.7
Falls with harm	0	0	2	1	4	0	1.2
FFT	-	-	0.0%	100.0%	50.0%	80.0%	72.7%
Staffing incidents	1	0	0	0	0	0	0.2
Medication incidents	0	1	1	3	2	3	1.7
Trust acquired pressure damage (all categories)	1	0	0	1	1	0	0.5

© Gateshead Health NHS Foundation Trust

Ward 14

Average Beds	Current Funded Establishment (wte)			Current Contracted staff (wte)			SNCT Recommendations (wte)			Nurse:Patient ratio Recommendation (wte)			Variance Funded V. SNCT (wte)			Variance Funded V. ratio recommendation (wte)		
	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW
26(25)	36.1	22.1	14.0	31.2	15.0	16.2	35.1	21.5	13.6	44.37	22.68	21.68	1.0	-0.6	-0.4	8.27	0.58	7.68

Comments: The acuity recorded in this period is not reflective of the acuity and dependency of the CEV patients as all CEV patients due to planned building work and recommend closer examination of next data when all CEV patients are repatriated on the ward. The ward was in escalation for a bed occupancy of 94.8%.

	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6
Level 0	13.0	10.2	9.2	15.0	0.0	0.0
Level 1a	5.2	9.2	8.2	5.0	0.0	0.0
Level 1b	11.4	9.0	11.8	9.7	0.0	0.0
Level 2	0.0	0.2	0.0	0.0	0.0	0.0
Level 3	0.0	0.0	0.0	0.0	0.0	0.0
SNCT Establishments 21% uplift	39.3	38.2	40.3	38.0		
Funded Establishments (WTE care staff)	35.7	35.7	35.7	35.7	35.7	35.7

Legend: Level 0; Level 1a; Level 1b; Level 2; Level 3; Funded Establishments (WTE care staff); Worked (Care Staff) Monthly figure Jan 2023; SNCT Establishments 21% uplift

Ward 14	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Average (6 months)
Observations on time	82.4%	72.7%	84.0%	83.6%	89.6%	80.2%	82.1%
Hand Hygiene	100.0%	100.0%	100.0%	100.0%	100.0%	75.0%	100.0%
Falls	2	8	1	1	5	0	2.8
Falls with harm	2	2	1	0	3	0	1.3
FFT	-	100.0%	100.0%	33.3%	-	100.0%	70.0%
Staffing incidents	0	0	0	0	0	2	0.3
Medication incidents	0	4	6	3	0	0	2.2
Trust acquired pressure damage (all categories)	1	1	1	1	1	0	0.8

© Gateshead Health NHS Foundation Trust

Medicine Service Line 3
Ward 22

Average Beds	Current Funded Establishment (wte)			Current Contracted staff (wte)			SNCT Recommendations (wte)			Nurse:Patient ratio Recommendation (wte)			Variance Funded V. SNCT (wte)			Variance Funded V. ratio recommendation (wte)		
	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW
31(29)	44.0	22.1	21.9	32.9	14.7	18.2	42.5	20.5	22.0	44.37	22.68	21.68	-1.5	-1.6	0.1	0.37	0.58	0.22
Comments:																		

	Level 0	Level 1a	Level 1b	Level 2	Level 3	Funded Establishments (WTE care staff)	
Week 1	13.0	5.2	11.4	0.0	0.0	35.7	39.3
Week 2	10.2	9.2	9.0	0.2	0.0	35.7	38.2
Week 3	9.2	8.2	11.8	0.0	0.0	35.7	40.3
Week 4	15.0	5.0	9.7	0.0	0.0	35.7	38.0
Week 5	0.0	0.0	0.0	0.0	0.0	35.7	
Week 6	0.0	0.0	0.0	0.0	0.0	35.7	

Ward 22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Average (6 months)
Obsevations on time	87.0%	86.8%	88.5%	90.4%	87.7%	88.9%	88.2%
Hand Hygiene	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Falls	18	5	20	13	5	11	12.0
Falls with harm	5	1	4	3	1	1	2.5
FFT	-	-	-	100.0%	85.7%	100.0%	91.7%
Staffing incidents	2	1	0	0	0	0	0.5
Medication incidents	1	3			4		2.7
Trust aquired pressure damage (all categories)	1	0	1	2	0	1	0.83

© Gateshead Health NHS Foundation Trust

Ward 23

Average Beds	Current Funded Establishment (wte)			Current Contracted staff (wte)			SNCT Recommendations (wte)			Nurse:Patient ratio Recommendation (wte)			Variance Funded V. SNCT (wte)			Variance Funded V. ratio recommendation (wte)		
	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW
24	31.5	15.1	16.4	32.8	12.0	20.8	34.6	16.6	18.0	36.24	19.97	16.26	3.1	1.5	1.6	4.74	4.87	-0.14

Comments:

Ward 23	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Average (6 months)
Observations on time	90.6%	94.6%	91.4%	90.4%	88.7%	85.9%	90.3%
Hand Hygiene	100%	100%	97%		100%	0%	99.3%
Falls	9	6	11	9	9	6	8.3
Falls with harm	3	2	1	3	2	1	2.0
FFT	100.0%	0.0%	100.0%	-	-	-	66.7%
Staffing incidents	0	0	0	1	0	1	0.3
Medication incidents	0	1	0	0	0	0	0.2
Trust acquired pressure damage (all categories)	0	0	1	0	0	0	0.2

© Gateshead Health NHS Foundation Trust

Ward 24

Average Beds	Current Funded Establishment (wte)			Current Contracted staff (wte)			SNCT Recommendations (wte)			Nurse:Patient ratio Recommendation (wte)			Variance Funded V. SNCT (wte)			Variance Funded V. ratio recommendation (wte)		
	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW
31(29)	44.0	22.1	21.9	36.9	14.5	22.4	43.5	21.0	22.5	44.37	22.68	21.68	-0.5	-1.1	0.6	0.37	0.58	-0.22

Comments: At the time of the Audit was running on 31 beds. LT plan ward to remain with medical optimised patients. Challenge with medication rounds, challenging enhanced care patients. Previously would of noted a difference in are requirements am to pm but has reduced.

	Level 0	Level 1a	Level 1b	Level 2	Level 3	Funded Establishments (WTE care staff)	SNCT Establishments 21% uplift
Week 1	13.0	5.2	11.4	0.0	0.0	35.7	39.3
Week 2	10.2	9.2	9.0	0.2	0.0	35.7	38.2
Week 3	9.2	8.2	11.8	0.0	0.0	35.7	40.3
Week 4	15.0	5.0	9.7	0.0	0.0	35.7	38.0
Week 5	0.0	0.0	0.0	0.0	0.0	35.7	
Week 6	0.0	0.0	0.0	0.0	0.0	35.7	

Legend: Level 0; Level 1a; Level 1b; Level 2; Level 3; Funded Establishments (WTE care staff); Worked (Care Staff) Monthly figure Jan 2023; SNCT Establishments 21% uplift

Ward 24	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Average (6 months)
Observations on time	89.2%	89.7%	85.5%	87.8%	87.7%	93.5%	88.9%
Hand Hygiene	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Falls	10	12	12	20	9	11	12.3
Falls with harm	2	1	3	4	2	2	2.3
FFT	100.0%	100.0%	100.0%	-	-	-	100.0%
Staffing incidents	0	1	1	0	0	0	0.3
Medication incidents	2	1	6	2			2.8
Trust acquired pressure damage (all categories)	1				2	5	2.67

© Gateshead Health NHS Foundation Trust

Ward 25

Average Beds	Current Funded Establishment (wte)			Current Contracted staff (wte)			SNCT Recommendations (wte)			Nurse:Patient ratio Recommendation (wte)			Variance Funded V. SNCT (wte)			Variance Funded V. ratio recommendation (wte)		
	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW
33(30)	44.0	22.1	21.9	39.3	14.6	24.6	48.3	23.3	25.0	44.37	22.68	21.68	4.3	1.2	3.1	0.37	0.58	-0.22

Comments: Data reflective of acuity. Care of the elderly

50.0
40.0
30.0
20.0
10.0
0.0

39.3 35.7 | 38.2 35.7 | 40.3 35.7 | 38.0 35.7 | 35.7 | 35.7

Week 1: 13.0, 5.2, 11.4, 0.0, 0.0
Week 2: 10.2, 9.2, 9.0, 0.2, 0.0
Week 3: 9.2, 8.2, 11.8, 0.0, 0.0
Week 4: 15.0, 5.0, 9.7, 0.0, 0.0
Week 5: 0.0, 0.0, 0.0, 0.0, 0.0
Week 6: 0.0, 0.0, 0.0, 0.0, 0.0

Level 0 | Level 1a | Level 1b | Level 2
Level 3 | Funded Establishments (WTE care staff) | Worked (Care Staff) Monthly figure Jan 2023 | SNCT Establishments 21% uplift

Ward 25	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Average (6 months)
Observations on time	86.2%	84.1%	84.2%	83.8%	80.6%	82.6%	83.6%
Hand Hygiene			100%		100%		100.0%
Falls	11	9	7	14	15	17	12.2
Falls with harm	0	2	2	5	2	3	2.3
FFT	100.0%	-	-	-	100.0%	-	100.0%
Staffing incidents	0	1	0	2	6	0	1.5
Medication incidents	1	1		3		1	1.5
Trust acquired pressure damage (all categories)	0	0	2	1	0	3	1.00

© Gateshead Health NHS Foundation Trust

JASRU

Average Beds	Current Funded Establishment (wte)			Current Contracted staff (wte)			SNCT Recommendations (wte)			Nurse:Patient ratio Recommendation (wte)			Variance Funded V. SNCT (wte)			Variance Funded V. ratio recommendation (wte)		
	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW
20	36.1	16.6	19.5	37.1	14.8	22.3	34.1	15.7	18.4	38.95	19.97	18.97	-2.0	-0.9	-1.1	2.85	3.37	-1.1

Comments: Stroke, high physical nursing needs.

50.0
40.0
30.0
20.0
10.0
0.0

	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6
Level 0	13.0	10.2	9.2	15.0	0.0	0.0
Level 1a	5.2	9.2	8.2	5.0	0.0	0.0
Level 1b	11.4	9.0	11.8	9.7	0.0	0.0
Level 2	0.0	0.2	0.0	0.0	0.0	0.0
Level 3	0.0	0.0	0.0	0.0	0.0	0.0
Funded Establishments (WTE care staff)	35.7	35.7	35.7	35.7	35.7	35.7
SNCT Establishments 21% uplift	39.3	38.2	40.3	38.0		

Level 0 | Level 1a | Level 1b | Level 2 | Level 3 | Funded Establishments (WTE care staff) | Worked (Care Staff) Monthly figure Jan 2023 | SNCT Establishments 21% uplift

JASRU	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Average (6 months)
Observations on time	77.3%	79.4%	80.1%	80.5%	79.7%	83.3%	80.1%
Hand Hygiene	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%
Falls	6	5	5	3	4	4	4.5
Falls with harm	2	1	0	1	0	0	0.7
FFT	-	100.0%	-	92.9%	83.3%	100.0%	93.3%
Staffing incidents	0	1	0	0	0	0	0.2
Medication incidents	1	1	0	0	1	1	0.7
Trust acquired pressure damage (all categories)	2	2	0	0	0	0	0.7

© Gateshead Health NHS Foundation Trust

St Bedes

Average Beds	Current Funded Establishment (wte)			Current Contracted staff (wte)			SNCT Recommendations (wte)			Nurse:Patient ratio Recommendation (wte)			Variance Funded V. SNCT (wte)			Variance Funded V. ratio recommendation (wte)		
	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW
10	20.6	12.1	8.5	19.3	11.9	7.4	15.7	9.2	6.5	24.38	14.89	9.49	-4.9	- 2.9	-2.0	3.78	2.79	0.99

Comments: EOL, SNCT does not capture accurately on a ward with this number of funded bed. Due to EOL complex medication regimes

50.0
40.0
30.0
20.0
10.0
0.0

Week 1: 13.0, 5.2, 11.4, 0.0, 0.0 (39.3, 35.7)
Week 2: 10.2, 9.2, 9.0, 0.2, 0.0 (38.2, 35.7)
Week 3: 9.2, 8.2, 11.8, 0.0, 0.0 (40.3, 35.7)
Week 4: 15.0, 5.0, 9.7, 0.0, 0.0 (38.0, 35.7)
Week 5: 0.0, 0.0, 0.0, 0.0, 0.0 (35.7)
Week 6: 0.0, 0.0, 0.0, 0.0, 0.0 (35.7)

Level 0 | Level 1a | Level 1b | Level 2 | Level 3 | Funded Establishments (WTE care staff) | Worked (Care Staff) Monthly figure Jan 2023 | SNCT Establishments 21% uplift

