MEETING OF THE BOARD OF DIRECTORS IN PUBLIC

Gateshead Health NHS Foundation Trust

Date: Wednesday 25th May 2022
Time: 9:30 am
Venue: Rooms 9&10, Education Centre

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.	9:35 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.	9:40 am	**Minutes of the meeting held on 30 March 2022** To be agreed as an accurate record	Agree	Enclosure 4
5.	9:42 am	**Matters Arising / Action Log**	Update	Enclosure 5
6.	9:45 am	**Patient & Staff Story** • Organ Donation	Assurance	Presentation
		ITEMS FOR DECISION		
7.	10:00 am	**Trust Strategy 2022/23 – 2024/25** To approve the new Trust Strategy presented By Hatching Ideas	Approval	Enclosure 7
8.	10:15 am	**Trust Objectives 2022/23** To approve the new objectives presented By the Chief Executive	Approval	Enclosure 8
		ITEMS FOR ASSURANCE		
9.	10:30 am	**Assurance from Board Committees** i. Finance and Performance Committee – 29th March & 24th May 2022 (verbal) ii. Quality Governance Committee – 20th April 2022 iii. Digital Committee – 11th April 2022 iv. POD Committee – 3rd May 2022	Assurance	Enclosure 9
10.	10:50 am	**Chief Executive's Update Report** To receive a briefing report from the Chief Executive	Assurance	Presentation
11.	11:05 am	**Governance Reports** i. **Organisational Risk Register** To receive the reports presented by the Chief Nurse	Assurance	Enclosure 11
12.	11:15 am	**Finance Update** To receive the report, presented by the Group Director of Finance and Digital	Assurance	Enclosure 12
13.	11:25 am	**Integrated Oversight Report** To receive the report, presented by the	Assurance	Enclosure 13

		Chief Operating Officer, Chief Nurse, Medical Director and Executive Director of People and Organisational Development		
14.	11:40 am	**Nurse Staffing Annual Capacity & Capability Report including monthly Exception Report** To receive the report, presented by the Chief Nurse	Assurance	Enclosure 14
15.	11:50 pm	**Learning from Deaths 6 Monthly Report** To receive the report, presented by the Medical Director	Assurance	Enclosure 15
16.	12:00 pm	**SIRO Report and Digital Update** To receive the report, presented by the Chief Informatics Officer	Assurance	Enclosure 16
17.	12:15 pm	**Ockenden 2 Update Report** To receive the report, presented by the Chief Nurse	Assurance	Enclosure 17
18.	12:25 pm	**QEF 6 Monthly Update Report** To receive the report, presented by the QEF Managing Director	Assurance	Presentation
19.	12:35 pm	**Well-Led Review Action Plan Update:** To receive the action plan update presented by the Company Secretary	Assurance	Enclosure 19
		ITEMS FOR INFORMATION		
20.	12:40 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 20
21.	12:45 pm	**Questions from Governors in Attendance** To receive any questions from governors in attendance		Verbal
22.	1:00 pm	**Date and Time of the next Meeting** The next scheduled meeting of the Board of Directors to be held in public will be 27th July 2022 at 9:30 am		Verbal
23.	1:00 pm	**Chair Declares the Meeting Closed**		Verbal
24.	1:00 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 30th March 2022, at Gateshead Marriott

NHS Gateshead Health NHS Foundation Trust

Present:	
Mrs J Baxter	Chief Operating Officer
Mr A Beeby	Medical Director
Mrs J Bilcliff	Group Director of Finance & Digital / Deputy Chief Executive
Dr R Bonnington	Non-Executive Director
Mrs L Crichton-Jones	Director of People & OD
Mrs G Findley	Chief Nurse
Cllr M Gannon	Non-Executive Director
Mrs H Parker	Non-Executive Director
Mrs M Pavlou	Non-Executive Director
Mr A Robson	Managing Director QE Facilities
Mr M Robson	Vice Chair / Non-Executive Director (Chair of the meeting)
Mrs A Stabler	Non-Executive Director
In Attendance:	
Miss J Boyle	Company Secretary
Ms A Wiseman	Director of Public Health for Gateshead (Item 22/06)
Governors and Members of the Public:	
Mr A Dougall	Public Governor – Eastern
Mr A Rabin	Public Governor – Central
Apologies:	
Mrs A Marshall	Chair
Mr A Moffat	Non-Executive Director
Mrs Y Ormston	Chief Executive
Dr M Sani	Associate Non-Executive Director (NExT Placement)
Mrs K Mackenzie	Deputy Director of Finance
Ms D Waites	Corporate Services Assistant

Agenda Item	Discussion and Action Points	Action By
22/01	**CHAIR'S BUSINESS:** The meeting being quorate, Mr M Robson, Trust Board Vice-Chair (chairing the meeting in the absence of Mrs A Marshall), 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. Mr M Robson welcomed the Trust's Governors to the first in-person meeting of the Trust Board since the start of the pandemic.	
22/02	**DECLARATIONS OF INTEREST:**	

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	Mr M Robson 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.	
22/03	**APOLOGIES FOR ABSENCE:** Apologies for absence were received from Mrs A Marshall, Mr A Moffat, Mrs Y Ormston, Dr M Sani, Mrs K Mackenzie and Ms D Waites.	
22/04	**MINUTES OF THE PREVIOUS MEETING:** The minutes of the meeting of the Board of Directors held on Monday 26 January 2022 were approved as a correct record.	
22/05	**MATTERS ARISING FROM THE MINUTES:** The Board action log was updated accordingly and there were no additional matters arising from the minutes.	
22/06	**DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT 2020/21** Mr M Robson welcomed Ms A Wiseman, Director of Public Health for Gateshead, to the meeting to present her Director of Public Health Annual Report for 2020/21. Ms Wiseman delivered a comprehensive presentation outlining the key points from the report, which covered the first year of the pandemic. The presentation provided a powerful insight into the wider determinants of health through the lens of the pandemic, the impact of the pandemic on communities and individuals and the changing role of public health. Lessons from the pandemic were identified as well as the need to strengthen the role and impact of ill-health prevention. Mr M Robson thanked Ms Wiseman for her excellent presentation. He noted that the role of public health had changed from one of assurance to one of action and community engagement. He queried how this pro-active engagement with the local community could be continued without the burden of disproportionate reporting and bureaucracy. Ms Wiseman responded that community partners had been vital in this change of focus by building relationships in communities, rather than approaching communities with a specific topic to discuss. In the most disadvantaged communities a researcher had been embedded into the	

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	community for a year to learn more about communities – this highlighted solutions which wouldn't have previously been identified. Mrs L Crichton-Jones, Executive Director for People and Organisational Development (OD) noted the link to the health and wellbeing of Trust staff, given that many staff live in the local community. She commented that the occupational health team were reporting higher instances of alcohol dependency and reliance on food banks. Mrs Crichton-Jones reported that the Trust currently had high vacancies but also high unemployment in the area, noting the need to help local people into employment. Mrs G Findley, Chief Nurse, commented that recovery of services from the prolonged period of stand-down to respond to the pandemic was proving to be challenging. She queried how the Trust could link up with the public health team and join forces on recovery. Ms Wiseman responded that whilst there is a national focus on reducing waiting lists, there should also be a focus on identifying those who have not accessed services and are therefore not yet on waiting lists but could still require treatment and support. She therefore indicated that developing close linkages between acute, community and primary care would be vital to recovery. Mrs A Stabler, Non-Executive Director, referred to the Making Every Contact Count initiative and queried how this could be used to identify vulnerable patients and their families. Ms Wiseman referred to the vital role that Primary Care Networks and link workers can play here. She also referred to the ongoing collaborative work between the Trust and the local authority on multiple complex needs, led by the Trust's Deputy Director of Corporate Services and Transformation. Ms Wiseman noted that effective delivery of this workstream should assist in delivering better outcomes for the most vulnerable. Councillor M Gannon, Non-Executive Director, referred to the irrefutable link between poverty and ill-health, noting that half of all Gateshead households have an income of less than £25,000 per annum. The issue was present prior to the pandemic, but has been exacerbated by it. Mrs J Bilcliff, Group Director of Finance and Digital / Deputy Chief Executive, expressed her sincere gratitude for all the help and support of Ms Wiseman and her colleagues during the pandemic. She cited this as an excellent example of partnership working and referred to the two key ongoing collaborative workstreams on multiple complex needs and the Trust's new Health Inequalities Board (for which Ms Wiseman is a member).	

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	Ms Wiseman added her thanks to the Trust for initiatives such as the provision of a named nurse for each care home and the support of the microbiologists in the Trust in providing Covid-related analysis and statistics. Members congratulated Ms Wiseman and her team on the excellent annual report and presentation, noting the commitment of the Trust to continuing to work collaboratively to address health inequalities in the local community.	
22/07	**BOARD ASSURANCE FRAMEWORK 2021/22** Miss J Boyle, Company Secretary, presented the closing position of the Board Assurance Framework (BAF) for 2021/22. An overall rating of partial assurance had been maintained, with the paper recognising the dynamic use of the BAF to inform assurance ratings throughout the year. The Board approved the closing position for the BAF, taking assurance from the detailed reviews undertaken at Board committee meetings throughout the year, as well as the quarterly presentation at Board.	
22/08	**QUALITY GOVERNANCE COMMITTEE TERMS OF REFERENCE** Miss J Boyle presented the Quality Governance Committee terms of reference for ratification following a number of amendments. Mrs Stabler and Mrs Findley provided assurance that they had worked closely on developing the amendments, including ensuring that there was clarification on the assurance flows relating to maternity services. The Board ratified the revised Quality Governance Committee terms of reference.	
22/09	**TRUST GREEN PLAN (2022-2025)** Mr A Robson, Managing Director QE Facilities, presented the Green Plan for approval, identifying some of the key highlights. He recognised the enormity of the work undertaken by the team to develop the Green Plan and informed the Board that this would in turn feed into the regional and national Green Plan for the NHS. Annual updates would be provided to the Board, with the QE Facilities' Sustainability Committee taking a lead on monitoring progress against the plan. The achievement of the International Green Apple Award for Environmental Best Practice was highlighted and Mr A Robson	

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	provided assurance that the Trust was leading the way in respect of sustainability. Mr M Robson queried the linkage of the Sustainability Committee to the Trust's governance structure. It was agreed that reporting would be via the Trust's Finance and Performance Committee and this would be added to the cycle of business. Mr M Robson identified that there were fifty actions within the plan and queried how appropriate focus on the ones with the biggest impact would be secured. In response Mr A Robson assured that there was strong support for the delivery of the plan by staff and other committees within the Group. He noted that the Group was seeking to develop a mature approach to delivery by embedding sustainability into everything staff do, rather than it being seen as a separate workstream. Mrs Crichton-Jones praised the comprehensive plan. She referred to the target for sustainability training and requested that this be included in the current core skills review. Members concurred that the ambition for the training was endorsed, subject to the core skills review. Mrs Stabler reflected on the achievements to-date and the need to promote the successes and commitment to the green agenda. Mr A Robson concurred and suggested greater use of social media to promote some of the successes. Dr R Bonnington, Non-Executive Director, provided positive feedback on the report. She noted the importance of the sustainability agenda to the younger generation and that it was now integrated into doctor training as standard. It was agreed that it would be beneficial to refer to the Green Plan and its commitments as part of recruitment strategies. Mrs Bilcliff referred to the earlier presentation from Ms Wiseman and identified the sustainability agenda as an area for further collaborative work with the local authority. She also noted that the plan would generate efficiency savings and it would be helpful to quantify these in future reports. Cllr Gannon concurred regarding the opportunities to work closely with the local authority, citing transport as an area for consideration in respect of major local employers encouraging sustainable travel. In summary Board Members expressed their thanks to the team for the development of the comprehensive plan and approved the plan for submission to the Integrated Care System (ICS).	JBoy / AR AR
22/10	**ASSURANCE FROM BOARD COMMITTEES**	

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	Finance and Performance Committee: Mr M Robson, Chair of the Finance and Performance Committee, noted that the Board had been appraised verbally of the key points from the January F&P meeting at the January 2022 Board of Directors' meeting. Mr M Robson also drew attention to the written assurance report for the February meeting of the F&P Committee. Mr M Robson provided a verbal overview of the meeting which had taken place on 29 March 2022. He noted: • Budgets for 2022/23 were being developed. A rating of partial assurance was awarded to reflect their continued development and the risks around inflation and the scale of the efficiency target. • The Finance and Performance Committee for April would be brought forward to enable approval of the annual plan prior to local submission, with all Board Members being invited to attend. • An update was provided on all elements of the annual plan, and the Committee was fully assured around the amount of work being undertaken to develop a comprehensive plan. The continued risks around recruitment, retention, elective and non-elective workstreams were noted. • The Integrated Oversight Report (IOR) was reviewed with particular concerns noted around delayed discharges and the impact of this on patient flow and other areas. The Committee also focussed on ambulance handover, cancer targets, staffing pressures, Serious Incidents (SIs) and the Hospital Standardised Mortality Ratio (HSMR). • The Committee had received a deep dive report on audiology targets, providing full assurance subject to the business case being approved. • Partial assurance was provided on corporate objective achievement, reflecting that some objectives remain ongoing. • The Committee received the Month 11 finance report. Full assurance was provided, given the financial target had been exceeded. It was noted that the year-end position would be subject to audit. • A risk was identified in respect of achieving the capital plan, noting the impact of this on the 2022/23 limit should capital schemes roll into the new financial year. **Quality Governance Committee:** Mrs A Stabler, Chair of the Quality Governance Committee (QGC), noted that the Board had been appraised verbally of the key points from the January QGC meeting at the January 2022 Board of Directors' meeting.	

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	Mrs Stabler drew the attention of members to the February 2022 report and specifically to the front section of the report which detailed progress against the recommendations from the Ockenden report. It was noted that the Trust had received the Ockenden One Year On Letter and this report provided a comprehensive overview of progress for discussion at the public Board. The Trust is fully compliant for Immediate Essential Actions (IEA) 1, 2, 4, 6 and 7 noting for IAE 2 further work will be required once the nation job description is released for the Trust Senior Advocate role. Partial compliance was given for IEA 3 noting confirmation that the Year 3 Maternity Incentive Scheme (MIS) £254k is ring fenced to ensure maternity service safety and quality improvements. Full compliance was being hampered by the ability to achieve full multi-disciplinary training compliance due to staffing / Covid issues (as recorded on the risk register) with mitigation in place through the utilisation of e-learning options. Partial compliance is also noted for IEA 5 with ongoing audits to demonstrate compliance and the development of choice of birth information for women. Progress is monitored at QGC and through the Integrated Oversight Report (IOR) report. Mrs Findley informed the Board that a piece of work to map flows of assurance regarding Ockenden and maternity to the Board via QGC had been completed. This included the incorporation of maternity metrics into the IOR. Mrs Findley informed the Board that the second Ockenden report had been released that day and assurance was provided that the Board would be briefed and appraised of progress using the same mechanisms. **Digital Committee** In the absence of the Chair of the Digital Committee, Mr M Robson provided a brief verbal overview to accompany the narrative report. He noted that there were no specific matters to escalate to the Board. Mr M Robson highlighted that a concern had been raised regarding the capacity of the Digital team to deliver the roadmap and a further assessment was being made on this. He noted that the Committee remained sighted on the Channel 3 work which was centred on looking at the future of the Patient Administration System (PAS), highlighting that this would be one of the most significant digital workstreams in the next ten years.	