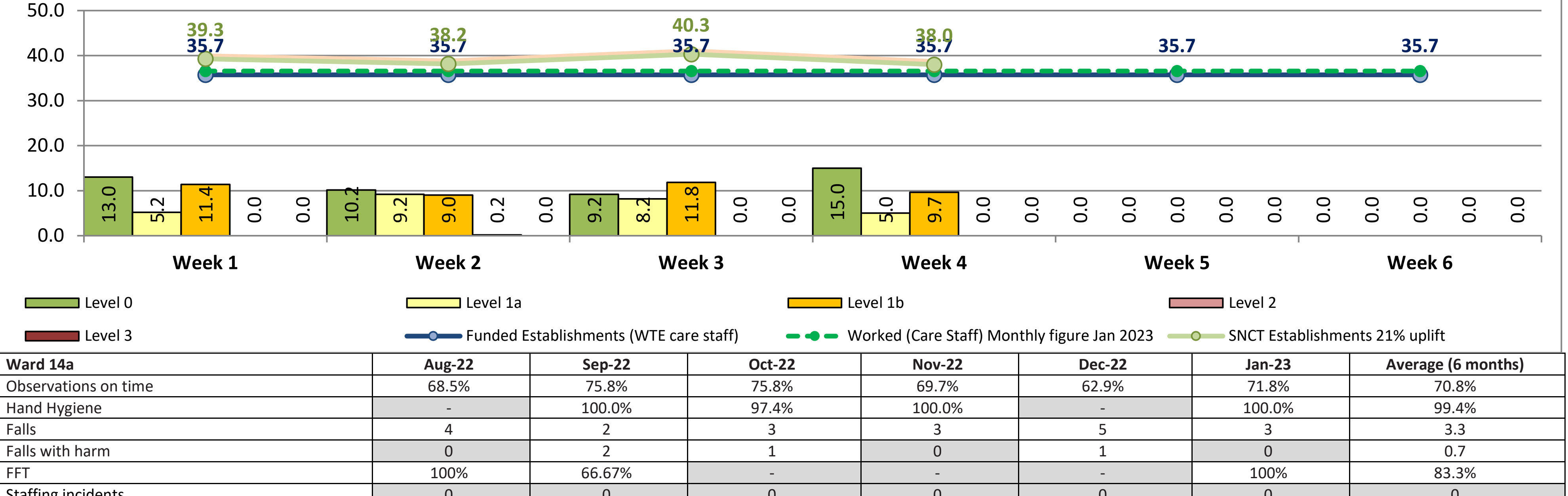
St Bedes	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Average (6 months)
Observations on time	69.7%	81.9%	85.5%	80.0%	76.5%	84.8%	79.7%
Hand Hygiene				100.0%			100.0%
Falls	4	0	3	0	2	0	1.5
Falls with harm	0	0	0	0	0	0	0.0
FFT	100.0%	100.0%	-	-	-	-	100.0%
Staffing incidents	1	0	1	1	0	0	0.5
Medication incidents	1	0	2	0	0	0	0.5
Trust acquired pressure damage (all categories)	0	1	1	2	1	2	1.1666667

© Gateshead Health NHS Foundation Trust

Surgery Service Line 1
Ward 14a

Average Beds	Current Funded Establishment (wte)			Current Contracted staff (wte)			SNCT Recommendations (wte)			Nurse:Patient ratio Recommendation (wte)			Variance Funded V. SNCT (wte)			Variance Funded V. ratio recommendation (wte)		
	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW
26(25)	40.2	19.7	20.5	38.1	17.7	20.3	40.4	19.8	20.6	38.95	19.97	18.97	0.2	0.1	0.1	1.25	- 0.27	1.53

Comments: reflective of patients with complex post-surgical care. Falls numbers inline with EOL wards. High number of patients awaiting POC. Increased pressure damage



Ward 14a	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Average (6 months)
Observations on time	68.5%	75.8%	75.8%	69.7%	62.9%	71.8%	70.8%
Hand Hygiene	-	100.0%	97.4%	100.0%	-	100.0%	99.4%
Falls	4	2	3	3	5	3	3.3
Falls with harm	0	2	1	0	1	0	0.7
FFT	100%	66.67%	-	-	-	100%	83.3%
Staffing incidents	0	0	0	0	0	0	0
Medication incidents	1	0	2	1	0	0	0.7
Trust acquired pressure damage (all categories)	2	4	1	3	2	2	2.3

© Gateshead Health NHS Foundation Trust

Ward 21/28

Average Beds	Current Funded Establishment (wte)			Current Contracted staff (wte)			SNCT Recommendations (wte)			Nurse:Patient ratio Recommendation (wte)			Variance Funded V. SNCT (wte)			Variance Funded V. ratio recommendation (wte)		
	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW
7(14)	27.1	14.1	13.0	18.5	9.8	8.7	19.2	10.0	9.2	21.91	13.78	8.13	-7.9	-4.1	-3.8	-5.19	-0.32	-4.87

Comments: Was taking medicine patients due to surgery during the audit period week 1&2

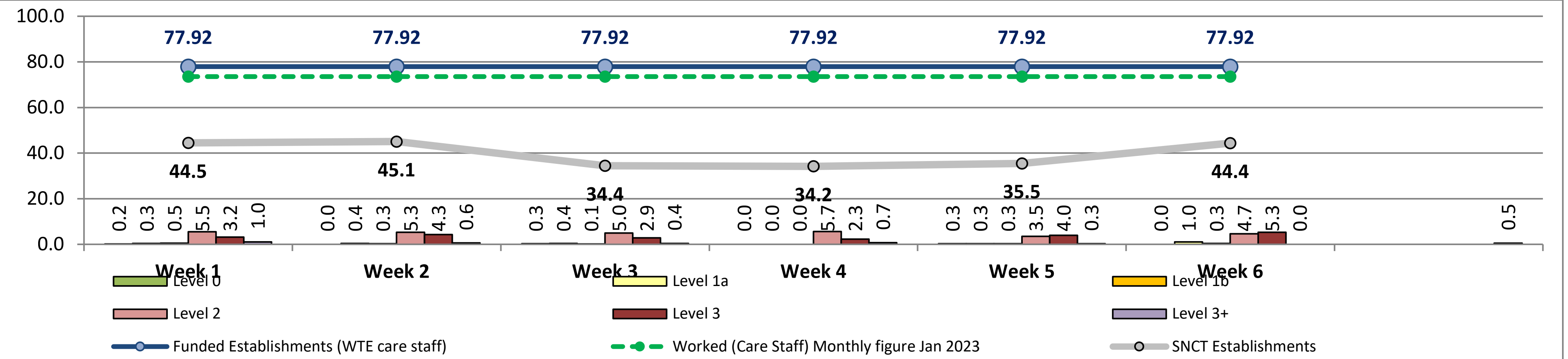
Ward 21 (Orthopaedic Elective)	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Average (6 months)
Observations on time	86.3%	86.3%	83.7%	86.2%	84.2%	81.6%	84.7%
Hand Hygiene	100.0%	100.0%	100.0%	100.0%	100.0%	-	100.0%
Falls	1	0	1	0	0	0	0.3
Falls with harm	1	0	0	0	0	0	0.2
FFT	100%	100%	100%	100%	100%	100%	100.0%
Staffing incidents	0	0	0	0	0	0	0.0
Medication incidents	0	0	0	1	1	0	0.3
Trust acquired pressure damage (all categories)	0	0	0	0	0	1	0.2

© Gateshead Health NHS Foundation Trust

Critical Care Department

Average Beds	Current Funded Establishment (wte)			Current Contracted staff (wte)			SNCT Recommendations (wte)			Nurse:Patient ratio Recommendation (wte)			Variance Funded V. SNCT (wte)			Variance Funded V. ratio recommendation (wte)		
	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW
12	78.2	70.1	8.1	74.3	63.9	10.4	40.03	35.88	4.15	84.72			-38.17	-34.22	-3.95	6.52		

Comments: Need to review staffing establishment in line with GPIC standards.



Critical Care Department	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Average (6 months)
Observations on time	25.3%	39.70%	29.50%	23.50%	27.00%	18,8%	29.0%
Hand Hygiene	88.9%	100.0%	100.0%	100.0%	100.0%	-	97.8%
Falls	0	0	3	0	0	0	0.5
Falls with harm	0	0	0	0	0	0	0.0
FFT	-	-	-	-	-	-	-
Staffing incidents	0	0	0	0	0	0	0
Medication incidents	1	1	2	3	3	3	2.2
Trust acquired pressure damage (all categories)	1	2	0	3	6	2	2.3

© Gateshead Health NHS Foundation Trust

Surgery Service Line 3
Ward 26

Average Beds	Current Funded Establishment (wte)			Current Contracted staff (wte)			SNCT Recommendations (wte)			Nurse:Patient ratio Recommendation (wte)			Variance Funded V. SNCT (wte)			Variance Funded V. ratio recommendation (wte)		
	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW
30	36.7	19.7	17.0	44.7	21.2	23.4	36.7	19.2	17.5	38.95	19.97	18.97	0	- 0.5	0.5	2.25	0.27	1.97

Comments: Increasing number of oncology patients requiring complex care needs (high numbers of level 2 patients) covering 3 specialities currently, gynie onc, ortho and Gynie. 30 bedded ward with side rooms. Additional training requirements for Gynie onc patients. Complex patient needs difficult to capture on data.

Ward 26	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Average (6 months)
Observations on time	64.4%	67.9%	70.4%	68.1%	62.1%	62.4%	65.9%
Hand Hygiene	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Falls	4	5	4	1	4	9	4.5
Falls with harm	1	1	2	0	3	3	1.7
FFT	90%	83.33%	100%	77.78%	93.75%	75.00%	85.5%
Staffing incidents	3	0	1	0	0	0	0.7
Medication incidents	4	0	4	1	2	1	2.0

© Gateshead Health NHS Foundation Trust

Trust acquired pressure damage (all categories)	0	0	2	0	2	0	0.7

Ward 27

Average Beds	Current Funded Establishment (wte)			Current Contracted staff (wte)			SNCT Recommendations (wte)			Nurse:Patient ratio Recommendation (wte)			Variance Funded V. SNCT (wte)			Variance Funded V. ratio recommendation (wte)		
	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW
30	35.7	18.7	17.0	34.9	15.4	19.4	39.3	20.6	18.7	38.95	19.97	18.97	3.6	1.9	1.7	8.67	3.98	4.68

Comments: increased no of CEV patients at time of audit. Elective surgery – required 1-6 ration inline with direct admission area. High number of theatre transfers, multiple ward round, multiple IV's TDS, same day cancer pathways. Review of GIRFT.

50.0
40.0
30.0
20.0
10.0
0.0

Week 1: 39.3, 35.7; bars 13.0, 5.2, 11.4, 0.0, 0.0
Week 2: 38.2, 35.7; bars 10.2, 9.2, 9.0, 0.2, 0.0
Week 3: 40.3, 35.7; bars 9.2, 8.2, 11.8, 0.0, 0.0
Week 4: 38.0, 35.7; bars 15.0, 5.0, 9.7, 0.0, 0.0
Week 5: 35.7; bars 0.0, 0.0, 0.0, 0.0, 0.0
Week 6: 35.7; bars 0.0, 0.0, 0.0, 0.0, 0.0

Level 0 | Level 1a | Level 1b | Level 2
Level 3 | Funded Establishments (WTE care staff) | Worked (Care Staff) Monthly figure Jan 2023 | SNCT Establishments 21% uplift

Ward 27	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Average (6 months)
Observations on time	75.2%	76.4%	75.7%	72.4%	73.4%	71.6%	74.1%
Hand Hygiene	100.0%	72.2%	50.0%	72.7%	70.0%	-	73.0%
Falls	5	3	1	7	2	4	3.7
Falls with harm	0	1	1	1	0	1	0.7
FFT	80%	71%	60%	100%	100%	80%	79.3%
Staffing incidents	0	1	0	0	1	2	0.7
Medication incidents	2	5	1	3	2	4	2.8

© Gateshead Health NHS Foundation Trust

Trust acquired pressure damage (all categories)	2	1	1	0	0	1	0.8

Community Services'- Older Persons Mental health
Cragside

Average Beds	Current Funded Establishment (wte)			Current Contracted staff (wte)			Professional Judgement Recommendations (wte)			Nurse:Patient ratio Recommendation (wte)			Variance Funded V. Prof Judgement (wte)			Variance Funded V. ratio recommendation (wte)		
	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW
16	29.7	14.2	15.5	28.4	13.0	15.4	35.5			33.53	14.55	18.97	5.8			3.83	0.35	3.47
Comments: For areas with																		