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	People and Organisational Development (POD) Committee Dr R Bonnington, Chair of the POD Committee, provided a brief verbal overview to accompany the narrative report. She advised that there were no items to escalate to the Board. Dr Bonnington informed the Board that there remained an ongoing focus on staff supply and the Committee had received a comprehensive presentation on this, although recognised that the risk around this remained significant. Whilst Covid vaccination was no longer mandatory as a condition of deployment, the Committee was assured that there remained ongoing implementation of the recommendations from professional bodies. A long discussion was held on staff health and wellbeing, recognising the stress that staff have been under and the importance of prioritising health and wellbeing support. As the Trust's Health and Wellbeing Guardian Dr Bonnington stated that the importance of this could not be over-emphasised and would be particularly key to both recruitment and retention. **Audit Committee** In the absence of the Chair of the Audit Committee, Mrs Bilcliff provided an update to accompany the narrative report. She noted that the report highlighted an item for escalation to the Board – the capacity to deliver a quality Head of Internal Audit opinion – although further discussions had occurred both internally and with Internal Audit to mitigate this risk since the Audit Committee meeting. Mrs Bilcliff informed the Board that assurance could be provided that the deadline for the delivery of the Head of Internal Audit opinion could be met. It was noted that the remaining audits had commenced and staff capacity to respond to the resulting requests had been secured. The Board noted the updates from each Board committee and the assurances and risks identified.	
22/11	**CHIEF EXECUTIVE'S UPDATE REPORT** In the absence of the Chief Executive this item was presented by Mrs Bilcliff, Deputy Chief Executive. Mrs Bilcliff referred to the current Covid numbers, noting that there were 79 Covid-positive patients in the hospital and 128 members of staff absent for Covid-related reasons. This represented a peak in respect of the current wave. She provided assurance that despite the increase in patient numbers, this was not translating into an increase in intensive care unit patients. The Chief Nurse and Medical Director	

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	were undertaking a significant piece of work on how the Trust could move forward in respect of living with Covid. Mrs Bilcliff referred to the national ask for all acute provider Boards to focus on ambulance handover delays. She informed the Board that whilst performance had been good, there had been a recent decline. Mrs Bilcliff highlighted the link to the level of medically optimised patients who no longer meet the criteria to reside and the impact that this has on the ability to manage handover delays. She provided assurance that this was a priority area for the Trust, with multiple discussions taking place with the local authority on care packages and beds. Mrs J Baxter, Chief Operating Officer, added that a lack of available care packages had resulted in some patients being discharged into care homes and into beds out of area, which was not the best solution or experience for patients and their families. She informed the Board that daily discussions were occurring with the local authority. Mrs Bilcliff informed Board Members that this was an area of significant risk. Mrs Bilcliff provided an update on the recruitment work currently ongoing, following on from the POD Committee update provided by Dr Bonnington. She informed the Board that a rapid process improvement workshop was in progress and the staffing task and finish group continued to meet fortnightly. The first cohort of international recruits was expected to join the Trust in the summer. Mrs Bilcliff noted that there was also a significant focus on retention, including implementing rotational programmes and new leadership development opportunities for colleagues. Mrs Bilcliff referred to the Provider Collaborative and the work ongoing to develop this forum within the new Integrated Care Board (ICB) framework. She noted that most appointments had been made to the ICB and engagement work had commenced in respect of this. The Board noted the update provided by the Deputy Chief Executive, including the significant risk relating to medically optimised patients and the work being undertaken to identify solutions and improve patient flow.	
22/12	**GOVERNANCE REPORTS** **Corporate Objective Delivery** Miss Boyle presented the year-end report on progress made against the fifteen priority objectives set at the beginning of the 2021/22 financial year.	

Agenda Item	Discussion and Action Points	Action By
	Board Members concurred that good progress had been made in respect of delivery, particularly given the backdrop of operational pressures during the year. The Board reviewed the report and noted the assurances provided on delivery. **Organisational Risk Register (ORR)** Mrs Findley presented the updated ORR to the Board, noting that it had been subject to monthly scrutiny at the Executive Risk Management Group (ERMG). Mrs Findley informed the Board that one risk had been closed since the ORR was reviewed by the Board in January 2022 (the risk around recruitment delays) and one risk had reduced in score (the risk around the implementation of vaccination as a condition of deployment given the national change in approach). Mrs Findley highlighted that there had been a reduction in compliance in respect of updating risk actions and this had been identified as an area for focus at ERMG. The Board reviewed the ORR and noted the progress made in managing the significant risks contained within it.	
22/13	**ANNUAL STAFF SURVEY RESULTS** Mrs Crichton-Jones provided a brief overview of the staff survey results, noting that nationally they had been publicly released on the day of the Board meeting. This would enable further local benchmarking to be undertaken. Mrs Crichton-Jones highlighted the increased response rate of 47%, an improvement of the previous year's response rate of 39%. She expressed her sincere thanks to all managers across the Trust who had supported their staff to complete the survey. Reflecting on the results, Mrs Crichton-Jones acknowledged that there were a number of areas of deterioration, which had been anticipated given the impact of the pandemic. Assurance was provided that these areas would be carefully reviewed. Key areas for review included presenteeism, supply, morale and flexible working opportunities. Overall Mrs Crichton-Jones concluded that the Trust compared favourably to others, achieving the average scores in the themed areas. She highlighted compassionate and inclusive leadership as an area in which the Trust had scored significantly better than its comparators.	

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	Mrs Crichton-Jones informed the Board that the next steps would be to review the benchmarking, discuss priority actions with the Senior Management Team and communicate the results to colleagues at a more granular level. This will support the development of local actions. Mrs Stabler referred to the full staff survey report and the need to recognise that it highlighted many positive achievements, particularly given the operational environment. She commented that it provided a strong platform for continued progress. Mrs Bilcliff thanked Mrs Crichton-Jones and her team for the significant effort in supporting the Trust to achieve the improved response rate. Mrs Pavlou concurred with this view. She noted that whilst the benchmarking would be important to understand, it should not distract from the analysis of the standalone results for the Trust, which would be of most interest to those who had completed the survey. Whilst in agreement with the principles behind this, Mrs Baxter noted that the benchmarking may be useful in assisting colleagues in understanding that some of the issues facing the Trust were also being experienced by other providers locally and nationally. The Board received the summary report for assurance, acknowledging the significant efforts of all involved and being assured that further analysis and action planning would be taking place.	
22/14	**FINANCE UPDATE:** Mrs Bilcliff provided the Board with a summary of performance as at 28 February 2022 (Month 11) for the Group (inclusive of Trust and QE Facilities, excluding Charitable Funds). She reported that a year to-date surplus of £10.3m had been achieved with a full-year forecast of £13m. It was recognised that this represented a highly unusual situation given the different funding regime in place during the year. NHS England and Improvement had been informed of the likely year-end position. Mrs Bilcliff reported that as at month 11 £7.2m had been spent on the capital programme and there was some way to go in order to achieve the Capital Departmental Expenditure Limit (CDEL). She drew the attention of Members to the following risks: • Risk of slippage on the capital programme, noting that funding sources and approval requirements had been changing on a very frequent basis which made internal management of this	

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	particularly challenging. It was noted that the Trust had worked well with QE Facilities to manage this and would make every effort to achieve the CDEL at year-end, but a risk of slippage remained. • Risk around the achievement of a significant surplus for 2021/22 but a move to a much more challenging financial environment from 1 April 2022 with a need to reintroduce cost improvements. The communication of this and the cultural shift presented a risk. • The risk of a change to the Month 12 position, given the year-end audit. It was noted that the Trust had new external auditors, which usually introduces a new and fresh look at processes and accounting treatments. Mr M Robson noted that both the Finance and Performance Committee and the Board were familiar with the position, given the forecasts and outturn remained consistent over a number of months. He expressed a high level of confidence in the accuracy of the reporting and that he was assured the Trust had done everything possible to spend additional funding for the benefit of patients and staff during the year. The Board received the finance report for assurance and noted the risks highlighted.	
22/15	**INTEGRATED OVERSIGHT REPORT:** Mrs Baxter introduced the Integrated Oversight Report (IOR) for January and February 2022. The paper has been discussed and received in-depth scrutiny by the various Board Committees. Mrs Baxter provided an overview of operational performance aligned to the Responsive domain within the IOR. She referred to the previously discussed increases in Covid in March and the challenges in respect of medically optimised patients who no longer meet the criteria to reside. Mrs Baxter informed the Board of the risk to the achievement of cancer targets due to increased referrals particularly in relation to breast and lung. She also highlighted the newly introduced community metrics in the report which demonstrated that the community teams had seen over 26,000 patients in February alone. Mrs Findley provided an overview of the quality and safety metrics contained within the IOR. She noted that seven SIs had been reported in the period, which included four historic incidents. She explained that the new Head of Patient Safety was thoroughly reviewing all open incidents. Some investigations had been delayed during the pandemic, but progress is now being made to bring investigations fully up to date.	

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	This provided good assurance that all moderate incidents are being subject to review. Mrs Findley summarised the SI themes as follows – one child protection issue, two falls, three failures to act on test results and one failure to rescue. In response to this Mr M Robson queried how historic the four SIs were. Mrs Findley explained that they covered the period of 2019 to October 2021, noting that historic SIs are frequently generated when cases are considered by the coroners' courts. Mrs Stabler informed the Board that she had attended the SafeCare meeting and SI panel the previous month and felt very assured by the work being undertaken by the Head of Patient Safety in this area. She commented that there was also clearer reporting of learning and corrective actions in this regard. Mrs Findley referred to the maternity metrics included in the IOR, noting that further actions would be added following review of the second Ockenden report. She drew members' attention to the two actions shown as partially addressed – risk assessments and pathways of care – noting that these were areas where documentation required improvement. As an example Mrs Findley provided assurance that risk assessments were being completed, but not electronically documented. This was included in the action plan. Mrs Crichton-Jones provided an overview of the people and OD metrics within the IOR. She informed the Board that sickness, appraisal and core training metrics were still not meeting the required levels. Work is underway with the newly-appointed POD team to assist managers in appropriately managing absence and the appraisal policy will be updated in the new financial year, although currently remains a concern. Mrs Crichton-Jones noted that improvements were starting to be seen in respect of core training. Mr Beeby, Medical Director, provided an overview of the Effectiveness metrics within the IOR. He referred to the HSMR which continued to flag concern, although the Standardised Hospital Mortality Indicator (SHMI) showed the Trust within the expected range. He explained that the impact of Covid on both indicators was not yet fully known nationally. As such the Trust continued to use other forms of review to triangulate and seek assurance in this area including mortality reviews, medical examiner reviews and patient safety investigations. He noted that cardiac failure deaths are being closely reviewed as they have been flagged up as part of investigations.	

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	Mrs Stabler informed the Board that she attends the mortality group where there are regular reports on deaths and outliers. She felt assured by the comprehensive nature of reviews at this forum. The Board received the report for assurance and noted the operational pressures directly impacting on the Trust's current performance.	
22/16	**NURSE STAFFING EXCEPTION REPORT:** Mrs Findley presented the nurse staffing exception report for February 2022 which provides assurance to the Board that staffing establishments are being monitored on a shift-to-shift basis. Mrs Findley informed the Board that there had been an improvement in the position compared to previous months. She noted that whilst Ward 22 was shown on the report and highlighted as not achieving the fill rate of 75%, this wasn't presenting a risk to patients. During the month the ward was used as a Covid ward with typically three to four patients. The fill rate calculation was based on the maximum capacity of the ward, which had not been reached given its alternative usage. Mrs Findley highlighted the addition of care hours per day to the report (which takes into consideration bed occupancy sensitivities in its calculation), noting that this compared favourably to local peers. The report would be further developed to triangulate this data with complaints and incidents, bringing a richer analysis to the Board. Mrs Stabler referred to her recent visit to maternity. She described the midwifery-led birth rate data review and staffing review which takes place every four hours. She queried how this review and the review of safe staffing within community services would be reported to Board. Mrs Findley responded that a report based on the birth rate plus tool would be presented to QGC each meeting. She noted that there was not an equivalent safe staffing tool for community services, which is reliant upon professional judgement at present, although some tools are being developed nationally. Mrs Baxter expressed her sincere thanks to Mrs Findley and her team for the continued work to develop the report. The Board received the report for assurance and noted the work being undertaken to address the shortfalls in staffing and further develop the report.	

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22/17	**CYCLE OF BUSINESS:** Miss Boyle presented the cycle of business which outlines forthcoming items for consideration by the Board. This will provide advanced notice and greater visibility in relation to forward planning. The Board received the cycle of business for information.	
22/18	**QUESTIONS FROM GOVERNORS IN ATTENDANCE:** Mr M Robson invited those Governors in attendance to ask a question, noting that some questions had been received in advance from a staff Governor who was unable to attend the meeting in person. Mr A Rabin, Acting Lead Governor, asked a question on behalf of Mr S Connolly, the staff Governor unable to attend the meeting. He queried whether the Board was aware of the impact of on-site parking challenges on staff and whether the Trust received any reimbursement from Parking Eye fines. Mr A Robson responded to this question. He informed that the Trust has a duty to create safe parking for visitors and staff. He stated that the Board understands that the current parking situation is very stressful for some staff. Parking is a standing item on the Executive Team's weekly meeting agenda. There is a need to keep the site safe, whilst also looking after the welfare of our staff, which is a difficult balance but one which the Board is committed to. Prior to the introduction of Parking Eye the Trust had received notices from the fire brigade who weren't able to get their fire engines around the site, representing a significant safety risk for staff and patients. In addition, there were instances where footpaths were blocked which prevented access to some areas for patients and staff in wheelchairs. Mr A Robson informed that the current demand for parking spaces on the Queen Elizabeth hospital site exceeds the number of spaces available and there had been an over-provision of on-site permits over the years. Other facilities available to staff include the Park and Ride and Park and Stride services. Amendments were recently made to the Park and Ride service to increase its accessibility for staff. Mr A Robson informed that the priority action was to review the criteria for on-site permits to ensure that those staff who really need a QE permit have one, and those who do not meet the criteria are	

Agenda Item	Discussion and Action Points	Action By
	provided with a permit for Park and Ride / Park and Stride. A parking group has been established to lead on this. This includes staff side representatives and representatives from various staff groups. He informed that the on-site team can support with the overturning of fines where they are considered to be inappropriate, although strict rules are in force for patient drop-off areas, as it is critical that they are kept free for the benefit of our patients who really need them. Mr A Robson confirmed that the Trust does not get any revenue from Parking Eye. Assurance was provided that the reissuing of permits is a top priority, as this will provide the greatest relief in terms of site pressures and reduce the stress for staff who need to park on the QE site. Mr Rabin asked a further pre-submitted question on behalf of Mr Connolly in relation to the staff survey - it is recorded that 80% of staff surveyed said that patient care was top priority. Mr Connolly had acknowledged that this was high but thought it would be higher and queried what the other 20% of staff responded. Mrs Crichton-Jones responded that this was a statement with which staff responded on a scale from 'strongly agree' through to 'strongly disagree' and therefore it would not be possible to identify what the 20% who disagreed thought was the top priority. She noted that benchmarking demonstrated that the Trust was above the average of 75.5%. The current engagement work on the strategy and vision would help the Trust to understand in more detail the views of staff on what the priorities of the Trust should be and help to continue this important conversation. Mr M Robson thanked Governor colleagues for their questions and attendance at the meeting.	
22/19	**DATE AND TIME OF THE NEXT MEETING:** The next meeting of the Board of Directors will be held at 9:30 am on Wednesday 25th May 2022.	

Agenda Item	Discussion and Action Points	Action By
22/20	**CLOSURE OF THE MEETING:** Mr M Robson declared the meeting closed.	

PUBLIC BOARD ACTION TRACKER

Gateshead Health NHS Foundation Trust

Item Number	Date	Action	Deadline	Executive Lead	Progress
21/159	28/09/2021	Draft Winter Plan – to provide position report for SDEC	26/01/2022	JMB	This was planned for the Jan 22 Board, but has been deferred in line with the NHS England and Improvement recommendations in their 'reducing the burden letter' which frees up time to respond to operational pressures. This will be presented as part of the Integrated Oversight Report in May 2022
22/09	30/03/2022	Trust Green Plan – to ensure that progress updates flow via the Finance and Performance Committee	25/05/2022	JBoy / AR	
22/09	30/03/2022	Trust Green Plan – to ensure sustainability training is incorporated into the current core skills review	25/02/2022	AR	

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Report Cover Sheet Agenda Item: 7

Report Title:	**Trust Strategy 2022-23 to 2024-25**			
Name of Meeting:	Board of Directors			
Date of Meeting:	25 May 2022			
Author:	Rebecca Bridger, Hatching Ideas Amanda Maskery Via extensive consultation with internal and external stakeholders, including Trust colleagues, Governors and the Board			
Executive Sponsor:	Chief Executive and Chair			
Report presented by:	Rebecca Bridger, Hatching Ideas Amanda Maskery			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☒	**Discussion:** ☐	**Assurance:** ☐	**Information:** ☐
	To seek formal Board approval of the Corporate Strategy and Behavioural Framework			
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*	Recent versions of the final outputs have been shared with the Board of Directors, Senior Management Team and Council of Governors for comment. This final version reflects the feedback received.			

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 Corporate Strategy and Behaviours Framework have been developed through extensive engagement and consultation with stakeholders including:
	  • Colleagues throughout the Trust
	  • External partners
	  • Senior Management Team
	  • Council of Governors
	  • Board of Directors
	• The Corporate Strategy maintains the five strategic aims that were in place during 2021/22 and the existing ICORE values (which continued to resonate with stakeholders). It identifies 3 key areas for strategic focus – patients, people and partners.			