Cragside	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Average (6 months)
Observations on time	69.9%	60.7%	71.3%	70.8%	69.7%	84.9%	71.2%
Hand Hygiene	-	-	-	-	100.0%	-	100%
Falls	2	4	5	1	4	3	3.2
Falls with harm	2	3	2	1	1	0	1.5
FFT	-	-	-	-	-	-	-
Staffing incidents	0	0	0	0	0	0	0.0
Medication incidents		1	1	2		1	1.3
Trust acquired pressure damage (all categories)	0	0	0	0	0	0	0.0

© Gateshead Health NHS Foundation Trust

Sunniside

Average Beds	Current Funded Establishment (wte)			Current Contracted staff (wte)			Professional Judgement Recommendations (wte)			Nurse:Patient ratio Recommendation (wte)			Variance Funded V. Prof Judgement (wte)			Variance Funded V. ratio recommendation (wte)		
	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW
10	20.7	13.1	7.6	24.4	14.8	9.6	27.1			24.89	11.34	13.55	6.4			4.19	-1.76	5.95
Comments:																		

Sunniside	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Average(6 months)
Observations on time	59.5%	56.3%	56.5%	65.3%	63.1%	66.1%	61.1%
Hand Hygiene	-	-	-	-	-	-	-
Falls	1	4	2	2	5	4	3.0
Falls with harm	0	0	0	0	3	0	0.5
FFT	-	-	-	-	-	-	-
Staffing incidents	0	0	0	0	0	0	0
Medication incidents	2	1	2	0	1	5	1.8
Trust acquired pressure damage (all categories)	0	0	0	0	0	0	0.0

© Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 16

Report Title:	**Maternity Integrated Oversight Report**			
Name of Meeting:	Board of Directors Part 1			
Date of Meeting:	Wednesday 24th May 2023			
Author:	Ms Karen Hooper, Ms Kate Hewitson and Ms Lesley Heelbeck			
Executive Sponsor:	Dr Gill Findley, Chief Nurse and Professional Lead for Midwifery and AHPs			
Report presented by:	Mrs Jane Conroy, Head of Midwifery			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
	This report presents a summary of the maternity indicators for the Trust.			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☒ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	This paper has been considered by Safecare/Risk and Patient Safety Council held on 16th May 2023.			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	The Maternity Integrated Oversight Report is under review and we plan to have a strengthened reporting format in place by June 2023. **Maternity dashboard** • In April 2023, we had 145 births, 0 perinatal loses (still-births or neonatal deaths) and 0 serious incidents (SI's). • Our PPH rate (>1.5 L blood loss after birth) was 8 which is higher than our target of 2. An audit is underway and a decision has been made to move to measured blood loss (rather than estimated blood loss) for all deliveries with immediate effect. • Maternity Incentive Scheme (MIS) metrics - we are above the 80% for those offered CO monitoring at booking and 36 weeks at 89.29% and 85.83% respectively. **GP trainee survey feedback** • This was largely positive, particularly around support received from the Consultant team and the experiences			

<table>
<tr><td colspan="2"></td><td colspan="5">

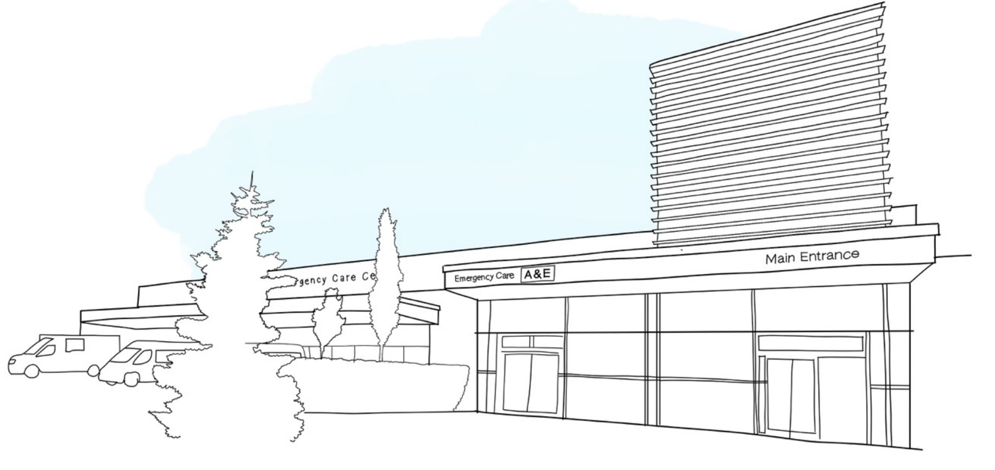
related to Obstetric and Gynae outpatient clinics and the development and consolidation of skills.
• Areas for improvement related to the intensity of on call shifts, the number of IT systems and appreciation/understanding of others roles.

Acuity red flags
• These are detailed within for Q4, and we can see a small number of instances where, for example, the labour ward coordinator was not supernumerary. This was for short periods only whilst arranging for further Midwives to move to Labour ward. The narrative surrounding these red flags will be strengthened for future reports.

MBRRACE Perinatal Summary 2021
• The stabilised and adjusted mortality rates for us at Gateshead were similar to, or lower than, those seen across similar Trusts and as such there are no recommended actions to take from this report, other than continuing to ensure that all eligible perinatal deaths are reviewed fully using the PMRT (the review tool that we use to review the circumstances and care leading up to and surrounding stillbirths and neonatal death).</td></tr>
<tr><td colspan="2">Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper</td><td colspan="5">The Board of Directors are asked to review the detail provided within this report for assurance and to note that a revised format for the Maternity Integrated Oversight Report will be presented at the next Board of Directors.</td></tr>
<tr><td colspan="2" rowspan="5">Trust Strategic Aims that the report relates to:</td><td>Aim 1
☒</td><td colspan="4">We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>Aim 2
☐</td><td colspan="4">We will be a great organisation with a highly engaged workforce</td></tr>
<tr><td>Aim 3
☐</td><td colspan="4">We will enhance our productivity and efficiency to make the best use of resources</td></tr>
<tr><td>Aim 4
☐</td><td colspan="4">We will be an effective partner and be ambitious in our commitment to improving health outcomes</td></tr>
<tr><td>Aim 5
☐</td><td colspan="4">We will develop and expand our services within and beyond Gateshead</td></tr>
<tr><td colspan="2">Trust corporate objectives that the report relates to:</td><td colspan="5"></td></tr>
<tr><td colspan="2">WLinks to CQC KLOE</td><td>Caring
☒</td><td>Responsive
☒</td><td>Well-led
☒</td><td>Effective
☒</td><td>Safe
☒</td></tr>
<tr><td colspan="7">Risks / implications from this report (positive or negative):</td></tr>
<tr><td colspan="2">Links to risks (identify significant risks and DATIX reference)</td><td colspan="5"></td></tr>
<tr><td colspan="2">Has a Quality and Equality Impact Assessment (QEIA) been completed?</td><td colspan="2">Yes
☐</td><td colspan="2">No
☐</td><td>Not applicable
☒</td></tr>
</table>

Maternity Oversight Report

May 2023



IOR Summary/contents

- Exception reports
  - GP survey feedback
  - Acuity red flags
  - MBRRACE perinatal summary 2021
- Serious Incidents – none reported in April 2023
- Maternity dashboard with April data plus narrative
- Exception report schedule
  - PMRT (Q3 & Q4 2022/23)

Maternity Dashboard 2023/24

- Maternity dashboard metrics & reporting undergoing review
- Metrics to be aligned to regional dashboard in line with Maternity Services Data Set reporting (MSDS)
- SPC charts to be reported in Maternity IOR from June 2023 onwards for key agreed metrics with narrative (aligned to regional SPC dashboard reporting)

- April 2023 key data points:
  - Births145
  - 0 perinatal losses (stillbirths/neonatal deaths)
  - PPH rate remains higher than target – 8 (5%) PPH>1500ml in April 2023 – audit underway – agreed to move to Measured Blood Loss for ALL deliveries with immediate effect

% of Offered C0 at Booking (In area bookings only)	80%	89.29%
% of Offered C0 at 36 wks (In area bookings only)	80%	85.83%

Maternity Dashboard

Financial Year 2023/24

		Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2022/23	Spark chart
			Activity													
Births - Live			145												145	
Births - Still		0	0												0	
Total Births			145												145	
Total Deliveries			142												142	
Home Births	(Inc. in Live Births)		3												3	
Sunderland CCG Deliveries (00P)	Patients who have delivered at QEH		13												13	
South Tyneside CCG Deliveries (00N)	Patients who delivered at QEH		23												23	
Singleton Births	All births where only 1 baby born		139												139	
Spontaneous Vaginal Births			82												82	
Spontaneous Vaginal Births (%)			56.55%												56.55%	
Elective C Section			19												19	
Elective C Section Rate			13.10%												13.10%	
Emergency C Section			28												28	
Emergency C Section Rate			19.31%												19.31%	
Unknown C-Section Type			0												0	
Total C-Sections			47												47	
C Section Rate			32.41%												32.41%	
Instrumental Deliveries	Ventouse and Forceps		16												16	
Instrumental Delivery Rate			11.27%												11.27%	
Inductions			59												59	
Induction Rate			41.55%												41.55%	
Right place of birth	To come from the service	95%													100.00%	
Predictive Deliveries	2022/2023 Predicitive Deliveries	N/A	185	168	176	188	177	164	171	143	0	0	0	0	1372	
Maternity Readmissions	Readmitted as PostPartum or Emergency	<42 Days	2												2	
Neonatal Readmissions	Readmitted Following Birth	<42 Days	12												12	
Smoking in Pregnancy	Percentage of known smokers at booking	15%	12.50%												12.50%	
	Smoking at time of delivery	6%	9.15%												9.15%	
	% of Offered C0 at Booking (In area bookings only)	80%	89.29%												89.29%	
	% of Offered C0 at 36 wks (In area bookings only)	80%	85.83%												85.83%	
	% of Offered C0 at Booking (All bookings)		82.91%												82.91%	
	% of Offered C0 at 36 wks (All bookings)		80.14%												80.14%	
Scheduled Bookings	Bookings (1st visit) scheduled by 10 wks	>87%	79.00%												79.00%	
Breastfeeding	Percentage of Initiated Breastfeeding	66.20%	58.62%												58.62%	
	Breastfeeding at Discharge (Transfer to Community)	56.20%	56.55%												56.55%	

Maternity Dashboard (continued)

			Workforce													
Staffing levels	Weekly hours of consultant cover on labour ward (h)	>48														
	midwife to birth ratio	quatr														
	Sickness absence rate	< 4%														
			Clinical Indicators													
Maternal morbidity	Eclampsia	<2	0												0	
	ICU admissions in Obstetrics	<2	0												0	
	Post partum hysterectomies	<2	0												0	
	3rd or 4th degree tear (Total)	<=4	3												3	
	3rd or 4th degree tear (Total) Percentage	<5%	2.11%												2.11%	
	3rd or 4th degree tear (Spontaneous Births)		2												2	
	3rd or 4th degree tear (Spontaneous Births) Percentage	<2.8%	2.44%												2.44%	
	3rd or 4th degree tear (Assisted Births)		1												1	
	3rd or 4th degree tear (Assisted Births) Percentage	<6.8%	6.25%												6.25%	
	Massive PPH >=1.5L (All births)	<2	8												8	
	Massive PPH >=1.5L (Singelton Cephalic Only)	<2	4												4	
	Percentage PPH >=1.5L (Singelton Cephalic Only)		2.88%												2.88%	
Neonatal morbidity	Admitted directly to NNU (SCBU) (>37 weeks)	<4	1												1	
	Live Births > 37 Weeks		134												134	
	Percentage Admitted directly to NNU (SCBU) (>37 weeks)	<6%	0.75%												0.75%	
	Agpar Score Less than 7 (>=37 weeks)		5												5	
	Neonatal Deaths														0	
Preterm birth rate	<=26+6 Weeks at birth		0.00%												1.38%	
	<=34 Weeks at birth		1.38%												13.79%	
	<=36+6 Weeks at birth	<6%	7.59%												68.97%	
Continuity of Carer	Percentage placed on Pathway (29 weeks)	35%	12.5%												12.5%	
	Percentage from BAME background	75%	47.1%												47.1%	
	Percentage from Area of Deprivation	75%	17.5%												17.5%	
Risk Management	SGA (<10th centile) detection rate quarterly															
	FGR (<3rd centile) detection rate quarterly															
	Number of SUIs														0	
	Moderate and above harm orange incidents														0	
	HSIB Cases														0	
Complaints	Total Complaints														0	