<table>
<tr><td></td><td colspan="5">Corporate objectives developed annually will support the delivery of the strategy each year.
Following final Board approval, the Corporate Strategy and Behaviours Framework will be launched in June 2022.</td></tr>
<tr><td>Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper</td><td colspan="5">It is recommended that the Board reviews and approves the Corporate Strategy and Behaviours Framework.</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 corporate objectives should support the delivery of the Corporate Strategy.</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">None 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>

NHS
Gateshead Health
NHS Foundation Trust

Our patients
Our people
Our partners

#GatesheadHealth Corporate Strategy
2022/23 - 2024/25

“Small enough to stay personal and large enough to provide high quality compassionate care.”

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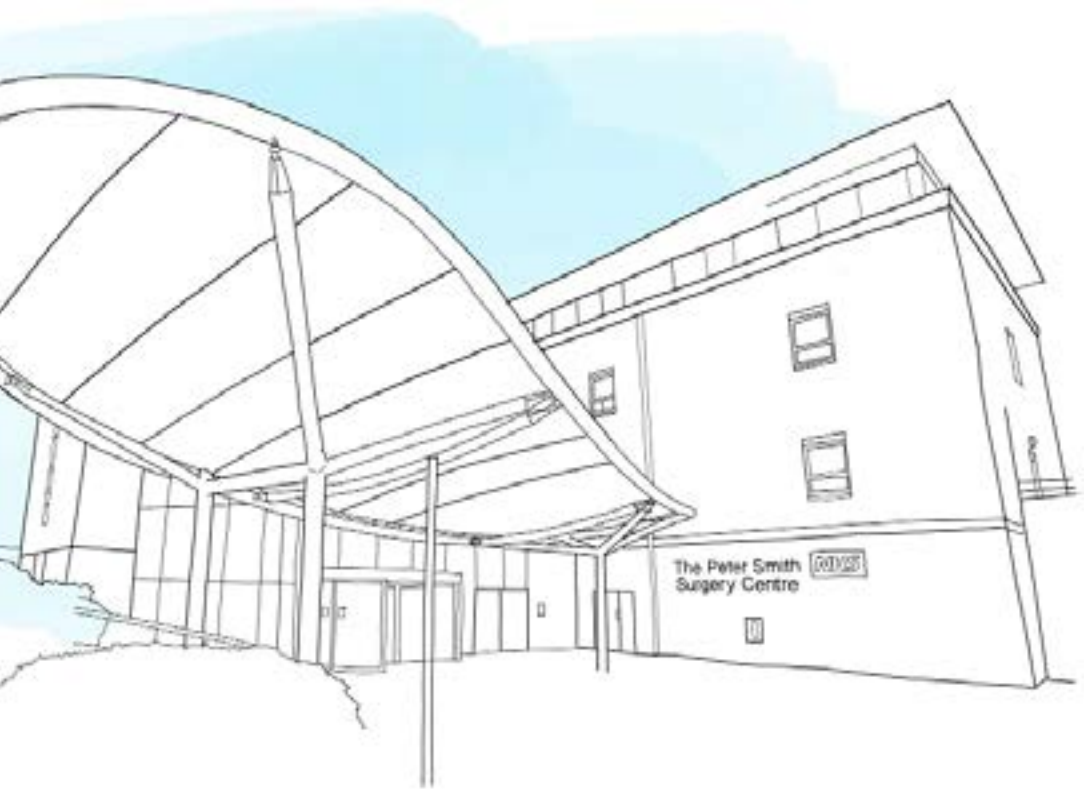


Introduction

I am so proud of all our dedicated, passionate and capable people at Gateshead Health NHS Foundation Trust

Covid-19 has impacted every part of Gateshead Health - from our people to the patient communities that we provide care to.

Our people have always provided care with kindness and compassion. We have risen to the challenges with determination, embraced new ways of working and supported one another along the way.

The engagement we have had in developing this strategy has shown our commitment to delivering the highest quality services and improving the healthcare and wellbeing of our patient communities in Gateshead and beyond.

We have heard from our people, patients, and partners in shaping this strategy for our future.

Whilst a lot has changed, our values have not - they are still at the very heart of what we do.

Gateshead Health NHS Foundation Trust is an exciting place to be, and we are optimistic and ambitious for what lies ahead. This is a time of transition and great transformation and we look forward to the future with confidence and courage.

I am delighted to share this with you which sets out what, I believe, we can achieve together over the next three years.

YOrmston

Yvonne Ormston
Chief Executive Officer

Gateshead Health

Based in the North East of England, Gateshead Health NHS Foundation Trust provides a range of acute and community services

Established in 2005, we were one of the first foundation trusts in the country and since then have consistently delivered the highest levels of care for our patients.

We now offer 440 hospital beds across the Gateshead region and employ approximately 4,200 people.

We provide a range of acute and community services across our key sites (i.e., Queen Elizabeth Hospital, Bensham Hospital and Blaydon Primary Care Centre) as well as a number of minor sites in Gateshead.

In addition to providing a range of district general hospital services, the Trust is also an integrated community provider, which includes offering care in the homes of our patients.

Partnership working

The Trust is an active partner in the "Gateshead Cares" system board.

We are committed to the Alliance Agreement which underpins collaborative system wide-working and accountability in Gateshead.

Specialist services

Alongside a full range of local hospital services, we also provide specialist services, including:

- Breast screening service for Gateshead, South Tyneside, Sunderland and parts of Durham. The Trust offers high standards of treatment – from screening and diagnosis to treatment.
- Specialist gynaecological cancer treatments provided by the Trust have developed a positive reputation both nationally and internationally. Services are now provided beyond the Gateshead region to the Scottish borders, through to Cumbria and Whitby.
- The North East Bowel Cancer Screening Hub hub for the National Bowel Cancer and AAA Screening Programmes, provides services for a population of around seven million people.
- Leading care in our state-of-the-art facilities. Including our Emergency Care Centre, Pathology Centre of Excellence and the North East Surgery Centre.
- Maternity services are rated as outstanding by the Care Quality Commission (CQC) and are among the best in the country.
- Robotic surgery capacity is available which allows for robotic keyhole surgery to be offered to patients.
- The Gateshead Fertility Centre is one of the top ten IVF clinics in the country, successfully having created hundreds of new families in the North East over the last decade.

Vision and values

Our vision captures what matters to us - delivering outstanding compassionate care

The Trust's vision was developed through engagement with our people to identify what matters to us as an organisation - now and in the future.

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

Through engagement with our people and partners, we have recognised how important it is that we use the title 'Gateshead Health' so as to be inclusive to all of the people who work for and represent the Trust.

Our values

Our values are the golden thread that runs through everything we do.

Following a Trust-wide consultation with our people, they remain unchanged as the feedback was that our values continue to resonate and remain important.

Our five values can easily be remembered by the simple acronym ICORE.

Innovation

We look for new ways to improve what we do and recognise that we all have a role to play in our continuous improvement.

Care

We care for our patients, communities, each other and ourselves with kindness and compassion.

Openness

We always act with integrity and transparency and are open and honest with ourselves and each other.

Respect

We treat everyone with respect and dignity, creating a sense of belonging and inclusion.

Engagement

We are inclusive and collaborative in our approach, working as a team and with our partners to deliver the best care possible.

Corporate strategy

Developed through open engagement with our patients, people and partners

Our strategy has been shaped by what we know about the people we serve, including:

- Changing demographics
- Deprivation in some of our communities
- A focus on integrated care systems

Strategic aims

Gateshead Health has five strategic aims.

1. We will continuously improve the quality and safety of our services for our patients
2. We will be a great organisation with a highly engaged workforce
3. We will be an effective partner and be ambitious in our commitment to improving health outcomes
4. We will develop and expand our services within and beyond Gateshead
5. We will enhance our productivity and efficiency to make the best use of our resources

Strategic areas

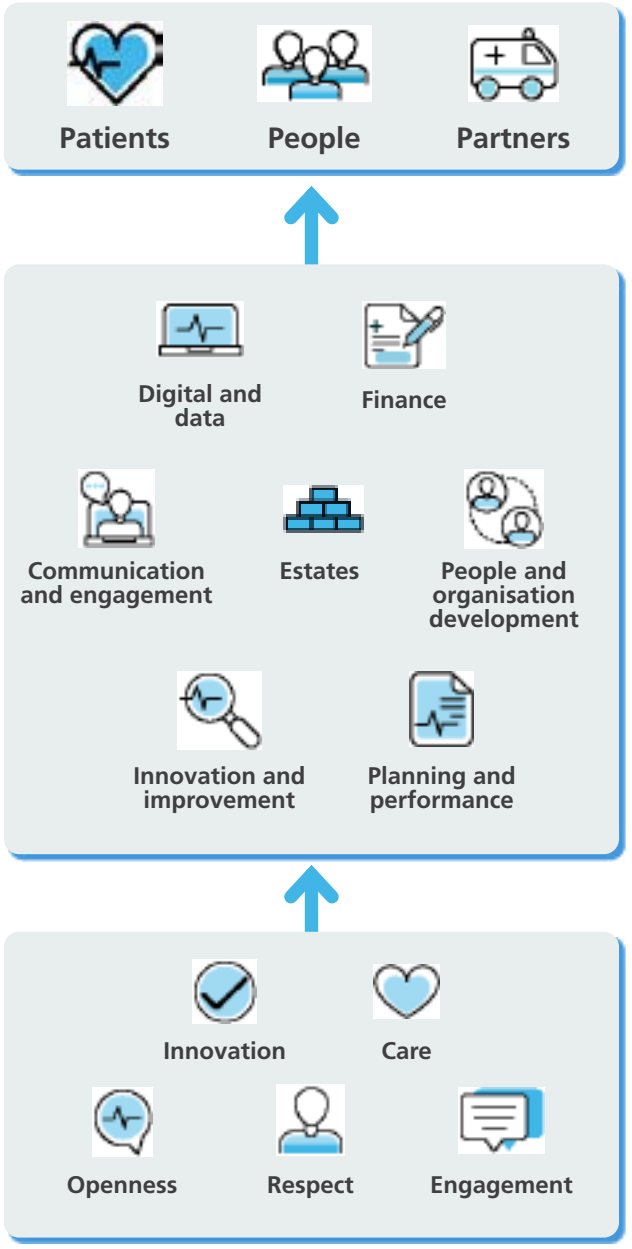
Our strategy is built around three strategic areas of focus.

Enabling functions

They are supported by seven enabling functions.

Our values

Our strategy is underpinned by our values



Enabling functions

Digital and data

- Increasing digitisation of our services where it adds value, increases safety and improves the patient experience.
- Investing in the skills our people and patients need to use these tools.
- Make the best use of the systems and data to continuously improve the clinical care provided.

Innovation and improvement

- Making sure our services are of benefit to the patient communities we serve.
- Provide the forums and environments that allow innovation to happen.
- Protecting time to share suggestions, feedback and new ideas.

Finance

- Ensuring robust governance structures and evidence-based decisions.
- Using data and financial forecasting to make the best use of our resources.

People and organisation development

- Investing in the recruitment, resourcing, and retention of our staff.
- Making it easy for people to join us.
- Providing the tools and resources our people need.

Communication and engagement

- Identifying and using new channels for communication.
- Making sure our values are visible in all we say and do.

Planning & Performance

- Providing services in a sustainable way.
- Involving the communities we serve, to create and deliver valuable services.
- Perform in the present whilst planning for the future.

Estates

- Making the most efficient and cost-effective use of our property.
- Providing safe, secure, high-quality healthcare buildings capable of supporting our needs.

Associated strategies and plans

That underpin each enabling function.

- Digital Gateshead strategic plan
- Annual digital roadmap
- Digital assurance programme
- Digital strategy

- Transformation strategy
- Research and development strategy
- Quality Strategy
- Clinical strategies
- Cancer strategy
- Professional strategies

- Annual plan
- Revenue and capital
- Financial strategy document

- NHS People Plan and Promise
- People strategies including:
  - Health and wellbeing strategy
  - Equality, diversity and inclusion strategy
  - Workforce strategy
- Annual work plan

- Annual communication and engagement strategy and rolling 3-month delivery plan
- Annual human rights, equality, diversity and inclusion strategy

- Planning guidance
- NHS constitutional standards
- NHS long term plan
- Planning guidance
- The green plan
- System oversight framework

- Estates strategy
- QEF's annual objectives

QE Facilities

QE Facilities (QEF) is a wholly-owned subsidiary of Gateshead Health NHS Foundation Trust. They are a separate legal body set up to provide a range of non-clinical Estates and Facilities services.

Patients

Compassionate care is at the very heart of everything we do at Gateshead Health

The patient communities we serve at Gateshead Health are very important to us.

Everyone who works at the Trust is committed to providing the highest standards of safe care to our patients at the right time and in the right place.

Our focus areas:

1. Caring for all our patient communities
2. Providing safe, high-quality care
3. Offering increasingly integrated care
4. Making every contact compassionate and caring

How will we measure our success?

- Friends and Family Test results
- An increase in compliments and reduction in common themes and trends within complaints
- Feedback via governor engagement
- National Patient survey results
- National Audit results
- Delivering our Quality priorities
- Positive patient feedback
- Meeting our performance standards
- Improvements in statistical measures of health and care outcomes
- Delivery of safety priorities and improvement of maternity metrics in the Integrated Oversight Report
- An 'Outstanding' CQC rating for caring.

Caring for all our patient communities

Gateshead has some of the most deprived people and families in the country. More than half of the people in Gateshead are just managing, and over a third are vulnerable or in need.

Our goal is to tackle health inequalities and ensure the best health outcomes for all the patient communities that we serve.

This includes refugees and ethnic minority groups, people with learning disabilities, those with severe mental illness, the travelling community, the Jewish community and many more.

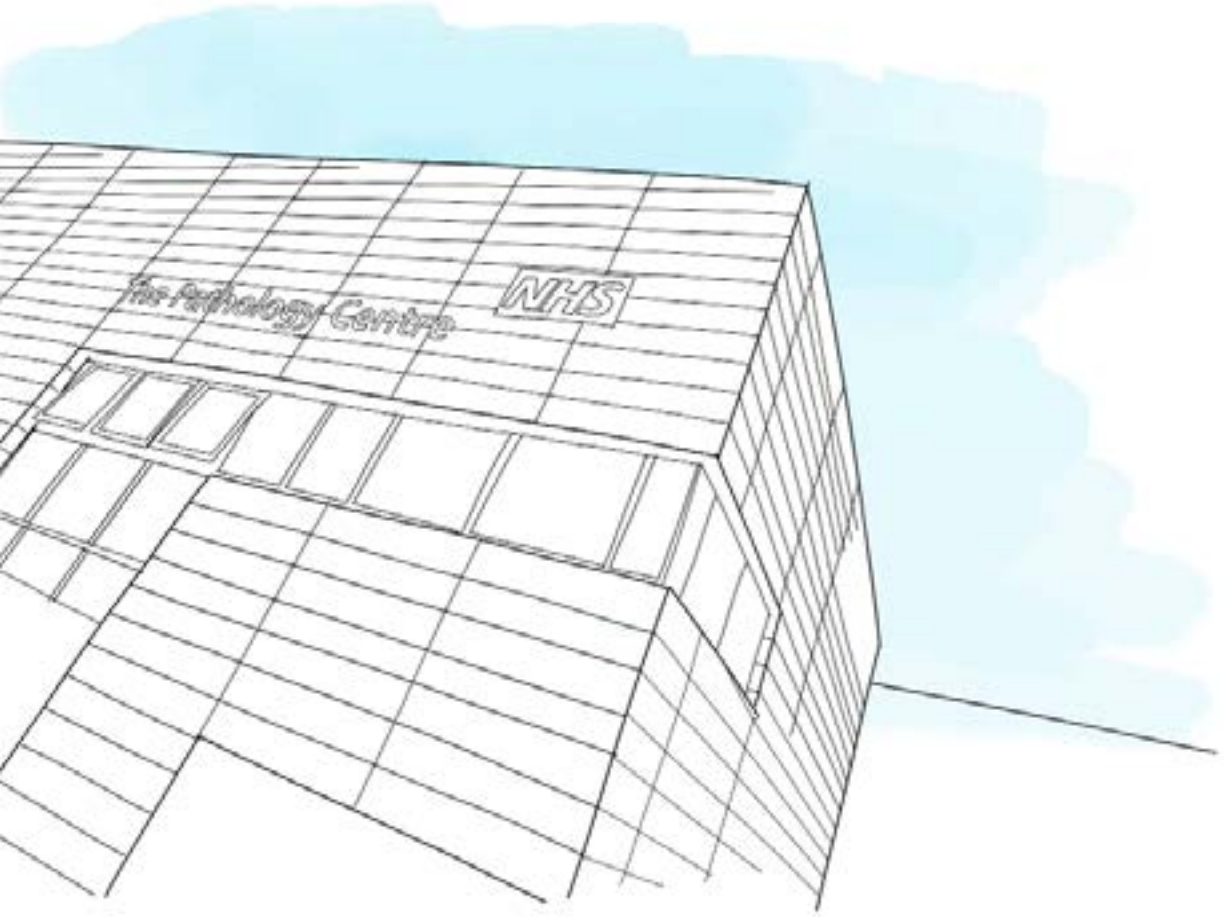
Patient Success Measurements

We are proud of our 'Outstanding' rating for caring, and 'Good' against the areas of safe, effective, responsive and well-led health and social care services as awarded in our last inspection by the Care Quality Commission (CQC).