Maternity Trust Comparison Table

Table flags
- Better than National Values
- Worse than National Values

Maternity Clinical Indicators - North East & North Cumbria

Measure	Latest Period	Unit of Measurement	Direction	Region	Trust							
				North East and Yorkshire	County Durham and Darlington NHS Foundation Trust	Gateshead Health NHS Foundation Trust	North Cumbria Integrated Care NHS Foundation Trust	North Tees and Hartlepool NHS Foundation Trust	Northumbria Healthcare NHS Foundation Trust	South Tees Hospitals NHS Foundation Trust	South Tyneside and Sunderland NHS Foundation Trust	The Newcastle Upon Tyne Hospitals NHS Foundation Trust
Deliveries Under 27 Weeks	June 2022	Percentage	N/A	0.6%	0.0%	3.7%	0.0%	0.0%	2.0%	1.5%	1.8%	1.0%
Deliveries Under 37 Weeks	June 2022	Percentage	N/A	7.2%	4.9%	3.7%	4.8%	5.4%	6.0%	7.4%	8.8%	9.5%
Spontaneous Delivery Rate	June 2022	Percentage	N/A	55.4%	55.7%	59.3%	53.7%	59.5%	50.0%	61.8%	59.6%	51.9%
Instrumental Delivery Rate	June 2022	Percentage	N/A	10.0%	9.8%	11.1%	12.2%	5.4%	12.0%	7.4%	15.8%	13.2%
Emergency Caesarean Section Rate	June 2022	Percentage	N/A	18.9%	16.4%	11.1%	19.5%	18.9%	18.0%	17.6%	10.5%	18.9%
Elective Caesarean Section Rate	June 2022	Percentage	N/A	15.1%	18.0%	18.5%	14.6%	16.2%	20.0%	14.7%	14.0%	15.1%
Robson group 1 - C-sec rate	3 months to June 2022	Percentage	N/A	5.9%	7.4%	0.0%	10.5%		.%	3.4%	4.5%	0.0%
Robson group 2 - C-sec rate	3 months to June 2022	Percentage	N/A	42.5%	47.6%	40.9%	50.0%		.%	19.6%	29.3%	0.0%
Robson group 5 - C-sec rate	3 months to June 2022	Percentage	N/A	80.4%	82.6%	77.8%	83.3%		.%	91.8%	73.3%	94.0%
Induction of labour as % of deliveries	June 2022	Percentage	N/A	34.8%	36.7%	40.0%	25.6%	43.2%	21.1%	48.5%	47.4%	26.9%
PPH >= 1500ml	May 2022	Rate per 1,000	Lower is Better	31.0	37.0	27.0	33.0	30.0	25.0	21.0	22.0	28.0
3rd/4th degree tears	3 months to June 2022	Rate per 1,000	Lower is Better	26.0	22.0	.	.	32.0	.	22.0	18.0	12.0
Stillbirth Rate	2019	Rate per 1,000	Lower is Better	3.6	3.8	5.5	5.2	3.9	2.3	2.7	3.7	2.8
Apgar Score < 7	3 months to June 2022	Rate per 1,000	N/A	15.0	20.0	29.0	.	18.0	.	10.0	16.0	11.0
Hypoxic Ischaemic Encephalopathy Diagnosis	June 2022	Rate per 1,000	N/A	0.9	0.0	0.0	0.0	0.0	0.0	2.9	6.5	1.8
Neonatal Mortality Rate	2019	Rate per 1,000	Lower is Better	1.8	0.9		1.1			1.9	1.9	3.8
Placement on Continuity of Carer pathway	June 2022	Percentage	Higher is Better	20.9%	98.6%	24.2%	35.4%	19.2%	.%	.%	6.3%	5.0%
Breast milk at first feed	June 2022	Percentage	N/A	63.4%	52.7%	57.7%	55.0%	100.0%	57.5%	56.5%	51.7%	.%
Smoking at Delivery	May 2022	Percentage	Lower is Better	10.5%	16.1%	10.3%	5.6%			.%	13.1%	10.1%
Smoking at Booking	June 2022	Percentage	Lower is Better	15.0%	13.3%	13.6%	15.6%	13.6%	10.1%	12.7%	26.7%	13.0%

Exception reporting

GP survey feedback

Positive feedback

- Positive comments regarding General Practice reported
- Positive feedback regarding support received from Consultant team
- GP trainees were positive about the number of outpatient clinics they were able to attend and the skills learned during these

Areas for improvement

- Derogatory comments about GPs in general made by clinical teams (has been reported in previous surveys)
- Intensity of on call shifts
- High number of IT systems they are required to be familiar with

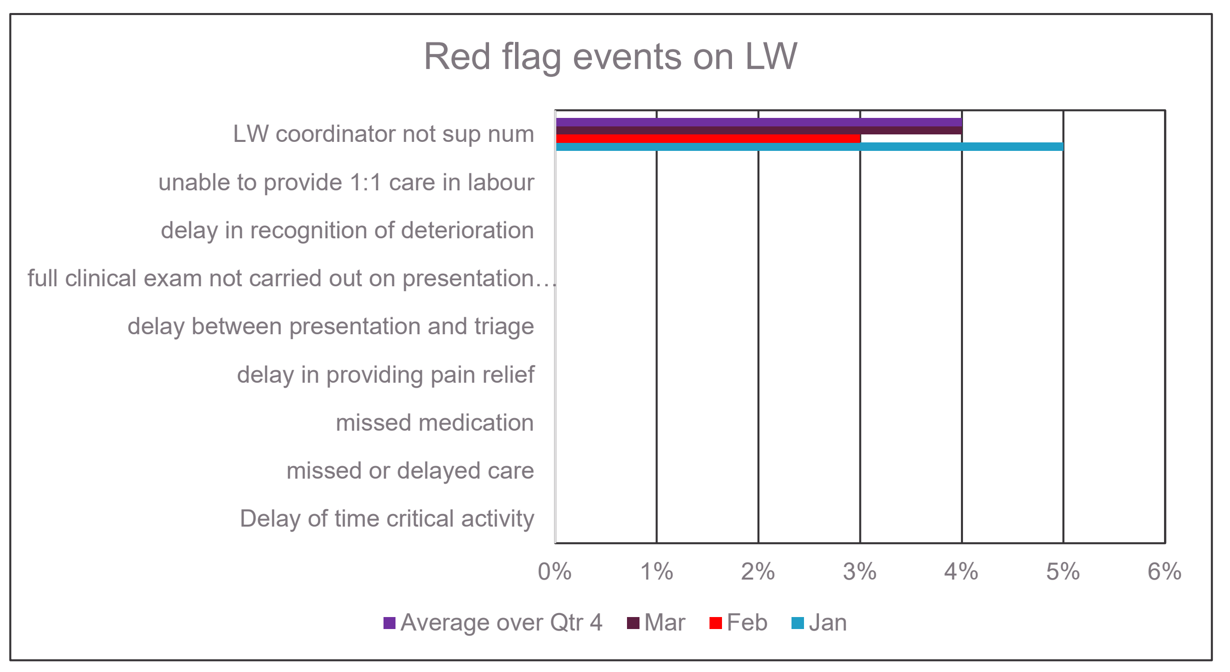
Actions

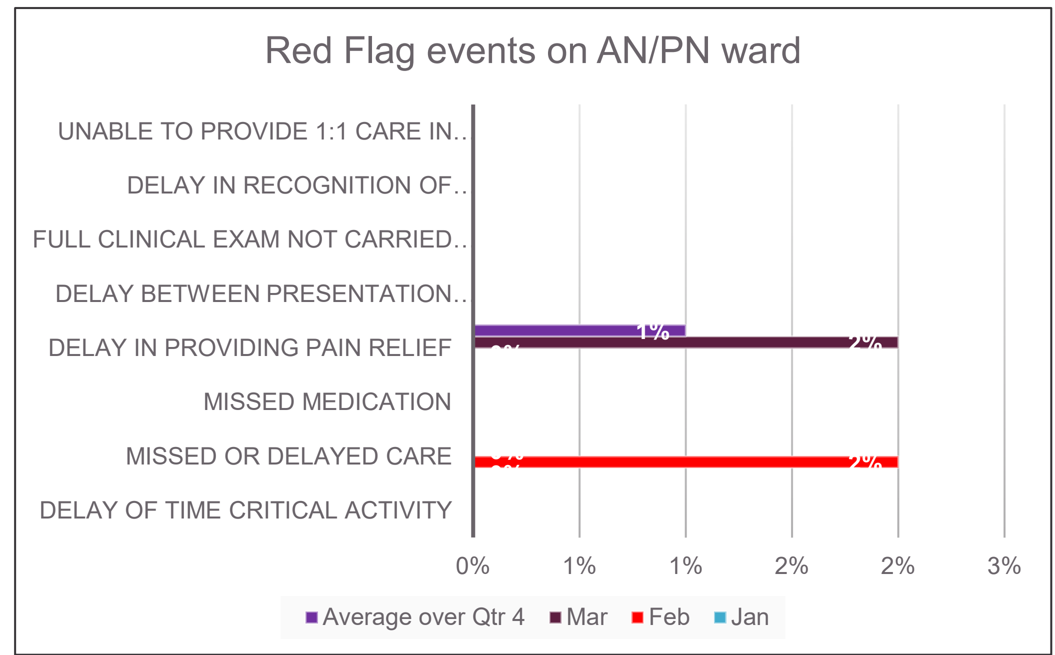
- Rota amended to provide more gaps between on call shifts
- Additional on call team member during weekdays
- Incorporate this feedback into planned away days, civility month & departmental culture work

Exception reporting

Maternity NHS Gateshead Health NHS Foundation Trust

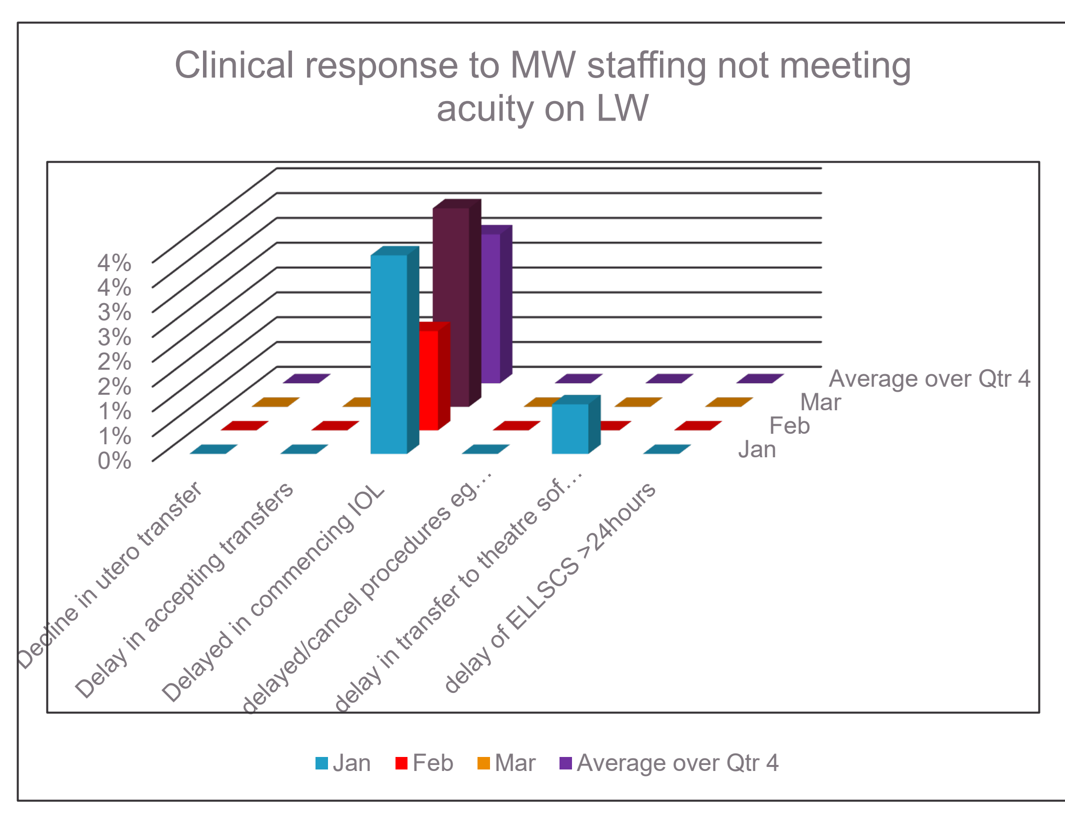
Red flag acuity report

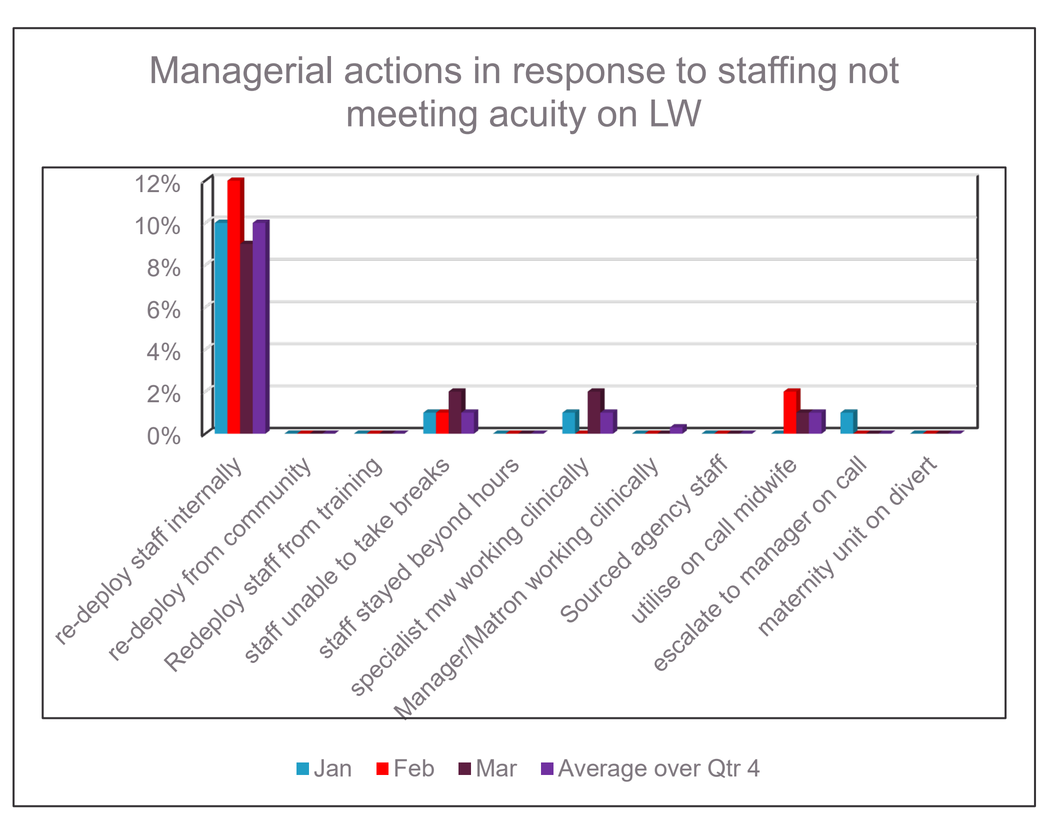




Exception reporting

Red flag acuity report



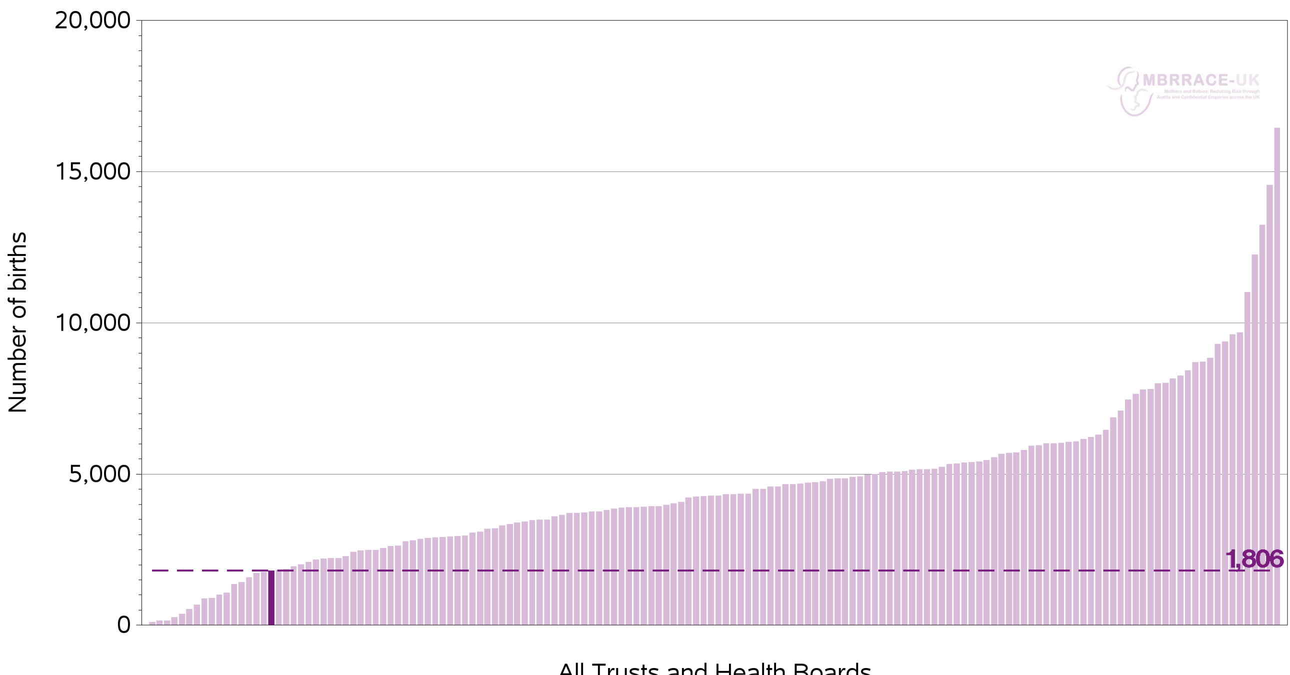


Exception reporting

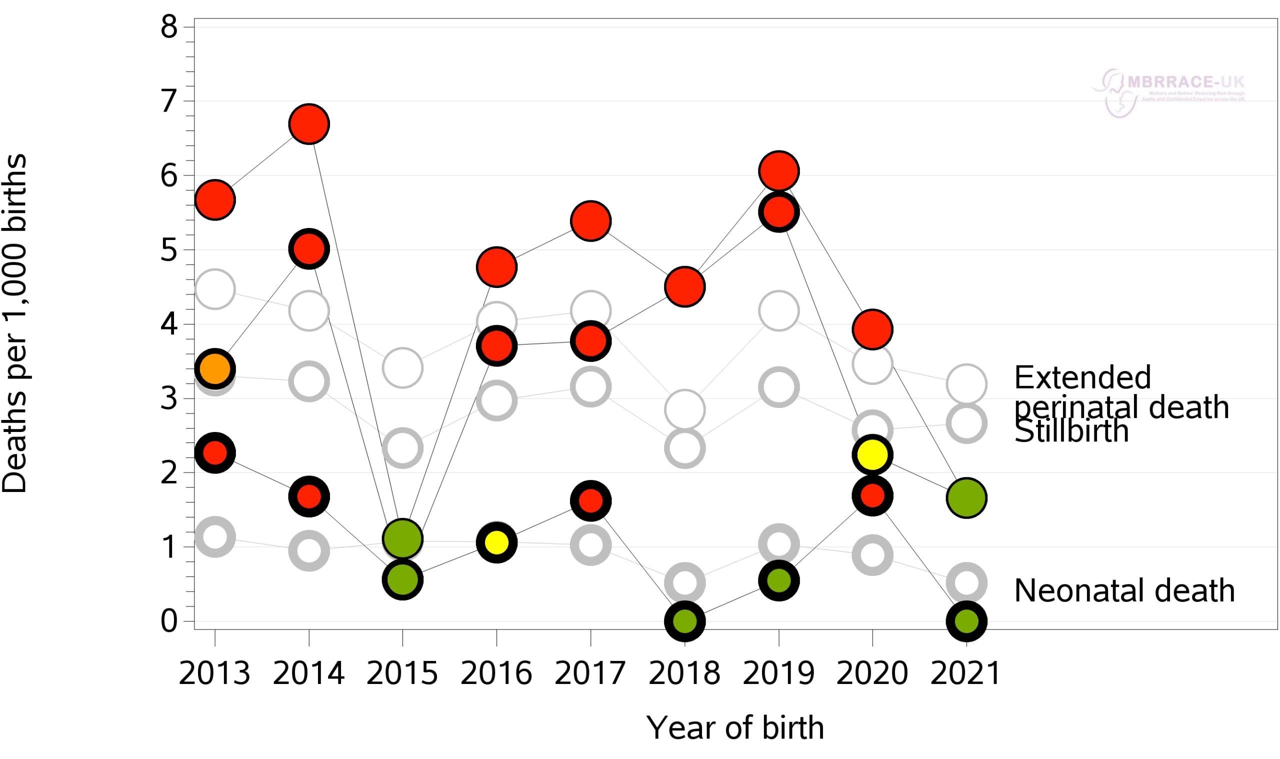
Gateshead Health NHS Foundation Trust

MBRRACE perinatal summary 2021

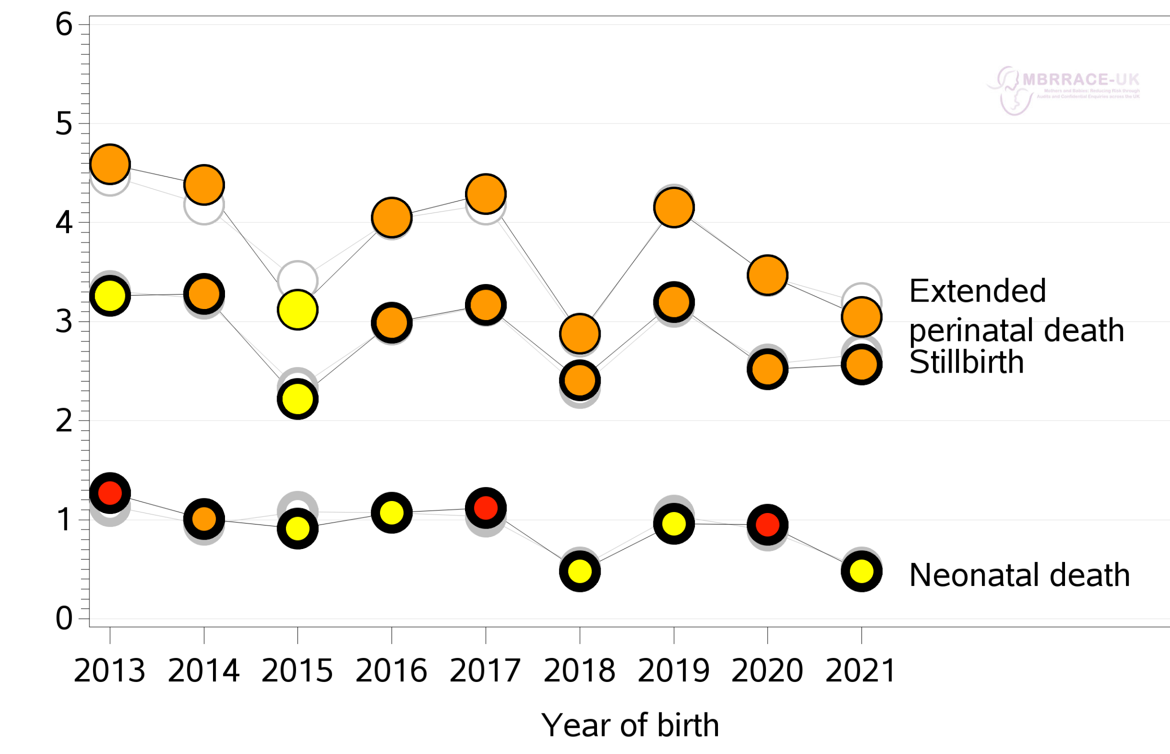
The stabilised & adjusted mortality rates for your Trust were similar to, or lower than, those seen across similar Trusts and Health Boards. There are no recommended actions to take from this report, other than continuing to ensure that all eligible perinatal deaths are reviewed fully using the PMRT.