We will do this by:

- Talking to and actively listening to the people in our communities, to capture and use information, data and feedback.
- Creating the time, space and opportunities for conversations with patients and carers to better understand them.
- Working closely with others to create and tailor services that meet changing and different needs.
- Improving how easy our digital and physical sites are to access. Such as making improvements to our website, or the signage used in our buildings.
- Continuing to improve our people's understanding of equality, diversity and inclusion.

“An organisation that delivers really high quality care in a really caring setting.”



Providing safe, high-quality care

We are committed to delivering high-quality person-centred care and the best clinical outcomes and experiences for our patients.

This means continuing to maintain our track record of delivering our services safely - for our people, patients and their families. Our commitment to keeping patient’s safe means making sure we have in place systems and processes that are fit-for-purpose and simple to use.

We will do this by:

- Constantly seeking to improve and where possible, standardise the processes, systems and approaches used across the Trust to ensure consistently high standards of healthcare are delivered.
- Ensuring our people receive training in safety and have a solid understanding of safeguarding procedures.
- Supporting a safety culture in which we create the mechanisms and time to hear more, share more, learn more and take more action to improve patient safety.

Offering increasingly integrated care

We want to ensure the experience of our patients is as seamless and joined up as possible and that they receive the support and information that they need at each step of their journey, both in Gateshead but also in the wider Integrated Care System.

We are committed to finding better, more flexible and responsive ways of delivering services and care that meet the individual preferences, needs and expectations of our patient communities and their carers.

We will do this by:

- Building on our position as an integrated acute and community provider we will offer seamless, integrated multi-disciplinary care experiences that are delivered as close to home as possible for our patients.
- Using technology to deliver quicker, safer and more flexible patient outcomes.
- Improving the patient experience to ensure it is as seamless and joined up as possible.
- Providing our patients with clear, simple and timely support and information that they need at each step of their journey.
- Collecting and acting on feedback and data through interviews, confidential feedback mechanisms and multidisciplinary review forums to improve the patient experience.

Making every contact compassionate and caring

Our goal is to treat all people and patients with respect, dignity and the compassion we would wish for our own families and loved ones.

This means providing friendly, compassionate care with kindness to patients, so that their experience with us is one we are proud of.

“We have a proud history of providing services locally and regionally that care.”

We will do this by:

- Taking the time to actively listen to our patients and their carers
- Being patient with our patients, approaching every interaction with openness, care and respect
- Supporting the active involvement of patients and carers in healthcare decisions that affect them.
- Dealing with any issues impacting patient experiences immediately, transparently and with compassion.
- Providing care with dignity and respect that meets the unique needs of the individual without judgement or discrimination.

People

The people at Gateshead Health are our greatest asset

Our people are key to achieving our aim of being a great organisation with a highly engaged workforce.

In every conversation held while developing this strategy, the value and importance of our people has shone through.

Our focus areas:

1. Caring for the health and wellbeing of our people
2. Being a great place to work
3. Ensuring a diverse, inclusive and engaged culture

How will we measure our success?

- Reduction in sickness absence
- Improvements in the WRES/WDES for delivering improved staff experience
- A reduction in vacancy rates and staff turnover
- Improved responses to staff survey
- Annual staff survey overall staff engagement score within the top 20% of our benchmark group
- Increase in annual staff survey % of staff experiencing opportunities for career and skills development.

Supporting the health and wellbeing of our people

At the very heart of the Trust are our people - they are our greatest strength.

The pandemic has had a big impact on their health and wellbeing, and we are committed to supporting them so that everyone who works at Gateshead Health feels valued, appreciated and supported for the brilliant work that they do.

The NHS People Plan & Promise

Published in July 2020, this sets out a vision to have more people, working differently, in a compassionate and inclusive culture within the NHS. Our People Promise aims to improve the experience of working in the NHS for everyone.

We will do this by:

- Offering the health and wellbeing support that our people need to keep them resilient, safe and well - physically, mentally, emotionally and socially.
- Seeking to create healthy environments for our people to work in.
- Providing our people with the flexibility that they need and protecting their time so they can rest, learn and connect with others.
- Continuing to take the time to acknowledge and recognise the hard work and efforts of our people.
- Celebrating our achievements and accomplishments.

Being a great place to work

The healthcare sector is facing many challenges that are impacting how NHS organisations across the UK are having to attract and retain people.

Our goal is to provide our people with fulfilling career paths, opportunities to progress and support at every stage of their career.

We are committed to being as innovative as possible in the employment opportunities that we offer.

"Gateshead Health is one of the largest employers and investors in the region which brings social and economic benefits to the region."

We will do this by:

- Engaging, supporting, developing, and rewarding our people.
- Supporting flexibility and variety in the way our people work to keep them motivated and engaged.
- Building on the successes of our apprenticeship programme by exploring opportunities across our clinical and corporate services.
- Exploring rewarding supervisory, teaching, and mentoring opportunities.
- Investing time to understand how we can offer more innovative and fulfilling development opportunities and career paths.
- Developing leadership and management capability at every level across our organisation.

Ensuring a diverse, inclusive and equitable 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.

"In many ways Gateshead Health operates like a small city with all manner of people working in different kinds or roles. We have people doing everything from catering, electricians, groundskeepers, and resuscitation training which can happen anywhere. While people think of doctors and nurses, there are a whole range of different roles."

We will do this by:

- Increasing opportunities for our people to have their voices heard.
- Empowering our people to invest time in developing relationships with one another through inclusive networks, communities and forums where they can interact.
- Gently but firmly holding one another to account for living our values in everything we do.
- Fostering an inclusive culture of belonging where everyone is seen, supported, respected and valued for their unique contributions.

Working in new and collaborative ways as "one team"

Covid-19 has meant new and different ways of working for everyone. Our adaptability has enabled us to respond to this crisis and show our ability to work together with purpose and urgency.

As we move into a world where we learn to live with Covid-19, we want to ensure we maximise our opportunities to collaborate, innovate and improve.

"When you work at this Trust, it feels like you belong to the same team. That we are one team. And that is when we are at our best."

We will do this by:

- Providing the time, space and resources to enable innovations to be realised.
- Empowering our people and bringing decision making closer to patients and the front line.
- Greater knowledge sharing, collaboration and partnering between our teams so we work together on key initiatives from inception to delivery.
- Fostering a culture of trust where we share lessons and learnings openly, honestly, and more broadly, overcoming barriers to learning and improving safety and performance outcomes.
- Embracing opportunities for continuous improvement, always working to better standardise our systems and ways of working across the Trust.

Partners

We respect and work closely with our partners to deliver outstanding care

We have always recognised the value of working closely with others that share our values and commitment to patient care.

Meaningful partnerships provide opportunities to address recruitment and retention challenges, generate economies of scale, and improve patient pathways.

Our focus areas:

1. Being a force for good
2. Acting as a key partner
3. Working with our education partners

How will we measure our success?

- Regularly seek and act on feedback from partners to become a truly collaborative organisation
- Increased footprint for service delivery
- Achieving our sustainability targets
- Positive feedback from members of the community
- Delivery of agreed health inequalities action plan
- Delivery of Gateshead Cares priorities and action plans
- Working with our key partners to deliver care closer to home to deliver a decrease in discharge times.

Being a force for good

As one of the largest employers in the region, we appreciate the part that we play in the community and recognise the corporate social responsibilities that we have.

We recognise the part we play in the community, and that our impact and influence goes beyond our role as a provider of healthcare services.

This is why we continue to contribute time and energy to working with our partners to develop the Gateshead experience, ensuring it is a fantastic place to live, work and receive care.

What is an anchor institution?

A large, non-profit, public-sector organisation whose long-term sustainability is linked to the wellbeing of the populations they serve.

We will do this by:

- Communicating and showcasing what Gateshead Health offers to the people of the region – both as a fantastic place to work and as a provider of high-quality patient care.
- Engaging others in the opportunities that Gateshead Health can offer people. Such as meaningful, stable employment and understanding what else can be done to improve this.
- Embracing new and different ways to communicate. Raising awareness of what we do and our role as an anchor institution in the community.
- Offering Gateshead residents the best start through our Maternity, Paediatric and Community Children's services, so that we support people to reach their full potential.

Acting as a key partner

We appreciate the benefit of working closely with our partners in Gateshead and beyond.

We are committed to investing time in being an important and valued partner to others. Not just through the Trust, but also through the services offered by our wholly-owned subsidiary, QE Facilities.

These partnerships are crucial to effectively tackling health inequalities, improving patient outcomes and providing sustainable healthcare to in the region.

QE Facilities

QE Facilities (QEF) was established by the Trust to help provide non-clinical NHS services in a more flexible and efficient way.

We will do this by:

- Partnering with organisations and charities that share our values and commitment to giving our patient communities the best care possible.
- Continuing to deliver and expand the services we offer in Gateshead and beyond.
- Sharing insights to tackle our shared regional health and efficiency challenges in partnership with others.
- Working with our place-based partners to continue reducing waste, improving efficiencies and productivity.
- Working closely with our partners to deliver care at the earliest possible opportunity, reducing unnecessary hospital admissions.
- Seek to further develop our role at place going forward.

Working with further and higher education providers

Investment in education and making sure that we have highly skilled and motivated people that can provide outstanding care to our patient communities is important to us.

Recognising our responsibility as one of the largest employers in the region, we work closely with further and higher education providers to ensure we can offer our people the development and growth opportunities they need.

"We're proud of the role that the Trust plays in the community that we live and work in."

We will do this by:

- Continuing to make sure our new and existing people are supported to have rewarding careers at Gateshead Health.
- Maintaining our close working relationships with higher and further education providers such as universities and colleges in the region.
- Working with education partners to support people into stable and secure employment at Gateshead Health.
- Offering our people the educational experiences, placements, development opportunities, and support that they need to develop, grow and make the best use of their skills and capabilities.

Thank You

For everyone's input and contributions in the creation of this document.

Contact us

For all the latest news and information about the Trust visit our website: qegateshead.nhs.uk

We can be contacted on: 0191 4453713

Our ‘ICORE’ behaviour framework

Gateshead Health NHS Foundation Trust

	Innovation	Care	Openness	Respect	Engagement
	We look for new ways to improve what we do and recognise that we all have a role to play in our continuous improvement.	**We care for our patients, communities, each other and ourselves with kindness and compassion.**	**We always act with integrity and transparency and are open and honest with ourselves and each other.**	**We treat everyone with respect and dignity, creating a sense of belonging and inclusion.**	**We are inclusive and collaborative in our approach, working as a team and with our partners to deliver the best care possible.**
Behaviours we LOVE to see from yourself and your colleagues...	· Seeing both successes and failures as an opportunity to learn. · Welcoming change and actively looking for opportunities to improve and innovate. · Nurturing an environment where innovation is encouraged without putting too much influence or control over it. · Role modelling continuous professional development and self-improvement.	· Offering help and support to patients, visitors and colleagues. · Taking the time to understand the perspective of others. · Asking others about their needs and preferences and being considerate to adapt one’s behaviour. · Making other people feel you have time for them when they need it.	· Openly sharing best practice and lessons learnt with others. · Clearly and honestly explaining to others why decisions have been made. · Creating opportunities for two-way dialogue and playing your part in fostering a collaborative approach. · Being open and honest, sharing information freely and transparently.	· Always treating others with respect in every interaction and any environment. · Going out of your way to include the voices of others. · Speaking up or taking action to challenge disrespectful or unacceptable words, actions or behaviours. · Contributing to a culture of belonging and inclusion.	· Promoting a “Team Gateshead” approach. · Championing and promoting services, skills and achievements with pride and confidence. · Networking and engaging with other areas and teams to build understanding, awareness and appreciation of what others do. · Finding and introducing ways to connect with and engage others.
Behaviours we EXPECT to see from yourself and your colleagues...	· Recognising and celebrating achievements and successes. · Demonstrating initiative to bring about change, new ideas and innovations. · An openness to change, by respectfully considering everyone’s ideas and listening to understand. · Seeing innovation and learning as something that is core to everyone’s role.	· Being kind and courteous when interacting with others. · Supporting others to invest in their health and wellbeing. · Demonstrating patience and tolerance to others - even when things are difficult or there is a lot of pressure. · Being welcoming, friendly, attentive and approachable in every interaction.	· Acting with authenticity and empathy – seeking to put oneself into the shoes of others. · Sharing issues, errors, or learnings openly so as to prevent mistakes. · Having honest conversations that get to the heart of the matter at hand. · Giving feedback in a constructive and a safe, non-judgemental way.	· Treating people with respect, dignity and courtesy. · Treating others in a considerate way that we would like ourselves or our loved ones to be treated. · Showing awareness of how one’s actions and words impact others. · Seeking to resolve disagreements or problems in a constructive way.	· Actively engaging and collaborating with colleagues, patients and partners. · Proactively seeking the views of others. · Challenging behaviours that do not reflect our values. · Collaborating with others when making decisions - seeking input and feedback in order to produce the best outcome.
Behaviours we do NOT or NEVER want to see from yourself and your colleagues...	· Blaming, criticising and focusing on the faults of others and personalising issues when things go wrong. · Being dismissive of the ideas and perspectives of others. · Protecting your own interests, resources or service area rather than taking a wider view. · Finding excuses to resist or avoid change and improvement.	· Justifying or making excuses for aggressive, bullying bad language or behaviour. · Failing to act if they see anyone in pain, stressed or upset. · Showing a lack of compassion or kindness in their interactions. · Being unapproachable or obstructive.	· Giving unkind, unhelpful or unconstructive feedback or criticism. · Putting personal agendas ahead of patient or Trust outcomes. · Avoiding unpopular, uncomfortable or challenging issues and decisions. · Breaching confidentiality or sharing information inappropriately.	· Incivility, discourtesy and disregard for others or their views. · Standing by or remaining silent when we see or hear disrespectful or unacceptable words, actions or behaviours. · Patronising or belittling the contribution or value of others. · Passing the buck or blaming others.	· Excluding others from discussion and decision making. · Bringing others into processes too late for them to contribute. · Just “ticking the box” and not being authentic in your actions. · Adopting or fostering an “us and them” mindset towards others.

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 8

Report Title:	**Corporate Objectives 2022-2023**			
Name of Meeting:	Board of Directors – Part 1			
Date of Meeting:	25th May 2022			
Author:	Kirsty Roberton, Deputy Director Corporate Services and Transformation			
Executive Sponsor:	Yvonne Ormston, Chief Executive			
Report presented by:	Yvonne Ormston, Chief Executive			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☒	**Discussion:** ☐	**Assurance:** ☐	**Information:** ☐
	To provide the board with the final version of the Trust Corporate Objectives for 2022/23.			
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 Trust Board held a Strategy session on the 27th April 2022 to discuss and review the draft Corporate Objectives and approach for 2022/23.			
Key issues: •	n/a			
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	The Board is asked to: • Approve the Corporate Objectives and process for development of detailed action plans and monitoring arrangements via the allocated board-committee • Agree that the Board Assurance Framework be developed via each Board-committee and be presented to July 2022 Board meeting for formal approval.			
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:	n/a				
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)	Strategic risks will be identified in line with the Strategic Aims and Corporate Objectives				
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒		

Corporate Objectives 2022-2023

1 Purpose of paper

1.1 For the Board to approve the Corporate Objectives for 2022-23 and agree how these will be monitored during 2022/23.

2 Background

2.1 A key role of the Board is to set strategic aims and objectives for the organisation and to hold the organisation accountable for the delivery of these. The Board Assurance Framework (BAF) is a tool through which risks to the achievement of the corporate objectives of the organisation are managed by the Board committees.

2.2 The Board has held discussions at a strategy session on 24th April 2022 where a draft set of corporate objectives were presented for discussion. A new designed BAF template was also reviewed at the session and agreed in principle.