Crude mortality rates for babies born at 24 weeks gestational age or later by year of birth

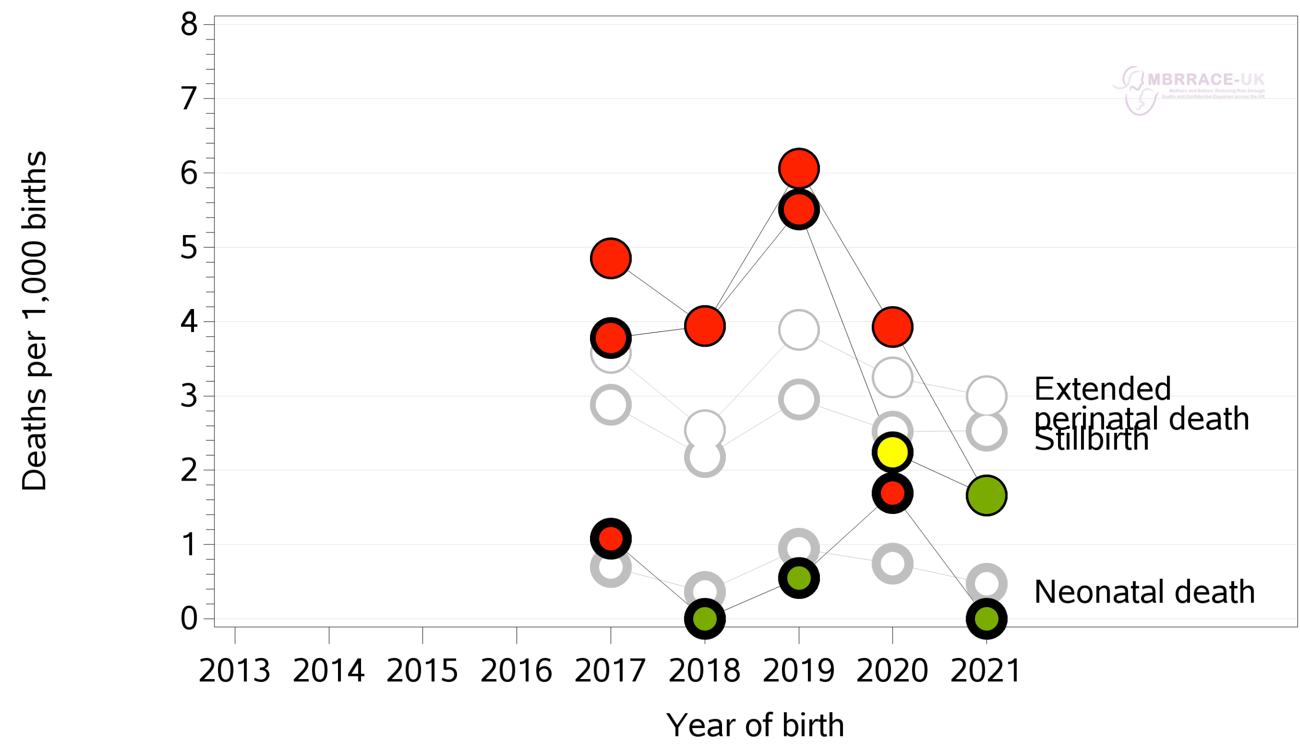


MBRRACE-UK
Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK



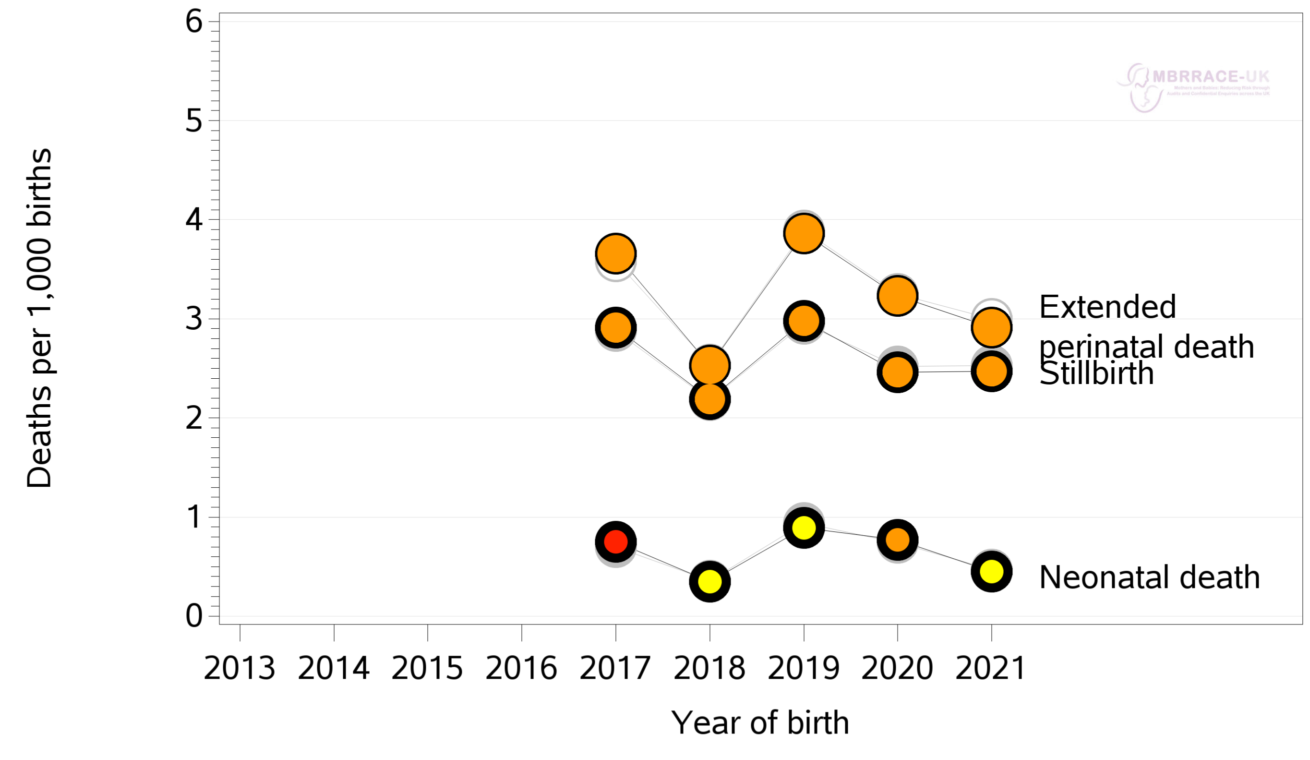
MBRRACE-UK
Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK

NHS
Gateshead Health
NHS Foundation Trust

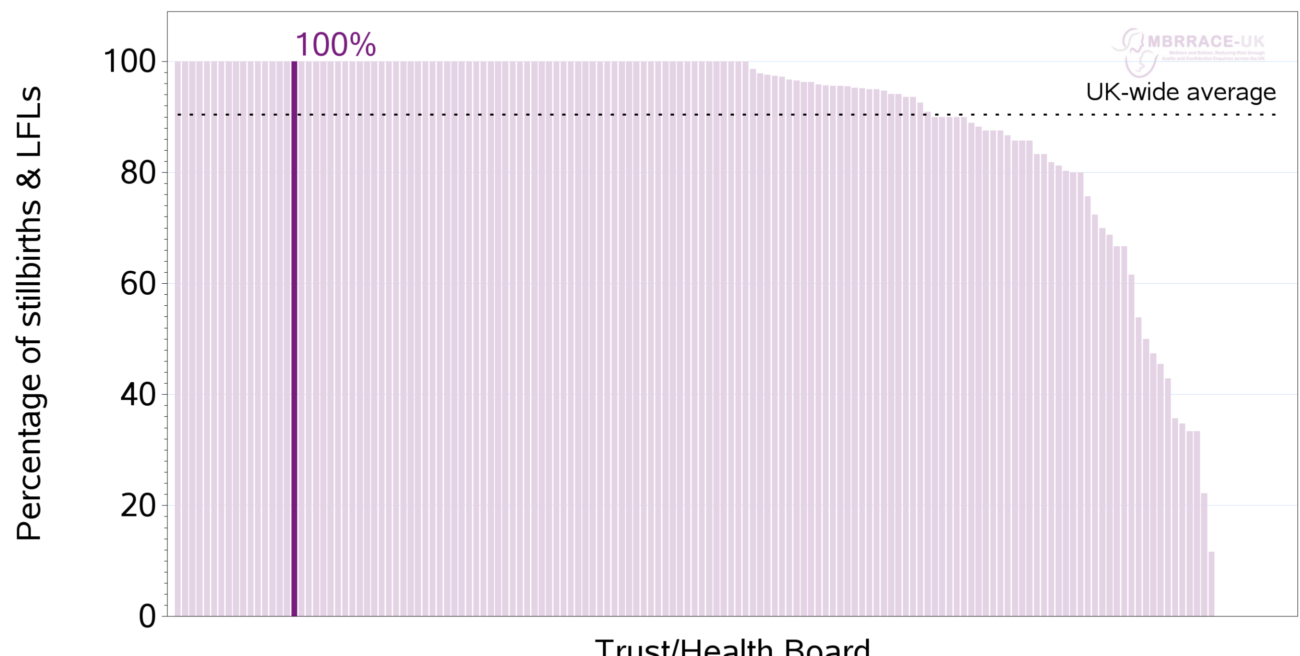

Crude mortality rates for babies born at 24 weeks gestational age or later by year of birth: excluding deaths due to congenital anomalies
Deaths per 1,000 births
8
7
6
5
4
3
2
1
0
2013
2014
2015
2016
2017
2018
2019
2020
2021
Year of birth
Extended perinatal death
Stillbirth
Neonatal death
MBRRACE-UK

MBRRACE-UK
Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK

NHS
Gateshead Health
NHS Foundation Trust


Stabilised & adjusted mortality rates for babies born at 24
tational age or later by year of birth: excluding deaths due to congenital a
Deaths per 1,000 births
6
5
4
3
2
1
0
MBRRACE-UK
Extended
perinatal death
Stillbirth
Neonatal death
2013
2014
2015
2016
2017
2018
2019
2020
2021
Year of birth

Percentage of stillbirths and late fetal losses in 2021 notified to MBRRACE-UK within 7 days



Exception reporting by schedule

Perinatal Mortality Review Tool (PMRT) – Q3 & Q4 2022/23 reports

- Detailed quarterly PMRT reports are presented to the Trust Mortality & Morbidity steering group

MBRRACE ID	Gestation & Outcome	DOB	Date added to MBRRACE	Date PMRT started	Reported to MBRRACE within 7 working days	Info complete within 1 month of death	PMRT review started within 2 months of death	External clinician
Case 1 84449	Antenatal stillbirth 26+6	7/11/22	11/11/22	11/11/22	Yes	Yes	Yes	Yes
Case 2 84830	Antenatal stillbirth at 27+3	4/12/22	5/12/22	5/12/22	Yes	Yes	Yes	Yes
Case 1 85368	Antenatal stillbirth at 28+5	5/1/2023	6/1/2023	6/1/23	Yes	Yes	Yes	Yes
Case 2 86144	Antenatal stillbirth at 22+0	16/2/2023	20/2/2023	20/3/23	Yes	Yes	Yes	Yes
Case 3 86741	40+0 NND at 15 days	9/3/2023 24/3/2023 (DOD)	30/3/2023	30/3/23	Yes	Yes	Yes	Yes

Report Cover Sheet   Agenda Item: 17

<table>
<tr><td>Report Title:</td><td colspan="4">Learning from Deaths – six monthly update</td></tr>
<tr><td>Name of Meeting:</td><td colspan="4">Trust Board</td></tr>
<tr><td>Date of Meeting:</td><td colspan="4">Wednesday 24th May 2023</td></tr>
<tr><td>Author:</td><td colspan="4">Andy Ward – Senior Information Analyst – Quality & Patient Safety
Wendy McFadden – Strategic Lead Clinical Effectiveness</td></tr>
<tr><td>Executive Sponsor:</td><td colspan="4">Andy Beeby – Medical Director</td></tr>
<tr><td>Report presented by:</td><td colspan="4">Andy Beeby – Medical Director</td></tr>
<tr><td rowspan="2">Purpose of Report
Briefly describe why this report is being presented at this meeting</td><td>Decision:
☐</td><td>Discussion:
☐</td><td>Assurance:
☒</td><td>Information:
☐</td></tr>
<tr><td colspan="4">To provide an update on Mortality and Learning from deaths over the last six months.</td></tr>
<tr><td>Proposed level of assurance – <u>to be completed by paper sponsor</u>:</td><td>Fully assured
☒
No gaps in assurance</td><td>Partially assured
☐
Some gaps identified</td><td>Not assured
☐
Significant assurance gaps</td><td>Not applicable
☐</td></tr>
<tr><td>Paper previously considered by:
State where this paper (or a version of it) has been considered prior to this point if applicable</td><td colspan="4">NA</td></tr>
<tr><td>Key issues:
Briefly outline what the top 3-5 key points are from the paper in bullet point format

Consider key implications e.g.
• Finance
• Patient outcomes / experience
• Quality and safety
• People and organisational development
• Governance and legal
• Equality, diversity and inclusion</td><td colspan="4">• The Trust’s latest publications of national mortality indicators places the Trust with bandings of ‘Lower than expected’ and ‘As expected for the SHMI and HSMR respectively.
• All Deaths scrutinised by the Medical Examiners office.
• 99.1 % of cases reviewed are identified as being definitely not preventable; 94.9% of cases reviewed were identified as good practice; No potentially preventable deaths were identified during the period.
• Revised Learning from deaths policy and new process incorporating Medical Examiners review as first level now live.</td></tr>
<tr><td>Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper</td><td colspan="4">To receive the paper for assurance</td></tr>
</table>

<table>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:</td><td colspan="2">Aim 1
☒</td><td colspan="4">We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td colspan="2">Aim 2
☐</td><td colspan="4">We will be a great organisation with a highly engaged workforce</td></tr>
<tr><td colspan="2">Aim 3
☐</td><td colspan="4">We will enhance our productivity and efficiency to make the best use of resources</td></tr>
<tr><td colspan="2">Aim 4
☐</td><td colspan="4">We will be an effective partner and be ambitious in our commitment to improving health outcomes</td></tr>
<tr><td colspan="2">Aim 5
☐</td><td colspan="4">We will develop and expand our services within and beyond Gateshead</td></tr>
<tr><td>Trust corporate objectives that the report relates to:</td><td colspan="6">List corporate objective reference and headline – e.g. 1.4 Maximise the use of Nervecentre to improve patient care</td></tr>
<tr><td>Links to CQC KLOE</td><td>Caring
☐</td><td colspan="2">Responsive
☐</td><td>Well-led
☐</td><td>Effective
☒</td><td>Safe
☒</td></tr>
<tr><td colspan="7">Risks / implications from this report (positive or negative):</td></tr>
<tr><td>Links to risks (identify significant risks and DATIX reference)</td><td colspan="6">NA</td></tr>
<tr><td>Has a Quality and Equality Impact Assessment (QEIA) been completed?</td><td colspan="2">Yes
☐</td><td colspan="2">No
☐</td><td colspan="2">Not applicable
☒</td></tr>
</table>

Mortality Report

Executive Summary

The latest SHMI was published on 13th April 2023 covering the period from December 2022 to November 2022. The Trust has a SHMI Banding of 'Lower Deaths than Expected' with a score of 0.87.