3 Strategic Aims

3.1 The Board agreed the following 5 strategic longer term aims for the organisation in April 2021.

	Strategic Aim:	**Executive Leads**
1	We will continuously improve the quality and safety of our services for our patients.	Chief Nurse and Professional Lead for Midwifery and AHPS, Medical Director and Chief Operating Officer
2	We will be a great organisation with a highly engaged workforce	Director of People and Organisational Development
3	We will enhance our productivity and efficiency to make the best use of our resources	Group Director of Finance and Digital & Chief Operating Officer
4	We will be an effective partner and be ambitious in our commitment to improving health outcomes	Executive Team Members
5	We will develop and expand our services within and beyond Gateshead	Chief Operating Officer & Managing Director, QEF

4 Proposed Corporate Objectives

4.1 A total of 11 Corporate Objectives have been identified for reporting to the Trust Board via Board committees in 2022-23. These objectives are outlined in the table below

Strategic Aim 1 **We will continuously improve the quality and safety of our services for our patients**		
Board Priorities	**We will know we have achieved this through**	**Board Board-Committee**
SA1.1 Continue to improve our maternity services in line with the wider learning from the Ockenden review	Delivery of the 19 safety priorities and improvement in the maternity metrics outlined and reported the IOR	Quality Governance Committee
SA1.2 Continuous Quality improvement plan	Quality Account Priorities achieved	
SA1.3 Digital where it makes a difference	Achievement of the Digital Strategy	Digital Committee
Strategic Aim 2 **We will be a great organisation with a highly engaged workforce**		
SA2.1 Protect and understand the health and well-being of our staff by looking after our workforce	Delivery of Health and Wellbeing Strategy and Futures priorities	People and OD Committee
SA2.2 Growing and developing our workforce	Development of a Workforce Strategy Reduced workforce gaps Improved responses to staff survey	
SA2.3 Development and Implementation of a Culture Programme (2-3 year Programme)	Programme Plan to be developed and ratified at Transformation Board Launch and embedding of strategy, values and behaviours within the people infrastructure i.e. appraisals, policies, development plans Improvement in annual/pulse survey results – particularly in the area of physiological safety measures	

Strategic Aim 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 and associated transformation plans	Improvement in the Responsive indicators in the Integrated Oversight Report	Finance and Performance Committee
SA3.2 Achieving financial sustainability	Achievement of the annual financial plans The development of the longer term strategy to manage recurrent position	
Strategic Aim 4 **We will be an effective partner and be ambitious in our commitment to improving health outcomes**		
SA4.1 Tackle our health inequalities	The delivery of an agreed health inequalities action plan	Quality Governance Committee
SA4.2 Work collaboratively as part of Gateshead Cares system to improve health and care outcomes to the Gateshead population	Delivery of Gateshead Cares priorities and action plans	
Strategic Aim 5 **We will develop and expand our services within and beyond Gateshead**		
SA5.1 We will look to utilise our skills and expertise beyond Gateshead	Development and delivery of a Commercial Strategy	Finance and Performance Committee

4.2 Detailed action plans will be developed by each Board committee to ensure the delivery of the these objectives.

5 Monitoring and reporting

5.1 Objectives will be monitored by Board committees at each meeting. At each meeting the Board committees will review their BAF and relevant extracts from the Organisational risk register to allow them to review risks and mitigating actions and agree assurances or make adjustments to the BAF.

5.2 On a quarterly basis the Board will receive a report on corporate objective delivery alongside the full version of the BAF.

6 Recommendation

The Board members are asked to:

- Approve the Corporate Objectives and process for development of detailed action plans and monitoring arrangements via the allocated Board committee; and
- Agree that the BAF be developed via each Board committee and be presented to July 2022 Board meeting.

Gateshead Health NHS Foundation Trust

Assurance Report

Agenda Item: 9i

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☐
Committee Reporting Assurance:	Finance and Performance Committee – 29.03.22 and 14.04.22			
Name of Meeting:	Board of Directors			
Date of Meeting:	25 May 2022			
Author:	Miss J Boyle			
Executive Lead:	Mrs J Bilcliff and Mrs J Baxter			
Report presented by:	Mr M Robson, Chair of Committee			
Matters to be escalated to the Board:	Delayed discharges – the number of patients no longer meeting the right to reside criteria with challenges in respect of securing onward care in collaboration with partners. It was agreed to escalate this issue to the Board, noting the impact on patient flow and ambulance handovers (March 22).			
Executive Summary: ***(outline assurances and gaps including mitigating actions)***	**March 2022 Meeting:** Budget Setting 2022/23 Capital and Revenue An update was provided on the budget setting process, with the Group Director of Finance and Digital seeking permission to commit expenditure in line with the draft financial plan. An update was also provided on the development of the draft financial plan. Approval was granted, noting that the full draft financial plan and associated budgets would be presented to an extraordinary meeting of the Committee in April. Recognising that the plan continued to develop, a rating of partial assurance was provided. Annual Planning Update The Committee received an update on the broader annual planning requirements, including a detailed overview of the operational and people-related elements of the plan. It was noted that whilst there were elements of risk associated with the draft plan, the new operating model should assist in protecting elective bed capacity. The Committee expressed assurance that plans to-date were robust and would again be revisited in the April meeting prior to local submission.			

	Integrated Oversight Report (IOR) The Committee reviewed the IOR, with a particular focus on the significant number of delayed discharges due to the lack of care packages, and the resulting impact of this on the front of house and patient flow. It was noted that discussions were ongoing with the local authority to work collaboratively to secure onwards care for patients ready for discharge. The challenges in relation to cancer targets (due to increased referrals), ambulance handovers, A&E performance and unscheduled care pathways were also highlighted. A month-on-month increase in elective activity was noted as an area of improvement. Given the operational challenges faced and the impact of delayed discharges, the Committee agreed a partial assurance rating. Audiology Recovery Report Audiology had been identified as an area for a deep dive at a previous Committee meeting. The report provided an update on the audiology waiting list and plans in place to reduce the waiting list to a compliant level. Noting the intent to develop a business case in order to secure the required additional resource, the Committee agreed a rating of full assurance. Supply Procurement Committee (SPC) This report identified direct awards and deviations from the Standing Financial Instructions (SFIs). It was noted that the figures were higher than usual due to the impact of Covid funding and urgency with which some services needed to be sourced. The Committee discussed the report and required a greater level of detail to understand the decisions made and the scrutiny received at the SPC. As such the Committee concluded that they were not assured by the report on this occasion. Corporate Objectives Update The report outlined the year-end position against the 2021/22 corporate objectives. It was noted that work relating to some objectives would be carried forward into the next financial year, although may not be formal objectives. The Committee requested clarification on how outstanding actions would be carried forward.

	Financial Revenue Report – Month 11 It was noted that the year-end forecast remained unchanged, although the risk of the late receipt of income was highlighted and there was a risk of material movement at year-end. It was noted that it was not yet known whether the CDEL would be achieved by year-end, although significant work was being undertaken in this area. The Committee acknowledged the impending move into a more challenging financial environment in 2022/23 and expressed assurance over the work undertaken by the finance team. Transformation Board Update The Committee received a report following the inaugural meeting of the newly-reformed Transformation Board. The Committee received the terms of reference for ratification and requested that the role of the Board in monitoring Cost Reduction Plans (CRP) be strengthened. The Committee was assured over the plans in place to deliver the priority programmes and ratified the terms of reference subject to some requested amendments. Organisational Risk Register Extract The Committee reviewed the extract and was fully assured that the appropriate risks were captured and being managed effectively. **April 22 – Extraordinary Meeting** Budget Setting and Financial Plan The Committee received an overview of the draft financial plan headlines, including the indicative draft capital plan. Specific risks to the plan were highlighted and discussed, including: further Covid impact; the ability to deliver planned activity; the ability to transact efficiencies; and unknown future priorities. The Committee granted approval to spend as per the plan, to make the local submission and to submit the plan for Board approval later in the month. Recognising the risks and uncertainties, a rating of partial assurance was granted. Annual Plan Submission The Committee received a presentation on the annual plan submission. This included consideration of downside and upside risks. The Committee discussed the importance of recruitment and the unpredictability of demand forecasting in respect of activity volumes. The importance of the new operating model in this respect was highlighted. The

<table>
<tr><td></td><td colspan="6">Committee reviewed the movement in the planned deficit position and was assured regarding the work undertaken. The Committee approved the local submission on behalf of the Board.</td></tr>
<tr><td>Recommended actions for Board</td><td colspan="6">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="5">We will continuously improve the quality and safety of our services for our patients</td></tr>
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☒</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">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="6">Risks identified on the Organisational Risk Register at the time of the meeting include:
FIN 2873 - Risk that the Trust is unable to form a suitable capital plan and programme due to reduced levels of CDEL available. (9)
FIN 2874 - Risk that we are unable to formulate a coherent financial plan due to uncertainty surrounding the financial framework. (3)
2868 – risks of further waves of Covid impacting upon the delivery of the new operating model (16)</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>Responsive
☒</td><td>Well-led
☒</td><td>Effective
☒</td><td colspan="2">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>

NHS
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Assurance Report

Agenda Item: 9ii

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☒
Committee Reporting Assurance:	Quality Governance Committee			
Name of Meeting:	Trust Board			
Date of Meeting:	26 May 2022			
Author:	Mrs A Stabler, Non-Executive Director			
Executive Lead:	Mrs 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:** **Integrated Oversight Report** The Committee acknowledged that a consistent approach of recording COVID-19 patients is required and the Duty of Candour process is going to be reviewed to ensure we are fully compliant with guidance. The Committee agreed partial assurance had been provided from this report. **Nurse Staffing Exception Report** The Committee acknowledged that February 2022 continued with significant staffing challenges following on from January 2022 as the Trust managed the impact of Covid on staffing resource and the clinical operating model. There was discussion regarding staff escalation protocols in maternity and the report has been developed to include incidents reported in the same period and care hours per day. The Committee agreed partial assurance had been provided from this report. **Serious Incident Report** The Committee acknowledged a total of 6 serious incidents were reported between February and March 2022, none of which related to Maternity Services. The Committee agreed partial assurance had been provided from this report.			

	Assurance Report from SafeCare, Risk and Safety Council The Committee acknowledged the SafeCare / Risk and Safety Council meetings are in progress. The Committee agreed full assurance had been provided from this update. **Assurance Report from Strategic Safeguarding Group** The Committee acknowledged there is a high level of complex cases with some relating to discharge and fragmented records are still an ongoing issue. The Committee agreed full assurance had been provided from this update. **Maternity 6 Month Update Report** The Committee acknowledged there has been some important movement with agreed reporting structures in line with Ockenden and it's still a work in progress. The Committee noted confirmation has been received for our incentive scheme rebate and a business case has been agreed for Neonatal Badger to go live project. The Committee agreed full assurance had been provided from this report. **Ockenden 2 Update Report** The Committee acknowledged the final report from Donna Ockenden and many of the 15 recommendations are based around a well-trained workforce with a lot of the families feeling they weren't being listened to. **Mental Health 6 Month Update Report** The Committee acknowledged that the new Sunniside unit opened on 1st December 2021 and we have been able to attract some staff into the service by utilising budgets to introduce new roles. The Committee agreed full assurance had been provided from this report. **Infection Prevention & Control 6 Monthly Update Report** The Committee acknowledged that there has been a national relaxation of the response to COVID-19 but there is pressure within the IPC Team due to several outbreaks. The Committee agreed full assurance had been provided from this report.

	Health and Safety Report inc COSHH Audit Update The Committee acknowledged that the new Health & Safety Policy is in draft form and will be reviewed at various Committees prior to approval and an environmental risk assessment is in progress. The Committee noted that the Health & Safety Committee continue to meet and the COSHH training has restarted. The Committee agreed a partial assurance level had been received from this report. **Objectives Delivery Report** The Committee noted the 12 corporate objectives are all on track which are mapped to the Committee. The Committee agreed partial assurance had been provided from this update. **Learning from Deaths Annual Report** The Committee acknowledged the HSMR for Gateshead in the last 12 months is "more deaths than expected" as calculated by the model and continues to be monitored closely. The Committee agreed full assurance had been provided from this report. **Proposed Clinical Plan 2022/23** This was ratified by the Committee.	
Recommended actions for Board	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.	
Trust Strategic Aims that the report relates to: **(Including reference to any specific risk)**	**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
Financial Implications:	None to Note	
Links to Risks (identify significant risks and DATIX reference)	ORR Risks, 2879 – Maternity, 2779 CQC Compliance/ Improvement, 2868 – Further wave of Covid, 2880	

People and OD Implications:	Gaps in workforce in nursing, midwifery and mental health.				
Links to CQC KLOE	Caring ☒	Responsive ☒	Well-led ☒	Effective ☒	Safe ☒
Trust Diversity & Inclusion Objective that the report relates to	**Obj.1** ☐	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			
	Obj. 2 ☒	All patients receive high quality care through streamlined accessible services with a focus on improving knowledge and capacity to support communication barriers			
	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			

Gateshead Health NHS Foundation Trust

Assurance Report

Agenda Item: 9iii

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☐
Committee Reporting Assurance:	Digital Committee Assurance Report from Meeting held on 11 April 2022			
Name of Meeting:	Board of Directors			
Date of Meeting:	25 May 2022			
Author:	Mr A Moffat, Chair of the Digital Committee			
Executive Lead:	Mrs J Bilcliff, Group Director of Finance and Digital			
Report presented by:	Mr A Moffat, Chair of the Digital Committee			
Matters to be escalated to the Board of Directors:	No specific matters to escalate to the Board for further action.			
Executive Summary: ***(outline assurances and gaps including mitigating actions)***	**Strategic Aims and Objectives / Strategy and Transformation Roadmap** The report provided a good level of assurance with the percentage progress updated, however slippage related to capacity/resourcing issues continued to be noted. The Committee had previously requested a review of workload priorities to ensure the finite resource capacity is focussed on the appropriate deliverables; this work was reported as ongoing . A rating of partial assurance was awarded. **Global Digital Exemplar Milestones** The GDE Programme closure report was accepted following approval and endorsement by NHS Digital. Excellent feedback provided by NHS Digital. A rating of fully assured was awarded. **Service Key Performance Indicators** Whilst the roll out of KPIs continues work remains to ensure they reflect the Committee's Terms of Reference and to fully populate the previously agreed KPI template so as to provide assurance on digital services. A rating of Not Assured reflects the quality of data presented to the Committee at this meeting and the tasks that remain outstanding. **Cyber Update** External Cyber review undertaken by Dionach. A rating of partial assurance was given as the related report is yet to be received.			

<table>
<tr><td></td><td colspan="6"><u>Internal Audit Reports</u>
Digital audit plan agreed, currently three outstanding audit actions, none of which are overdue; a rating of full assurance was awarded.

<u>Digital Strategy</u>
Channel 3 outline business case has been produced in draft, with excellent engagement across the organisation noted. The business case will be shared with the Committee in June. A rating of full assurance was awarded.