The HSMR for the period February 2022 to January 2023 is 100.1 showing 'Deaths as Expected'.

All deaths are initially scrutinised by the Trusts Medical Examiner office and since October 2022 are scored or referred for further review where appropriate.

99.1 % of cases are identified as being definitely not preventable.
94.9% of cases reviewed were identified as good practice.
No potentially preventable deaths were identified during the period. (Hogan score >=4)

Where mortality alerts have been triggered, case note review demonstrates that in the main cases are identified as 'definitely not preventable'. Those cases that demonstrate evidence of preventability continue to be reviewed by the Trust's Mortality Council where learning and actions are identified.

The Lead Medical examiner and Medical Examiner team continue to provide scrutiny of deaths within the Trust, supporting learning from deaths within the trust and development of the Trusts mortality review process. The Medical examiner pathway includes feedback mechanisms to clinicians and/or nursing staff whilst ensuring any escalation of concerns or areas for quality improvement and patient safety are shared with the correct teams.

1. Introduction:

The purpose of this paper is to update the Board upon on going work in relation to mortality within Gateshead Health NHS Foundation Trust. Within the paper is an update on the Summary Hospital-level Mortality Indicator (SHMI) which is the national mortality ratio score developed for use across the NHS, a summary of the Hospital Mortality Standardised Ratio (HSMR) provided by Healthcare Evaluation Data (HED) and learning from mortality review.

2. The National Picture: Summary Hospital-level Mortality Indicator (SHMI)

The SHMI is currently published monthly, and each publication includes discharges in a rolling twelve-month period.

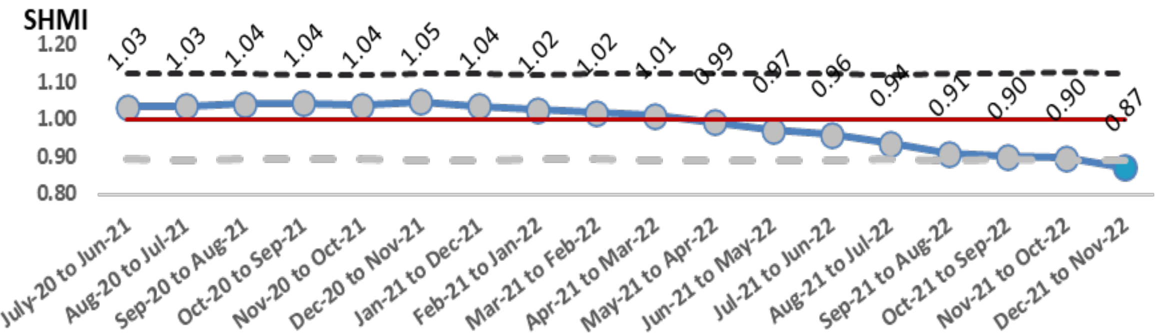
The SHMI compares the actual number of patients who die following hospitalisation (both in- hospital deaths and deaths within 30 days of discharge) at a trust with the number that would be expected to die based on average England figures, given the characteristics of the patients treated there.

For any given number of expected deaths, an upper and lower bound of observed deaths is considered to be 'as expected'. If the observed number of deaths falls outside of this range, the trust in question is considered to have a higher or lower SHMI than expected.

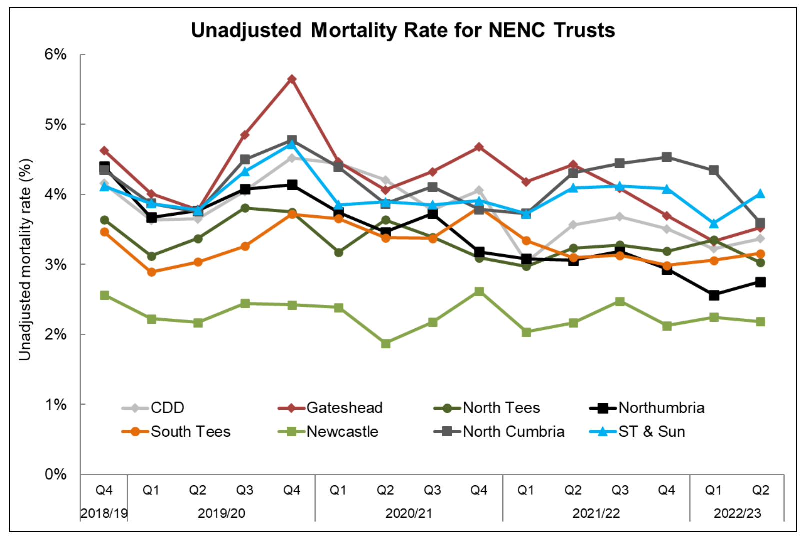
COVID-19 activity excluded from the SHMI. The SHMI is not designed for this type of pandemic activity and the statistical modelling used to calculate the SHMI may not be as robust if such activity were included.

SHMI Trust Position December 2021 to November 2022

The latest SHMI was published on 13th April 2023 covering the period from December 2022 to November 2022. The Trust has a SHMI Banding of 'Lower Deaths than Expected' with a score of 0.87, below the national baseline of 1.00. This is the first time the Trust has received the banding of 'Lower Deaths than Expected.'



The SHMI for trusts in the region mirrors unadjusted mortality.
Unadjusted mortality varies between trusts from approximately 2% to 6%.
The unadjusted mortality rate for Gateshead has fallen in recent months and this has been echoed in the SHMI.



3. Trust based data analysis:

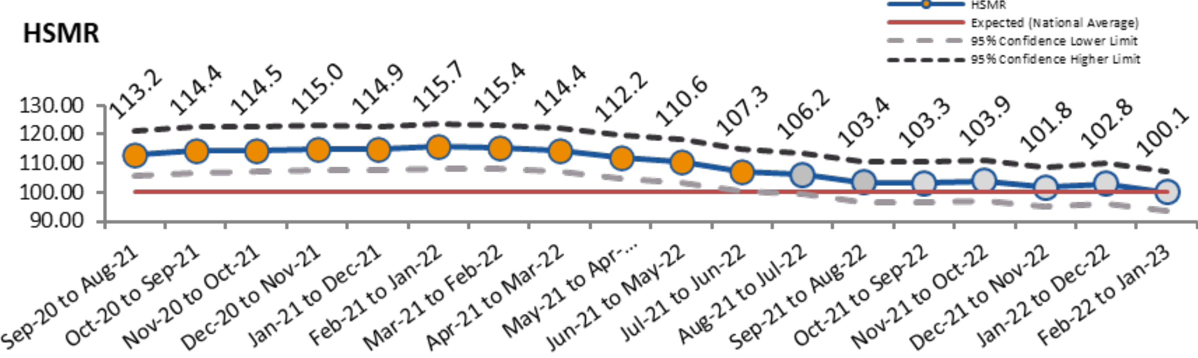
The Hospital Standardised Mortality Ratio (HSMR) is a risk-based assessment using a basket of 56 primary diagnosis groups which account for approximately 80% of hospital mortality.

The HSMR is the ratio between the number of patients who die in hospital compared to the expected number of patient deaths based on average England figures given the characteristics e.g., presenting and underlying conditions, age, sex, admission method, palliative coding.

COVID 19 activity is excluded from the HSMR based on the clinical coding of patient spells placing these deaths outside of the 56 diagnosis groups considered by the model. However, a patient may be still included if their primary diagnosis does not include COVID-19 but a subsequent diagnosis does.

HSMR Trust Position February 2022 to January 23

The HSMR for the period February 2022 to January 2023 is 100.1 showing 'Deaths as Expected'.
The recent trend has been encouraging with a number of consecutive reductions and the Trust remaining with 'Deaths as Expected' for seven consecutive periods.



Mortality Alerts from HED (Healthcare Evaluation Data)

Below are details of the recent mortality alerts identified in HED, the system used to monitor and analyse mortality indicators by the Trust.

	Alert	CCS Diagnostic Group	Period	Observed Deaths	Expected Deaths	Obs -Exp	HSMR SHMI / CUSUM Score	% Reviewed (where death within Trust)	% Definitely not preventable	% NCEPOD Good Practice
	SHMI	Peripheral and visceral atherosclerosis	Jan-22 to Dec-22	14 (11 in hospital)	6	8	230	55.0%	100%	100%
	HSMR CUSUM*	Cancer of bronchus lung	Jan-23	17	8	9	5.1	100%	100%	100%
	HSMR CUSUM*	Congestive heart failure	Jan-23	13	9	4	4.9	92.3%	100%	91.7%
	HSMR CUSUM*	Other lower respiratory disease	Jan-23	5	2	3	3.6	100%	100%	100%
	HSMR CUSUM*	Aspiration pneumonitis; food vomitus	Dec-22	25	17	8	5.1	88.0%	100%	100%
	HSMR CUSUM*	COPD and bronchiectasis	Dec-22	15	10	5	3.1	80.0%	100%	83.3%
	HSMR CUSUM*	Aortic; peripheral; and visceral artery aneurysms	Nov-22	4	2	2	3.9	50%	100%	100%

* For CUSUM alerts, cases within the three months prior to the alert are considered in the figures

SHMI: Peripheral and Visceral Atherosclerosis

This diagnosis group alerted between January and December 2023 with 14 deaths observed (11 of which occurring in hospital) against 6 expected by the model. More than half of the hospital death cases have been reviewed and all cases reviewed were deemed to be 'Definitely not preventable' and 'Good practice'

HSMR: CUSUM Alerts

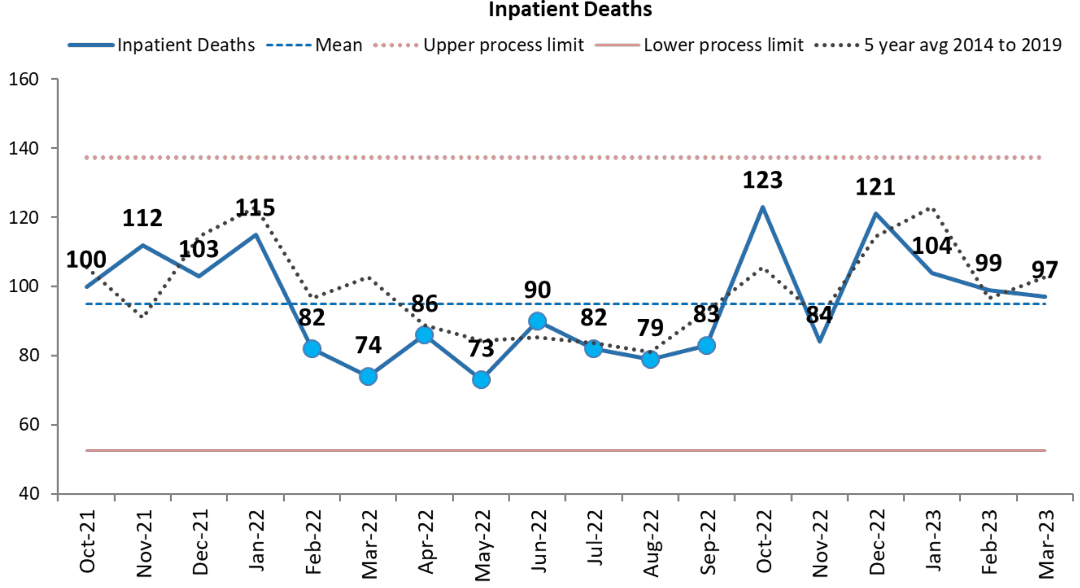
CUSUM alerts flag any diagnosis groups with consecutive months where the observed deaths are higher than the expected deaths. For the CUSUM alerts listed, none have re-alerted in the most recent month and where cases have been reviewed, they were deemed in the main to be 'Definitely not preventable. '

Alerts continue to be presented and discussed at each Mortality and Morbidity Steering Group where any further actions or investigation can be discussed and agreed.

Inpatient mortality

The chart below provides the figures for the Trust inpatient deaths.

Inpatient mortality remained below the 18 month mean for 8 months between Feb-22 and Sep-22 with the monthly volumes observed to be now tracking the pre pandemic 5-year average.



4. Learning from Deaths and Mortality Review

Mortality Review Reporting March 2022 to February 2023

Mortality Review Deaths 01/03/2022 to 28/02/2023 Data Extracted 12/04/2023

	Deaths in period	Deaths reviewed by Medical Examiner	Learning Disability Deaths reviewed at Mortality Council	Severe Mental Illness deaths reviewed at Mortality Council	Total cases fully reviewed and scored	Number awaiting scoring further scoring at Ward Team and/or Mortality Council	Number awaiting Ward Level review following referral by ME
	1175	1175	7	5	779	79	25
Denominators		1175	8	15			
		100.0%	87.5%	33.3%			

The scores below relate to reviews undertaken by either the Medical Examiner Scrutiny, Mortality Council, or the Ward based team.
The figures below represent the outcomes of 779 cases fully reviewed and scored.

Hogan 1 - Definitely Not Preventable	Hogan 2 - Slight Evidence of Preventabiliy	Hogan 3 - Possibly Preventable (Less than 50:50)	Hogan 4 - Probably preventable (more than 50:50)	Hogan 5 - Strong Evidence Preventable	Hogan 6 - Definitely Preventable	Potentially avoidable deaths (Hogan 4 and above)
99.1%	0.8%	0.1%	0.0%	0.0%	0.0%	0.0%

NCEPOD Score 1 Good Practice	NCEPOD Score 2 Room for improvement - Clinical Care	NCEPOD Score 3 Room for Improvement - Organisational Care	NCEPOD Score 4 Room for Improvement Clinical and Organisational Care	NCEPOD Score 5 Less Than Satisfactory	NCEPOD score 6 Insuficient data
94.9%	0.8%	3.5%	0.8%	0.1%	0.0%

Figures bassed on the following priority order of scoring: Mortality Council > Ward Based Team Review > ME Scrutiny.

100% of deaths have been reviewed by the medical examiner in the latest reporting period.

87.5% (7/8) of Learning disasblity deaths and 33.3% (5/15) of deaths from patients with severe mental ilnness (SMI) have been reviewed.

Since the inroduction of initail scoring by the Medical Examiners office in October 2022 a total of 779 cases have been fully reviewed (including ward level reviews and or Mortality Council reviews where required). The outcomes from those reviews are:

- 99.1 % of cases are identified as being definitely not preventable.
- 94.9% of cases reviewed were identified as good practice.
- 5.1 % of cases identified room for improvement.
- 0 deaths identified as potentially avoidable (Hogan score >=4)

There are 82 cases that required a further review by either the Ward based team or the Mortality Council from deaths witin the period.

5. Learning from Mortality Council

For the period March 2022 – February 2023, 153 cases were reviewed by the Mortality Council. The scores of the review are detailed in the table below:

Hogan 1 – Definitely not preventable	129
Hogan 2 – Slight evidence of prevention	17
Hogan 3 – Possibly preventable, less than 50:50	3
Hogan 5	1*

*this is a historical case of a patient who died in 2018 that was reviewed again by the Council in July 2022, following completion of lengthy internal and external investigations.

NCEPOD 1 – Good practice	90
NCEPOD 2 – Room for improvement clinical care	3
NCEPOD 3 – Room to improve organisation of care	37
NCEPOD 4 – Room to improve clinical and organisational	18
NCEPOD 5 – Less than satisfactory	2

Three cases were unable to be scored and will come to the committee on completion of the relevant investigations.

Good practice

- Collaboration between teams
- Provision of activity co-ordinators on wards
- Continuity of care for patients
- Safety netting advice given appropriately
- Supporting patient to comfort eat at end of life
- Evidence of collaborative working across organisations for those with complex mental health needs
- Documentation of Emergency Department consultation
- Senior involvement and documentation
- ECHO availability

Caring for patients with a learning disability

- Learning disability patients being brought to A&E on their own – to target triage team to highlight this with care homes/ care providers
- Learning disability nurse not being alerted of admission of learning disability patients
- MCA/DOLS not being completed when required
- Capacity assessments for patients with a learning disability to be documented – even when they have capacity
- DNACPR completion remains an issue in some cases – mock up DNACPR form to be used as good practice
- Verbal communication – communicate methods must be adapted to meet the needs of the individual. Patients who do not communicate verbally does not automatically mean they can't hear.

Caring for patients with a serious mental illness

- Patients can suffer with constipation be mindful of this during assessments
- Smoking cessation/health screening for patients with serious mental illness – work to be done to ensure this group of patients are engaged in health promotion
- Access to EEGs is problematic, good access for critical care patients, however an issue for patients on base wards

- Lithium level monitoring requires pharmacy expertise and JAC prompt to be explored

Care and treatment
- Accessibility of Careflow for out of hours GPs
- Senior clinicians to be involved in NG tube insertion for patients with difficult access
- Lack of earlier senior review for patients when there has been multiple failed attempts at a procedure
- Confirmation bias for patients with decompensated liver failure – they can have other conditions
- Plan B required for treatment for patients who self-discharge
- Pathways required for patients who present with leg weakness to ensure CT scans undertaken when required
- Importance of continuing to manage electrolytes in metastatic breast cancer
- Documentation of discussions with family on the DNACPR form as well as within the patient's records
- Importance of reviewing outcomes of all investigations prior to patient's being discharged
- Diabetic foot pathway – ensure patients are referred to the Freeman Hospital as per protocol

Governance
- Reminder to log all inpatient falls on Datix
- Reminder to log all self discharges on Datix
- Improve the process of feeding back outcomes of reviews to junior doctors for learning and educative opportunities
- Civility/ professionalism important in terms of looking after patients who don't always comply with treatment – this could be for various reasons

A review of a further sample of heart deaths reviewed by the Mortality Council in February 2023, the following learning was identified;

- Good practice;
  Heart failure outcome letter very comprehensive
  Involvement with family
  Thoughtful and proactive approach to end of life care
  Inpatient echo carried out within 48 hours of admission which allowed for timely new diagnosis
  Evidence of good MDT working.

- Learning;
  Number of diagnoses missing from the GP notification of death letter
  No main diagnosis and a lack of detail
  Discharge letter not accessible on system
  Issue navigating careflow system – correspondence in various places which contributes to inefficiencies in the system

In response to a theme identified via the Medical Examiners Office, an extraordinary meeting of the Mortality Council took place on 30th March 2023. Learning included;

- Need to raise awareness and promote the arrangements in place to support relatives and carers and how ward staff are made aware of who the initiatives are applicable to.

- End of Life care training – face to face modules required for palliative care and dementia.
- Dementia nurse support – referred to team too late in the patient's journey, earlier referrals allow specialists to get to know patients, referral process on nervecentre required.
- Environment – no therapeutic environment on ward areas, which leads to longer lengths of stay, readmissions, deconditioning and higher levels of care required after discharge. Activity Co-Ordinator forum to be expanded to include care home activity facilitators. Involvement of nutrition and dietetic teams earlier in the journey.
- RM80 rapid tranquilisation – clarity required around use of haloperidol for patients with dementia, is it all dementias?
- Patient boarded and ward team instigated end of life in the middle of the night without any consultation with speciality team or review by clinician the following day.

Good practice identified;

- Discussions with family
- Open visiting
- Use of enhanced care
- Documentation of care plans
- Invaluable frailty team involvement

6. Recommendation

The Board is asked to receive this paper for information and assurance.

Meeting:	Trust Board
Chair:	Alison Marshall
Financial year:	2023/24

	Lead	Type of item	Public/Private	May-23	June 23 (year end only)	Jul-23	Sep-23	Nov-23	Jan-24	Mar-24
Standing Items			Part 1 & Part 2							
Apologies	Chair	Standing Item	Part 1 & Part 2	√	√	√	√	√	√	√
Declaration of interests	Chair	Standing Item	Part 1 & Part 2	√	√	√	√	√	√	√
Minutes	Chair	Standing Item	Part 1 & Part 2	√		√	√	√	√	√
Action log	Chair	Standing Item	Part 1 & Part 2	√		√	√	√	√	√
Matters arising	Chair	Standing Item	Part 1 & Part 2	√		√	√	√	√	√
Chief Executive's Update Report	Chief Executive	Standing Item	Part 1 & Part 2	√		√	√	√	√	√
Cycle of Business	Company Secretary	Standing Item	Part 1 & Part 2	√		√	√	√	√	√
Patient & Staff Story	Company Secretary	Standing Item	Part 1	√		√	√	√	√	√
Questions from Governors	Chair	Standing Item	Part 1	√		√	√	√	√	√
Items for Decision			Part 1 & Part 2							
Annual Declarations of Interest	Company Secretary	Item for Decision	Part 1							√
Approval of new Strategic Objectives	Deputy Director of Corporate Services & Transformation	Item for Decision	Part 1	√						
Board Assurance Framework - quarterly updates	Company Secretary	Item for Assurance	Part 1			√		√		
Board Assurance Framework - approval of closing and opening position	Company Secretary	Item for Decision	Part 1							√
Standing Financial Instructions, Delegation of Powers, Constitution and Standing Orders - annual review	Company Secretary / Group Director of Finance	Item for Decision	Part 1				√			
Calendar of Board Meetings	Company Secretary	Item for Decision	Part 1					√		
Winter Plan	Chief Operating Officer	Item for Decision	Part 1				√			
Board Committee Annual Reviews of Effectiveness and Terms of Reference Update	Company Secretary	Item for Decision	Part 1	√						
CQC Statement of Purpose and Registration	Chief Nurse	Item for Decision	Part 1						√	
Items for Assurance			Part 1 & Part 2							
Board Committee Assurance Reports	Committee Chairs	Item for Assurance	Part 1	√		√	√	√	√	√
Trust Strategic Objectives - quarterly updates	Company Secretary	Item for Decision	Part 1			√		√		√
Board Assurance Framework - quarterly updates	Company Secretary	Item for Assurance	Part 1			√		√		
Organisational Risk Register	Chief Nurse	Item for Assurance	Part 1	√		√	√	√	√	√
Annual Staff Survey Results	Exec Director of People & OD	Item for Assurance	Part 1							√
Finance Report	Group Director of Finance	Item for Assurance	Part 1	√		√	√	√	√	√
Integrated Oversight Report	Chief Operating Officer	Item for Assurance	Part 1	√		√	√	√	√	√
Maternity Integrated Oversight Report	Chief Nurse	Item for Assurance	Part 1	√		√	√	√	√	√
Nurse Staffing Exception Report	Chief Nurse	Item for Assurance	Part 1	√		√	√	√	√	√
Nurse Staffing Annual Capacity & Capability Report	Chief Nurse	Item for Assurance	Part 1	√						
Learning from Deaths (6 monthly report)	Medical Director	Item for Assurance	Part 1	√				√		
SIRO Report & Digital Update	Group Director of Finance	Item for Assurance	Part 1	√				√		
EPRR Core Standards Self-Assessment Report	Chief Operating Officer	Item for Assurance	Part 1				√			
CNST Maternity Compliance Report	Chief Nurse	Item for Assurance	Part 1						√	
Green Plan (formally Sustainable Development Management Plan)	QEF Managing Director	Item for Assurance	Part 1				√			√
QEF 6 monthly update report	QEF Managing Director	Item for Assurance	Part 1	√				√		
Freedom to Speak Up Guardian Report	Exec Director of People & OD	Item for Assurance	Part 1				√			√
WRES and WDES Report	Exec Director of People & OD	Item for Assurance	Part 1				√			√
Quality Accounts Priorities 6 monthly update	Chief Nurse	Item for Assurance	Part 1					√		
Items for Information			Part 1 & Part 2							
Register of Official Seal	Company Secretary	Item for Information	Part 1				√			
Ad Hoc Items (i.e. items emerging during the year)			Part 1 & Part 2							