<u>Sub-Group Reporting</u>
Assurance reports were received from the Digital Transformation Group and the Digital Assurance Group. As no gaps in assurance were identified, full assurance was awarded.</td></tr>
<tr><td>Recommended actions for the Board of Directors</td><td colspan="6">The Board is requested to take assurance from the work of the Committee and note the assurances, actions and decisions of the Committee in framing related items on the Board agenda.</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:
(Including reference to any specific risk)</td><td>Aim 1
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<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">None to note</td></tr>
<tr><td>Links to Risks (identify significant risks and DATIX reference)</td><td colspan="6">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="6">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 colspan="2">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
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	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

Gateshead Health NHS Foundation Trust

Assurance Report

Agenda Item: 10iv

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☐
Committee Reporting Assurance:	People and OD Committee – May 2022			
Name of Meeting:	Trust Board			
Date of Meeting:	19 May 2022			
Author:	Ferne Clements, Head of People Planning, Performance & Quality			
Executive Lead:	Lisa Crichton-Jones, Director of People & OD			
Report presented by:	Ruth Bonnington, Non-Executive Director			
Matters to be escalated to the Board:	No items identified for escalation			
Executive Summary: ***(outline assurances and gaps including mitigating actions)***	The key agenda items discussed were as follows: <u>Update on Supply</u> The supply presentation from the Board Development Session was shared setting the strategic context of supply. The Committee was partially assured on the item overall, recognising the monumental amount of work. <u>Staff Survey</u> The committee was fully assured that every action required is in place but this stream of work was ongoing. <u>Update Report from POD Portfolio Board</u> The Committee was partially assured on this item, given that workstreams were in the early stages of restarting and some meetings had been stood down due to operational pressures. <u>People & OD Metrics</u> A presentation was shared highlighting the key areas of focus within each of the 'Heads of' portfolios. The committee welcomed the presentation format and were partially assured, understanding a recovery plan is required for core skills and appraisals. <u>Strategic Objective Update</u> The Committee received a summary report which provided a progress update against the strategic objectives mapped to the Committee for monitoring. It was highlighted that			

<table>
<tr><td></td><td colspan="5">existing strategic objectives would need to be closed inline with the new strategic objectives.
The Committee awarded this area partial assurance, recognising the continued progress being made.</td></tr>
<tr><td>Recommended actions for Board</td><td colspan="5">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="4">We will continuously improve the quality and safety of our services for our patients</td></tr>
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☐</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">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="5">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="5">As set out</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>

Gateshead Health
NHS Foundation Trust

Gateshead Health NHS Foundation Trust

Chief Executive Update

Yvonne Ormston MBE
May 2022

Operational performance

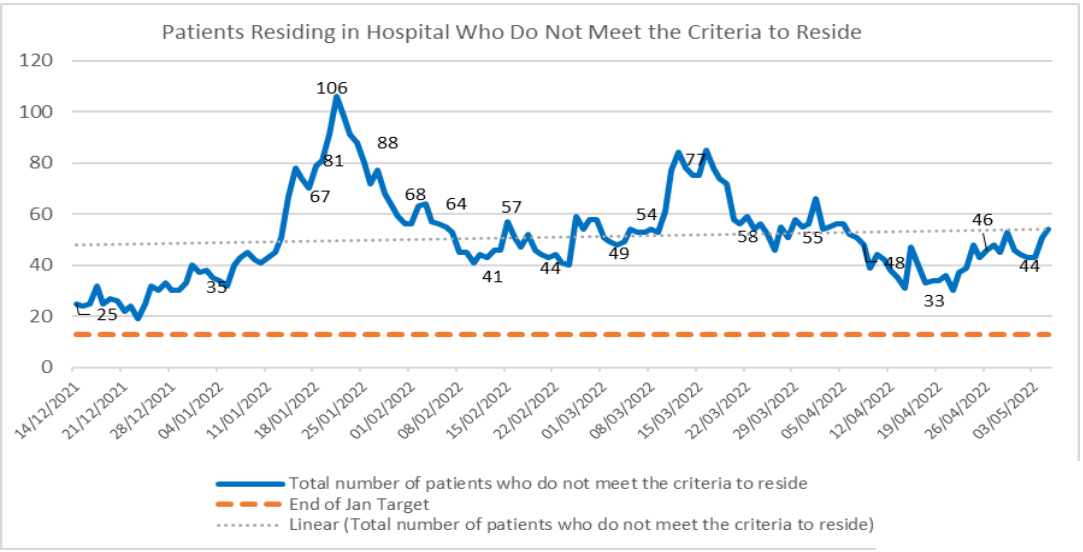
Gateshead Health
NHS Foundation Trust

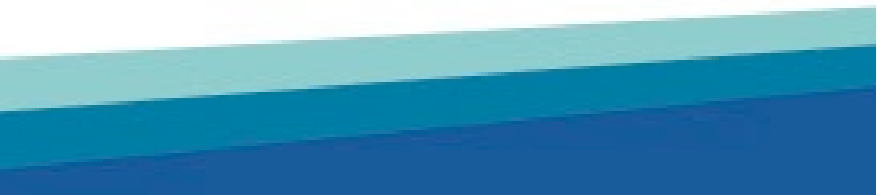
Operational performance

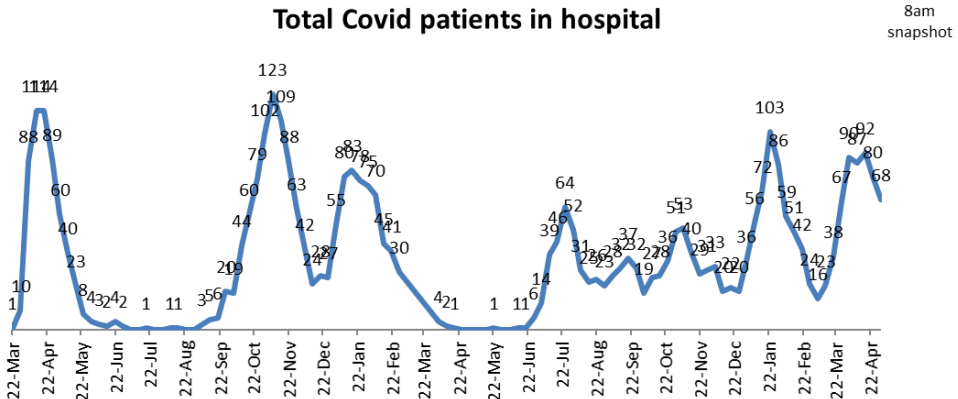
Gateshead Health NHS Foundation Trust

Medically optimised patients

- There have been some small improvements in the average daily patient delay rate improving from an average of 60.6 patients per day in March to 44.2 patients per day in April
- Despite these improvements April's delays equate to a significant volume, circa 2 wards of bed capacity lost or 'blocked' each day.
- Trust internal delays – 9% of patients in April
- Local Authority delays – 91% of patients in April





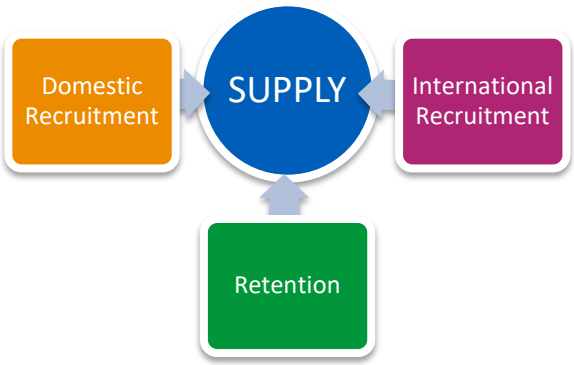


Performance benchmarking

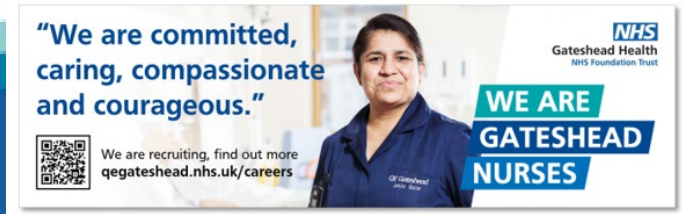
Gateshead Health NHS Foundation Trust

Indicator	Gateshead Health Performance	Period	Position
A&E 4 hour waiting time	77.3%	March	15th / 139 NHS Providers
Latest weekly PTL: patients waiting > 104 weeks	0	w/e 01/05/22	Joint 1st /8 Providers in ICS
Latest weekly PTL: patients waiting > 52 weeks	50	w/e 01/05/22	2nd / 8 Providers in ICS
Latest weekly PTL: patients waiting > 62 days for cancer treatment	74	w/e 01/05/22	1st / 8 Providers in ICS
62 day backlog as % of waiting on the list	8.7%	w/e 03/04/22	73 (top 20 under NHSE/I scrutiny

Recruitment



- Significant focus on recruitment – top priority.
- Staffing Task and Finish Group meeting fortnightly.
- Launched domestic recruitment campaign this month.
- Recruitment events planned, including 4 HCA events per year, as well nursing recruitment events (April event).
- Longer term – work experience placements, school career days, working with Gateshead College, apprenticeship strategy
- First cohort of international recruits expected in July.
- International recruitment team in place and first cohort of international staff expected to join the Trust in the summer.
- Recruitment and retention initiatives being progressed – including health and wellbeing, focus on development, rotational programmes



Equality, Diversity and Inclusion

Gateshead Health NHS Foundation Trust

- The Workforce Race Equality Standard for 2021 was published in April 22.
- We were pleased to feature in the top ten best performing trusts for 2 indicators;
- Indicator 2 - White applicants being appointed from shortlisting compared to BME applicants
- Indicator 5 - Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
- The full report can be accessed below and our work on this will continue with oversight via our EDI Human Rights Group

NHS England » Workforce Race Equality Standard 2021

Gateshead Health
NHS Foundation Trust

Provider Collaborative

Provider Collaborative Prospectus and Operating Model to be considered at signed off at each provider Board.

Meeting held on 17 May to include updates on:
- Diagnostic workstreams
- Elective recovery

Provider Collaborative prospectus is under review to ensure alignment with ICB requirements. It will be shared with provider boards in June.

Integrated Care System/Integrated Care Board (ICS/ICB)

Health and Care Bill received Royal Assent on 28 April to become the Health and Care Act 2022. This places ICSs on a statutory footing from 1 July and sets out the role of ICBs (which will replace Clinical Commissioning Groups as the NHS funding channel and strategic commissioning body).

Two Independent Non-Executive Member appointments have been announced:
- Professor Eileen Kaner
- Jon Rush

Two further appointments will be made shortly.

Work continues on the health and wellbeing strategy for the ICS.

Consultation on the operating model continues and there is a significant focus on ICB structures, given that circa 1,000 staff from legacy organisations will be employed in the ICS / ICB.

General Update

- Visits:
  - Occupational health team
  - Surgical ward
  - Hosted external visits to the QE Hospital from Mark Adams and Sam Allen
- Meetings
  - ICS Management Group
  - Regional Urgent and Emergency Care meeting
  - Regional Roadshow
  - CEO strategic session with the Integrated Care Partnership
  - Inclusion with Humanity webinar
  - National Women's network meeting
  - Regional Operating Model Session – North East and Yorkshire
  - Gateshead Health Patient Safety Conference
  - Speaker at:
    - Healthcare Partnership Network Conference
    - Celebrating National Day for Staff Networks
    - Gateshead Health Nursing Conference
  - North East and North Cumbria ICS vision workshop
  - Pathology network development
  - ICB recruitment panel
  - Provider Collaborative Board
  - Fortnightly ICS Chief Executive calls
- Planning and Development
  - Annual Planning sessions
  - SMT and EMT Development
  - Strategy Development

Board of Directors

Gateshead Health NHS Foundation Trust

Report Cover Sheet

Agenda Item: 11.i

Report Title:	Organisational Risk Register			
Name of Meeting:	Board of Directors			
Date of Meeting:	25th May 2022			
Author:	Kendra Marley, Corporate Risk Manager			
Executive Sponsor:	**Gill Findley, Chief Nurse**			
Report presented by:	**Gill Findley, Chief Nurse**			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☒	**Assurance:** ☒	**Information:** ☐
	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.			
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 attached report is now received in the Executive Team Meeting each week, and monthly at the Executive Risk Management Group.			
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*	Two finance risks relating to the 2021/22 financial year have been closed with delivery plans met and risk mitigated. One risk, relating to the maternity estate and safety of services has been escalated from 8 to 12.			

<table>
<tr><td>

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

</td><td colspan="6">Risk and action review compliance shows improvement, and this is reflective of the improvements being observed across the wider trust registers.</td></tr>
<tr><td>Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper</td><td colspan="6">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 rowspan="5">Trust Strategic Aims that the report relates to:</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
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<tr><td>Aim 5
☒</td><td colspan="5">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">Each risk is linked to a corporate objective, see report.</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><td></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">Included in report</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>

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 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.

This report covers the period 12th March to 17th May 2022 (extraction date for this report).

Organisational Risk Register - Movements

Following the last meeting 2 risks from the organisational risk register have been closed;

- Risk 2873 Finance - *Risk that the Trust is unable to form a suitable capital plan and programme due to reduced levels of CDEL available.*
- Risk 2874 Finance - *Risk that we are unable to formulate a coherent financial plan due to uncertainty surrounding the financial framework.*

Both relate to the 2021/22 financial year and following the successful delivery of the plans, the risks have been closed. Financial risks for the current year are currently being reviewed.

One risk has been escalated in score;

- Risk 2879 COO - *Risks relating to the trusts Maternity estate that have the potential to impact on the delivery of safe maternity services.* Current risk score increased from 8 to 12. While plans to address some of the risk relating to the estate are being progressed, the recent release of Ockenden 2 requires a gap analysis to identify and consider any additional considerations.

Risk and action review compliance shows improvement, and this is reflective of the improvements being observed across the wider trust registers.

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 ongoing management of risk.

Organisational Risk Register Report

Reporting Period: 12-Mar-2022 to 17-May-2022

Comparison Date: 14-Mar-2022

Gateshead Health NHS Foundation Trust

Risk Profile (Current/Managed)

Competency - 1

POD 2765 - No Leadership and OD strategy in place across the trust resulting in failure to support our workforce (12)

Resources - 2

COO 2744 - Risk of low or inadequate staffing to operate effective and efficient service provision as a result of covid surge and response. (16)

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

Wellbeing - 1

POD 2759 - We are not able to appropriately support the health and wellbeing needs of our workforce (12)

Business Continuity - 1

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

Digital - 1

COO 2945 - Availability of Business Intelligence (12)

Effectiveness - 2

COO 2869 - Unintended harm to patients, due to the impact of reduced services, delayed treatment and pathway starts (16)

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

Safety - 1

COO 2879 - Risks relating to the trusts Maternity estate that have the potential to impact on the delivery of safe maternity services (12)

Compliance - 3

POD 2963 - Covid Vaccine next steps uncertainty for NHS staff - staff may leave roles/ employment (9)

CEOL2 2964 - There is a risk that there is insufficient and formal oversight on the 4 GP practices currently hosted by the trust (16)

NMQ 2779 - The Trust fails to meet the CQC Fundamental Standards. (12)

Delivery of Objectives - 2

COO 2868 - Further waves of Covid may impact on the ability to deliver key performance targets and recovery plans (16)

CEOL2 2880 - Risk that Place/ICS/ICP strategy and plans do not fully align with our objectives and aspirations to tackle health inequalities. (9)

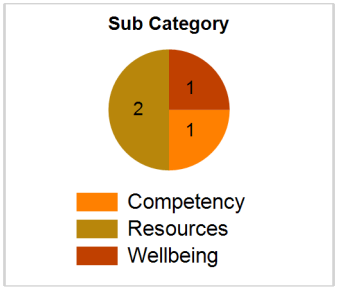
Organisational Risk Register Report

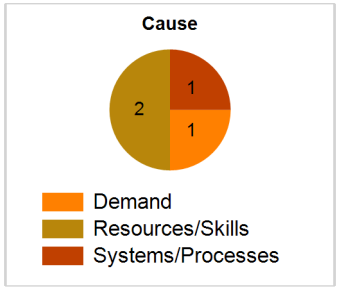
Reporting Period: 12-Mar-2022 to 17-May-2022

Comparison Date: 14-Mar-2022

Gateshead Health NHS Foundation Trust

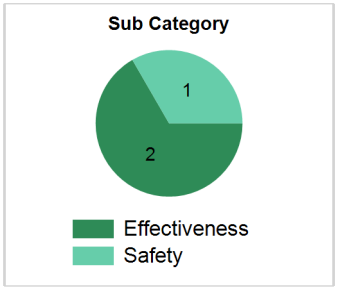
People & Resources

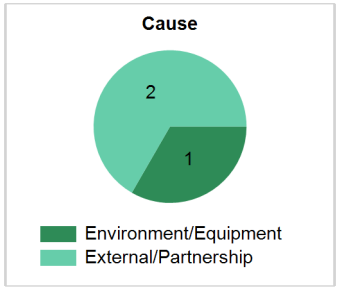




Risk Sub Cat	Risk Cause	No. Risks
Competency	Systems/Processes	1
Resources	Resources/Skills	2
Wellbeing	Demand	1

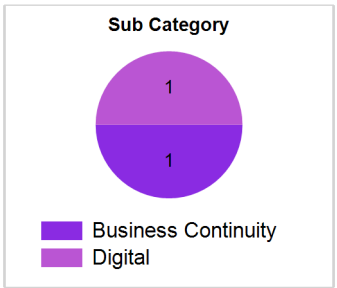
Quality Outcomes

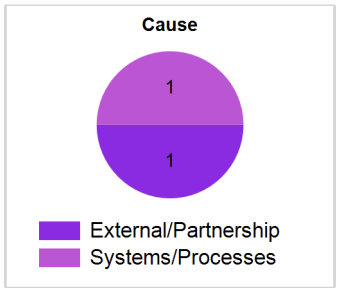




Risk Sub Cat	Risk Cause	No. Risks
Effectiveness	External/Partnership	2
Safety	Environment/Equipment	1

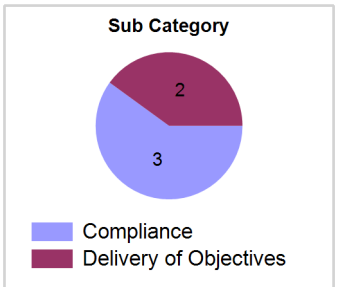
Finance & Efficiency

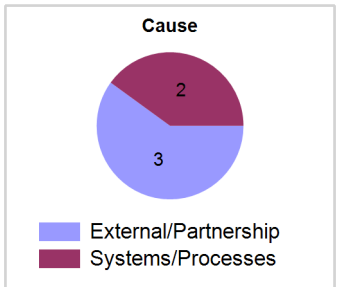




Risk Sub Cat	Risk Cause	No. Risks
Business Continuity	External/Partnership	1
Digital	Systems/Processes	1

Regulation & Compliance, Reputation





Risk Sub Cat	Risk Cause	No. Risks
Compliance	External/Partnership	1
	Systems/Processes	2
Delivery of Objectives	External/Partnership	2

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

Organisational Risk Register Report

Reporting Period: 12-Mar-2022 to 17-May-2022

Comparison Date: 14-Mar-2022

Gateshead Health NHS Foundation Trust

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
2744 01/07/2020 Joanne Baxter Chief Operating Officer EPRR & Site Resilience 16/06/2022 BU_DIR COO ORG 3.8P Deliver the Operational transformation programme to improve productivity and efficiency of service delivery and recovery post covid	Risk of low or inadequate staffing to operate effective and efficient service provision, due to significant gaps in nursing, AHP's, Medics, and other staff groups, as a result of covid surge and response, resulting in service interruption, pathway delays, potential impact on patient safety, effectiveness and experience and staff safety and wellbeing.	20	1.Annual review and establishment of safe nursing staffing levels. 2.Safe staffing report (nursing)produced and forecasting robust. 3.Workforce bank in place (see linked risk) 4.Expanded Agency usage (process for approval) 5.Critical staff payment offer approved and in place. 6.Workforce absence etc captured via ESR/ healthroster 7.New operating model aligns staffing requirements to activity and service plans. 8. Volunteers - recruitment and use 9.Deployment Hub to improve use of available resources	16	Review of temporary staffing solutions	Joanne Baxter 31/07/2022	6
					Triangulation of incidents and low staffing	Shelley Dyson 31/07/2022	
					active recruitment to vacancies	Lisa Crichton-Jones 30/09/2022	
					International recruitment programme	Lisa Crichton-Jones 30/09/2022	
2764 17/11/2020 Ferne Clements People and OD Human Resources 21/05/2022 BAF HRC ORG 2.3P Develop a trust wide approach to strategic workforce planning	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 resulting in failure to deliver current and future services that are fit for purpose.	20	Task and finish group established to coordinate all strands of work relating to staffing International recruitment is progressing and is on track Domestic recruitment is being actively pursued and monitored Over recruiting to HCSW positions to fill some of the Registered Nurse vacancies Recruitment process streamlined (RPIW) Refreshed dataset provided to The Whole System Partnership on 01 March 2022. (to enable workforce planning)	16	Workforce planning to be scoped and future resource identified.	Ferne Clements 31/07/2022	8
2868 27/04/2021 Joanne Baxter Chief Operating Officer EPRR & Site Resilience 16/06/2022 BAF COO EPRR FPC ORG QGC 3.8P Deliver the Operational transformation programme to improve productivity and efficiency of service delivery and recovery post covid	Further waves of covid impact on the delivery of the new operating model and associated transformation plans therefore impacting on key performance and recovery plans.	20	EPRR incident response and surge plans in place Reconfiguration from previous waves and learning applied. Workforce management plans in place and monitoring of staff absences available Current model for managing covid within the clinical environment is being changed in line with national guidance.	16	De-escalation	Nicola Bruce 30/06/2022	6
					re-start of elective programme	Helen Routh (Completed 28/02/2022)	

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

Organisational Risk Register Report

Reporting Period: 12-Mar-2022 to 17-May-2022

Comparison Date: 14-Mar-2022

Gateshead Health NHS Foundation Trust

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
2869 27/04/2021 Helen Routh Chief Operating Officer EPRR & Site Resilience 16/06/2022 COO ORG 3.8P Deliver the Operational transformation programme to improve productivity and efficiency of service delivery and recovery post covid	There is a risk of unintended harm to patients, due to the impact of reduced service provision, delayed treatment and pathway starts as a result of Covid 19. This may Result in patients accessing treatment who are more unwell than otherwise would have been, longer stays in hospital and longer recovery periods	20	Detailed elective recovery plans have been developed and are underway Additional capacity is being facilitated to reduce waiting times Clear trajectory to reduce long waiters Clinical review of those long waiters	16	work with newly appointed public health consultant and gateshead system to determine health inequalities	Andrew Beeby 30/06/2022	8
					deliver the planned and elective recovery transformation plan	Helen Routh 26/09/2022	
					delivery trajectory to address all 52 week waiters	Helen Routh (Completed 16/05/2022)	
2964 28/10/2021 Jacqueline Bilcliff Chief Executive Office Chief Executive Office 16/06/2022 BU_DIR ORG 2.5 Strengthen approaches to people related quality, performance and governance measures	There is a risk that there is insufficient and formal oversight on the 4 GP practices currently hosted by the trust resulting in clinical, quality, financial and people risks not being sufficiently understood or mitigated against	16	Some informal oversight by Medical Director / Chief Nurse and COO.	16	Longer term strategy for primary care / GP practices under consideration.	Jacqueline Bilcliff 30/06/2022	6

Business Intelligence

Organisational Risk Register Report

Reporting Period: 12-Mar-2022 to 17-May-2022

Comparison Date: 14-Mar-2022

NHS Gateshead Health NHS Foundation Trust

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
2982 06/12/2021 Amy Muldoon Medical Services Medical Services - Divisional Management 26/05/2022 BU_DIR COO ORG 3.8P Deliver the Operational transformation programme to improve productivity and efficiency of service delivery and recovery post covid	description: Increased risk of delay in transfer to community due to lack of social care provision and intermediate care beds. Risk of: 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. Due to: there is currently 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. Resulting in: patient harm or death, patients deconditioning and increased risk of failed discharge secondary to this. Staff health and wellbeing, job dissatisfaction and poor performance due to pressures.	20	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.	16			9

Organisational Risk Register Report

Reporting Period: 12-Mar-2022 to 17-May-2022

Comparison Date: 14-Mar-2022

Gateshead Health NHS Foundation Trust

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
2759 16/11/2020 Amanda Venner People and OD Human Resources 26/05/2022 BAF HRC ORG 2.1P Establish a post covid health and well being programme to incorporate; The development of a hwb strategy, roll out of HWB conversations, the continuing arrangement for a Trust Testing Track & Trace & vaccine service and a review of the OH service	Risk that we are not able to appropriately support the health and wellbeing needs of our workforce due to insufficient capacity to support these needs resulting in backlog of Occupational Health work and slow turn around times for management referrals, counselling and proactive management of staff HWB. Resulting in reduced resilience levels low, with mental and physical health needs emerging, potentially resulting in higher levels of absence and turnover and safety incidents as well as an inability to deliver of the relevant HWB aspects of the NHS people plan.	16	HWB Programme team recruited and fully in place from June 2021 Occupational Health Service Manager appointed. Board HWB Guardian identified. Regional HWB established which GHNT is part of. Partnered with Talk Works to provide talking therapies and counselling services to reduce waiting times for counselling and psychological support services. Access to local and national resources. Occupational health referral systems(self referral and management referral)and process in place. HWB stalls set up to seek the views on HWB gaps/needs/wants/views of staff. Rebranding of HWB programme underway. Occupation Health external review completed, with improvement plan now being implemented. HWB "check ins" rolled out across the Trust. Ts and Vs Business case to extend Covid testing and tracing service to end March 2022 agreed. HWB initiatives received confirmation of ICS funding for Emotional Health and Wellbeing support for staff. Health and Wellbeing dashboard of early warning metrics established and discussed at the programme board, ops meetings and HRC health needs assessment in place. Regional funding secured to fund the team until June 2023 Interim physio support agreed internally Work progressing to secure a Junior Dr in Occupational Health	12	Engagement on HWB Strategy to be undertaken during May 2022, with strategy finalised and agreed in June 2022 Improved alignment with ICS	Amanda Venner 01/07/2022 Lisa Crichton-Jones (Completed 31/03/2022)	8

Key: CRR - Current Risk Rating PRR - Previous Risk Rating
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Business Intelligence

Organisational Risk Register Report

Reporting Period: 12-Mar-2022 to 17-May-2022

Comparison Date: 14-Mar-2022

NHS Gateshead Health NHS Foundation Trust

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
2765 17/11/2020 Laura Farrington People and OD Workforce Development 26/05/2022 BAF HRC ORG 2.4P Develop a leadership and OD Strategy with clear outcomes	Risk that we have leaders in the organisation that do not demonstrate the Trust values and lead with an expected level of competence and that we do not invest in, develop and nurture leaders of the future due to no leadership and OD strategy being in place across the Trust resulting in a failure to support our workforce in the way we would strive to.	20	Head of Leadership, OD & Staff Experience in post, with wider OD team now in position. Leadership & OD Programme Board underway, with Exec sponsor in place. POD Committee updated via wider POD Strategic update.	12	Pilot of Leading Well 3 day programme Initial Roll out and review of the leading well programme	Laura Farrington 30/06/2022 Laura Farrington 31/08/2022	8
2779 01/07/2020 Jane Conroy Nursing, Midwifery & Quality Quality Governance 07/06/2022 BAF ORG QGC 1.10P Develop Route Map to CQC Outstanding	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 readiness action plan 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.	12	Ensure any areas of improvement from last inspection are in place Develop a route map to Outstanding	Jane Conroy 07/06/2022 Jane Conroy 07/06/2022	6
2879 29/04/2021 Joanne Baxter Chief Operating Officer EPRR & Site Resilience 16/06/2022 BAF ORG QGC 1.1P Implementation of the recommendations of the Ockenden report on Maternity Services	There are risks relating to the trusts Maternity estate that have the potential to impact on the delivery of safe maternity services and the ability to satisfactorily address actions from local and national requirements (HSIB/ Ockenden/ Continuing Care/ Birthrate Plus.	12	Ockenden Compliance Report – Assurance Assessment tool separate specific risks on register (see linked risks) Quality and safety of services monitored	12	Gap Analysis of Ockenden 2 requirements Agree a plan to mitigate current risk Deliver the full project plan for a new maternity build in collaboration with QEF	Lesley Heelbeck 31/07/2022 Kate Hewitson 01/08/2022 Joanne Baxter 20/10/2022	4

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Comparison Date: 14-Mar-2022

Gateshead Health NHS Foundation Trust

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
2945 14/09/2021 Joanne Baxter Chief Operating Officer EPRR & Site Resilience 16/06/2022 BU_DIR ORG 3.8P Deliver the Operational transformation programme to improve productivity and efficiency of service delivery and recovery post covid	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	• Assess what is currently available and set up in yellow fin under relevant business units	Michael Smith 31/05/2022	4
					project groups established and PID developed and plans developed for delivery	David Thompson 30/06/2022	
					• 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	
					• Improve data quality by working with teams and provide resilience to teams doing the RTT etc	Debbie Renwick 30/09/2022	

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Business Intelligence

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NHS Gateshead Health NHS Foundation Trust

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1636 10/11/2014 David Thompson Digital IT 07/06/2022 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	10	Complete Cyber Essential Plus Accreditation Manage replacement of End of life Network Hardware	Jon Potts 31/05/2022 Jon Potts 30/07/2022	5
2880 30/04/2021 Mr Andrew Beeby Chief Executive Office Medical Directorate 16/08/2022 BAF ORG QGC 4.3P Strong partner working at place, ICP, ICS levels and beyond to manage population health and tackle health inequalities - Appoint a consultant in Public Health jointly with LA & CCG	Risk that Place/ICS/ICP strategy and plans do not fully align with our objectives and aspirations to tackle health inequalities. Due to slightly different aims and objectives, or ways of doing things. 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.	9			6

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Gateshead Health NHS Foundation Trust

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
2963 28/10/2021 Amanda Venner People and OD Human Resources 21/07/2022 BU_DIR ORG 2.3P Develop a trust wide approach to strategic workforce planning	Risk that uncertainty relating to next steps for covid vaccine for NHS staff - staff may leave roles/ employment impacting on service delivery and further staff pressures/ wellbeing, impact on recruitment.	9	Current vaccination program and known % of staff vaccinated New recruits asked for vaccination status Current progress and project plan known Agreed process for discussing vaccination status, redeployment/ other options	9	Task and finish group to complete actions below	Laura Farrington 30/04/2022	4
							14

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
2879 29/04/2021 Joanne Baxter Chief Operating Officer EPRR & Site Resilience 16/06/2022 BAF ORG QGC 1.1P Implementation of the recommendations of the Ockenden report on Maternity Services	Risks relating to the trusts Maternity estate that have the potential to impact on the delivery of safe maternity services	12	Ockenden Compliance Report – Assurance Assessment tool separate specific risks on register (see linked risks) Quality and safety of services monitored	12	Gap Analysis of Ockenden 2 requirements	Lesley Heelbeck 31/07/2022	4	Work on the build has started.	8
					Agree a plan to mitigate current risk	Kate Hewitson 01/08/2022			
					Deliver the full project plan for a new maternity build in collaboration with QEF	Joanne Baxter 20/10/2022			
									1

Risks Moved to Managed in Period

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

Organisational Risk Register Report

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Gateshead Health NHS Foundation Trust

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
							0

Risks Closed 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 / (Open Actions)	TRR	Closure Details	PRR
2873 30/04/2021 Kris MacKenzie Finance Finance 31/03/2022 BAF FPC ORG 3.4P Develop an approved capital and revenue plan	Risk that the Trust is unable to form a suitable capital plan and programme due to reduced levels of CDEL available.	20	Approved Capital and Revenue Plan 2021/22 Additional funding is being made available centrally, which may impact on size of CDEL available	1			1	Plan achieved as part of year end closedown.	9
2874 30/04/2021 Kris MacKenzie Finance Finance 31/03/2022 BAF FPC ORG 3.4P Develop an approved capital and revenue plan	Risk that we are unable to formulate a coherent financial plan due to undertainty surrounding the financial framework.	20	Financial report regularly to F&P and Board.	1			1	Plan was achieved as part of financial year closedown.	3
									2

Risks Added in Period

Risk ID / Date Identified	Risk Description	IRR	Current Controls	CRR	Action	Action Owner	TRR	Latest Progress Note

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

Organisational Risk Register Report

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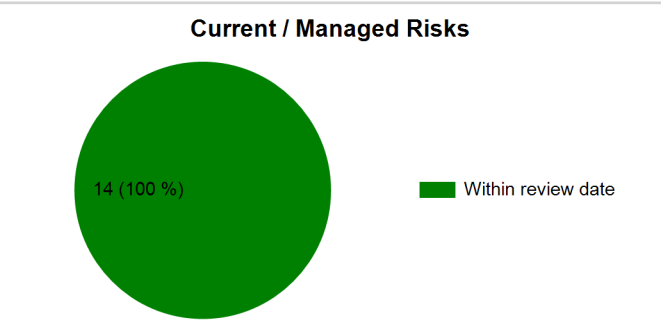
Gateshead Health NHS Foundation Trust

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

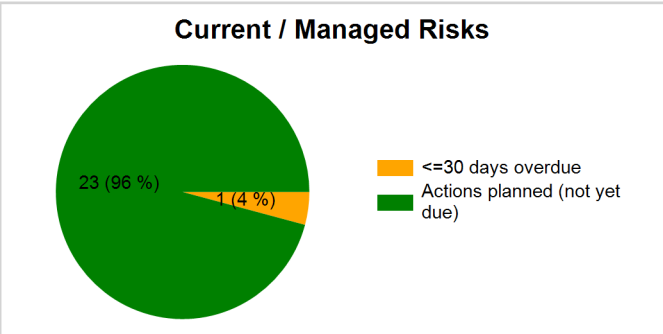
Risks Removed in Period

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

Risk Review Compliance



Risk Action Compliance



Movements in CRR

				CRR											
BU	Service Line	ID	Risk Description	14-Mar	15-Mar	16-Mar	17-Mar	18-Mar	19-Mar	20-Mar	21-Mar	22-Mar	23-Mar	24-Mar	25-Mar
Chief Executive Office	Chief Executive Office	2964	There is a risk that there is insufficient and formal oversight on the 4 GP practices currently hosted by the trust	16	16	16	16	16	16	16	16	16	16	16	16

Key: **CRR** - Current Risk Rating **PRR** - Previous Risk Rating
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Organisational Risk Register Report

Reporting Period: 12-Mar-2022 to 17-May-2022

Comparison Date: 14-Mar-2022

Gateshead Health NHS Foundation Trust

				CRR											
BU	Service Line	ID	Risk Description	26-Mar	27-Mar	28-Mar	29-Mar	30-Mar	31-Mar	01-Apr	02-Apr	03-Apr	04-Apr	05-Apr	06-Apr
Chief Executive Office	Chief Executive Office	2964	There is a risk that there is insufficient and formal oversight on the 4 GP practices currently hosted by the trust	16	16	16	16	16	16	16	16	16	16	16	16

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

Organisational Risk Register Report

Reporting Period: 12-Mar-2022 to 17-May-2022

Comparison Date: 14-Mar-2022

Gateshead Health NHS Foundation Trust

				CRR											
BU	Service Line	ID	Risk Description	07-Apr	08-Apr	09-Apr	10-Apr	11-Apr	12-Apr	13-Apr	14-Apr	15-Apr	16-Apr	17-Apr	18-Apr
Chief Executive Office	Chief Executive Office	2964	There is a risk that there is insufficient and formal oversight on the 4 GP practices currently hosted by the trust	16	16	16	16	16	16	16	16	16	16	16	16

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

Organisational Risk Register Report

Reporting Period: 12-Mar-2022 to 17-May-2022

Comparison Date: 14-Mar-2022

Gateshead Health NHS Foundation Trust

				CRR											
BU	Service Line	ID	Risk Description	19-Apr	20-Apr	21-Apr	22-Apr	23-Apr	24-Apr	25-Apr	26-Apr	27-Apr	28-Apr	29-Apr	30-Apr
Chief Executive Office	Chief Executive Office	2964	There is a risk that there is insufficient and formal oversight on the 4 GP practices currently hosted by the trust	16	16	16	16	16	16	16	16	16	16	16	16

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

Organisational Risk Register Report

Reporting Period: 12-Mar-2022 to 17-May-2022

Comparison Date: 14-Mar-2022

Gateshead Health NHS Foundation Trust

				CRR											
BU	Service Line	ID	Risk Description	01-May	02-May	03-May	04-May	05-May	06-May	07-May	08-May	09-May	10-May	11-May	12-May
Chief Executive Office	Chief Executive Office	2964	There is a risk that there is insufficient and formal oversight on the 4 GP practices currently hosted by the trust	16	16	16	16	16	16	16	16	16	16	16	16

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

Organisational Risk Register Report

Reporting Period: 12-Mar-2022 to 17-May-2022

Comparison Date: 14-Mar-2022

Gateshead Health NHS Foundation Trust

				CRR				
BU	Service Line	ID	Risk Description	13-May	14-May	15-May	16-May	Today
Chief Executive Office	Chief Executive Office	2964	There is a risk that there is insufficient and formal oversight on the 4 GP practices currently hosted by the trust	16	16	16	16	16

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

Organisational Risk Register Report

Reporting Period: 12-Mar-2022 to 17-May-2022

Comparison Date: 14-Mar-2022

Gateshead Health NHS Foundation Trust

				CRR											
BU	Service Line	ID	Risk Description	14-Mar	15-Mar	16-Mar	17-Mar	18-Mar	19-Mar	20-Mar	21-Mar	22-Mar	23-Mar	24-Mar	25-Mar
Chief Executive Office	Medical Directorate	2880	Risk that Place/ICS/ICP strategy and plans do not fully align with our objectives and aspirations to tackle health inequalities.	9	9	9	9	9	9	9	9	9	9	9	9
Chief Operating Officer	EPRR & Site Resilience	2744	Risk of low or inadequate staffing to operate effective and efficient service provision as a result of covid surge and response.	16	16	16	16	16	16	16	16	16	16	16	16
		2868	Further waves of Covid may impact on the ability to deliver key performance targets and recovery plans	16	16	16	16	16	16	16	16	16	16	16	16
		2869	Unintended harm to patients, due to the impact of reduced services, delayed treatment and pathway starts	16	16	16	16	16	16	16	16	16	16	16	16
		2879	Risks relating to the trusts Maternity estate that have the potential to impact on the delivery of safe maternity services	8	8	8	8	8	8	8	8	8	8	8	8
		2945	Availability of Business Intelligence	12	12	12	12	12	12	12	12	12	12	12	12
Digital	IT	1636	UCRF R01/R03/R20/R23 - Malware such as Ransomware Compromising Unpatched Endpoints, Servers and Equipment	10	10	10	10	10	10	10	10	10	10	10	10
Medical Services	Medical Services - Divisional Management	2982	Risk of delayed transfers of care and increased hospital lengths of stay	16	16	16	16	16	16	16	16	16	16	16	16
Nursing, Midwifery & Quality	Quality Governance	2779	The Trust fails to meet the CQC Fundamental Standards.	12	12	12	12	12	12	12	12	12	12	12	12
People and OD	Human Resources	2759	We are not able to appropriately support the health and wellbeing needs of our workforce	12	12	12	12	12	12	12	12	12	12	12	12
		2764	Workforce - Risk of not having the right people in right place at the right time with the right skills.	16	16	16	16	16	16	16	16	16	16	16	16
		2963	Covid Vaccine next steps uncertainty for NHS staff - staff may leave roles/ employment	9	9	9	9	9	9	9	9	9	9	9	9
	Workforce Development	2765	No Leadership and OD strategy in place across the trust resulting in failure to support our workforce	12	12	12	12	12	12	12	12	12	12	12	12

Key: **CRR** - Current Risk Rating **PRR** - Previous Risk Rating
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Organisational Risk Register Report

Reporting Period: 12-Mar-2022 to 17-May-2022

Comparison Date: 14-Mar-2022

Gateshead Health NHS Foundation Trust

				CRR											
BU	Service Line	ID	Risk Description	26-Mar	27-Mar	28-Mar	29-Mar	30-Mar	31-Mar	01-Apr	02-Apr	03-Apr	04-Apr	05-Apr	06-Apr
Chief Executive Office	Medical Directorate	2880	Risk that Place/ICS/ICP strategy and plans do not fully align with our objectives and aspirations to tackle health inequalities.	9	9	9	9	9	9	9	9	9	9	9	9
Chief Operating Officer	EPRR & Site Resilience	2744	Risk of low or inadequate staffing to operate effective and efficient service provision as a result of covid surge and response.	16	16	16	16	16	16	16	16	16	16	16	16
		2868	Further waves of Covid may impact on the ability to deliver key performance targets and recovery plans	16	16	16	16	16	16	16	16	16	16	16	16
		2869	Unintended harm to patients, due to the impact of reduced services, delayed treatment and pathway starts	16	16	16	16	16	16	16	16	16	16	16	16
		2879	Risks relating to the trusts Maternity estate that have the potential to impact on the delivery of safe maternity services	8	8	8	8	8	8	8	8	8	8	8	8
		2945	Availability of Business Intelligence	12	12	12	12	12	12	12	12	12	12	12	12
Digital	IT	1636	UCRF R01/R03/R20/R23 - Malware such as Ransomware Compromising Unpatched Endpoints, Servers and Equipment	10	10	10	10	10	10	10	10	10	10	10	10
Medical Services	Medical Services - Divisional Management	2982	Risk of delayed transfers of care and increased hospital lengths of stay	16	16	16	16	16	16	16	16	16	16	16	16
Nursing, Midwifery & Quality	Quality Governance	2779	The Trust fails to meet the CQC Fundamental Standards.	12	12	12	12	12	12	12	12	12	12	12	12
People and OD	Human Resources	2759	We are not able to appropriately support the health and wellbeing needs of our workforce	12	12	12	12	12	12	12	12	12	12	12	12
		2764	Workforce - Risk of not having the right people in right place at the right time with the right skills.	16	16	16	16	16	16	16	16	16	16	16	16
		2963	Covid Vaccine next steps uncertainty for NHS staff - staff may leave roles/ employment	9	9	9	9	9	9	9	9	9	9	9	9
	Workforce Development	2765	No Leadership and OD strategy in place across the trust resulting in failure to support our workforce	12	12	12	12	12	12	12	12	12	12	12	12

Key: **CRR** - Current Risk Rating **PRR** - Previous Risk Rating
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Organisational Risk Register Report

Reporting Period: 12-Mar-2022 to 17-May-2022

Comparison Date: 14-Mar-2022

Gateshead Health NHS Foundation Trust

				CRR											
BU	Service Line	ID	Risk Description	07-Apr	08-Apr	09-Apr	10-Apr	11-Apr	12-Apr	13-Apr	14-Apr	15-Apr	16-Apr	17-Apr	18-Apr
Chief Executive Office	Medical Directorate	2880	Risk that Place/ICS/ICP strategy and plans do not fully align with our objectives and aspirations to tackle health inequalities.	9	9	9	9	9	9	9	9	9	9	9	9
Chief Operating Officer	EPRR & Site Resilience	2744	Risk of low or inadequate staffing to operate effective and efficient service provision as a result of covid surge and response.	16	16	16	16	16	16	16	16	16	16	16	16
		2868	Further waves of Covid may impact on the ability to deliver key performance targets and recovery plans	16	16	16	16	16	16	16	16	16	16	16	16
		2869	Unintended harm to patients, due to the impact of reduced services, delayed treatment and pathway starts	16	16	16	16	16	16	16	16	16	16	16	16
		2879	Risks relating to the trusts Maternity estate that have the potential to impact on the delivery of safe maternity services	8	8	8	8	8	8	8	8	8	8	8	8
		2945	Availability of Business Intelligence	12	12	12	12	12	12	12	12	12	12	12	12
Digital	IT	1636	UCRF R01/R03/R20/R23 - Malware such as Ransomware Compromising Unpatched Endpoints, Servers and Equipment	10	10	10	10	10	10	10	10	10	10	10	10
Medical Services	Medical Services - Divisional Management	2982	Risk of delayed transfers of care and increased hospital lengths of stay	16	16	16	16	16	16	16	16	16	16	16	16
Nursing, Midwifery & Quality	Quality Governance	2779	The Trust fails to meet the CQC Fundamental Standards.	12	12	12	12	12	12	12	12	12	12	12	12
People and OD	Human Resources	2759	We are not able to appropriately support the health and wellbeing needs of our workforce	12	12	12	12	12	12	12	12	12	12	12	12
		2764	Workforce - Risk of not having the right people in right place at the right time with the right skills.	16	16	16	16	16	16	16	16	16	16	16	16
		2963	Covid Vaccine next steps uncertainty for NHS staff - staff may leave roles/ employment	9	9	9	9	9	9	9	9	9	9	9	9
	Workforce Development	2765	No Leadership and OD strategy in place across the trust resulting in failure to support our workforce	12	12	12	12	12	12	12	12	12	12	12	12

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Organisational Risk Register Report

Reporting Period: 12-Mar-2022 to 17-May-2022

Comparison Date: 14-Mar-2022

Gateshead Health NHS Foundation Trust

				CRR											
BU	Service Line	ID	Risk Description	19-Apr	20-Apr	21-Apr	22-Apr	23-Apr	24-Apr	25-Apr	26-Apr	27-Apr	28-Apr	29-Apr	30-Apr
Chief Executive Office	Medical Directorate	2880	Risk that Place/ICS/ICP strategy and plans do not fully align with our objectives and aspirations to tackle health inequalities.	9	9	9	9	9	9	9	9	9	9	9	9
Chief Operating Officer	EPRR & Site Resilience	2744	Risk of low or inadequate staffing to operate effective and efficient service provision as a result of covid surge and response.	16	16	16	16	16	16	16	16	16	16	16	16
		2868	Further waves of Covid may impact on the ability to deliver key performance targets and recovery plans	16	16	16	16	16	16	16	16	16	16	16	16
		2869	Unintended harm to patients, due to the impact of reduced services, delayed treatment and pathway starts	16	16	16	16	16	16	16	16	16	16	16	16
		2879	Risks relating to the trusts Maternity estate that have the potential to impact on the delivery of safe maternity services	8	8	8	8	8	8	8	8	8	8	8	8
		2945	Availability of Business Intelligence	12	12	12	12	12	12	12	12	12	12	12	12
Digital	IT	1636	UCRF R01/R03/R20/R23 - Malware such as Ransomware Compromising Unpatched Endpoints, Servers and Equipment	10	10	10	10	10	10	10	10	10	10	10	10
Medical Services	Medical Services - Divisional Management	2982	Risk of delayed transfers of care and increased hospital lengths of stay	16	16	16	16	16	16	16	16	16	16	16	16
Nursing, Midwifery & Quality	Quality Governance	2779	The Trust fails to meet the CQC Fundamental Standards.	12	12	12	12	12	12	12	12	12	12	12	12
People and OD	Human Resources	2759	We are not able to appropriately support the health and wellbeing needs of our workforce	12	12	12	12	12	12	12	12	12	12	12	12
		2764	Workforce - Risk of not having the right people in right place at the right time with the right skills.	16	16	16	16	16	16	16	16	16	16	16	16
		2963	Covid Vaccine next steps uncertainty for NHS staff - staff may leave roles/ employment	9	9	9	9	9	9	9	9	9	9	9	9
	Workforce Development	2765	No Leadership and OD strategy in place across the trust resulting in failure to support our workforce	12	12	12	12	12	12	12	12	12	12	12	12

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

Organisational Risk Register Report

Reporting Period: 12-Mar-2022 to 17-May-2022

Comparison Date: 14-Mar-2022

Gateshead Health NHS Foundation Trust

				CRR											
BU	Service Line	ID	Risk Description	01-May	02-May	03-May	04-May	05-May	06-May	07-May	08-May	09-May	10-May	11-May	12-May
Chief Executive Office	Medical Directorate	2880	Risk that Place/ICS/ICP strategy and plans do not fully align with our objectives and aspirations to tackle health inequalities.	9	9	9	9	9	9	9	9	9	9	9	9
Chief Operating Officer	EPRR & Site Resilience	2744	Risk of low or inadequate staffing to operate effective and efficient service provision as a result of covid surge and response.	16	16	16	16	16	16	16	16	16	16	16	16
		2868	Further waves of Covid may impact on the ability to deliver key performance targets and recovery plans	16	16	16	16	16	16	16	16	16	16	16	16
		2869	Unintended harm to patients, due to the impact of reduced services, delayed treatment and pathway starts	16	16	16	16	16	16	16	16	16	16	16	16
		2879	Risks relating to the trusts Maternity estate that have the potential to impact on the delivery of safe maternity services	8	8	8	8	8	8	8	8	8	8	8	8
		2945	Availability of Business Intelligence	12	12	12	12	12	12	12	12	12	12	12	12
Digital	IT	1636	UCRF R01/R03/R20/R23 - Malware such as Ransomware Compromising Unpatched Endpoints, Servers and Equipment	10	10	10	10	10	10	10	10	10	10	10	10
Medical Services	Medical Services - Divisional Management	2982	Risk of delayed transfers of care and increased hospital lengths of stay	16	16	16	16	16	16	16	16	16	16	16	16
Nursing, Midwifery & Quality	Quality Governance	2779	The Trust fails to meet the CQC Fundamental Standards.	12	12	12	12	12	12	12	12	12	12	12	12
People and OD	Human Resources	2759	We are not able to appropriately support the health and wellbeing needs of our workforce	12	12	12	12	12	12	12	12	12	12	12	12
		2764	Workforce - Risk of not having the right people in right place at the right time with the right skills.	16	16	16	16	16	16	16	16	16	16	16	16
		2963	Covid Vaccine next steps uncertainty for NHS staff - staff may leave roles/ employment	9	9	9	9	9	9	9	9	9	9	9	9
	Workforce Development	2765	No Leadership and OD strategy in place across the trust resulting in failure to support our workforce	12	12	12	12	12	12	12	12	12	12	12	12

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

Organisational Risk Register Report

Reporting Period: 12-Mar-2022 to 17-May-2022

Comparison Date: 14-Mar-2022

Gateshead Health NHS Foundation Trust

				CRR				
BU	Service Line	ID	Risk Description	13-May	14-May	15-May	16-May	Today
Chief Executive Office	Medical Directorate	2880	Risk that Place/ICS/ICP strategy and plans do not fully align with our objectives and aspirations to tackle health inequalities.	9	9	9	9	9
Chief Operating Officer	EPRR & Site Resilience	2744	Risk of low or inadequate staffing to operate effective and efficient service provision as a result of covid surge and response.	16	16	16	16	16
		2868	Further waves of Covid may impact on the ability to deliver key performance targets and recovery plans	16	16	16	16	16
		2869	Unintended harm to patients, due to the impact of reduced services, delayed treatment and pathway starts	16	16	16	16	16
		2879	Risks relating to the trusts Maternity estate that have the potential to impact on the delivery of safe maternity services	8	8	8	8	12
		2945	Availability of Business Intelligence	12	12	12	12	12
Digital	IT	1636	UCRF R01/R03/R20/R23 - Malware such as Ransomware Compromising Unpatched Endpoints, Servers and Equipment	10	10	10	10	10
Medical Services	Medical Services - Divisional Management	2982	Risk of delayed transfers of care and increased hospital lengths of stay	16	16	16	16	16
Nursing, Midwifery & Quality	Quality Governance	2779	The Trust fails to meet the CQC Fundamental Standards.	12	12	12	12	12
People and OD	Human Resources	2759	We are not able to appropriately support the health and wellbeing needs of our workforce	12	12	12	12	12
		2764	Workforce - Risk of not having the right people in right place at the right time with the right skills.	16	16	16	16	16
		2963	Covid Vaccine next steps uncertainty for NHS staff - staff may leave roles/ employment	9	9	9	9	9
	Workforce Development	2765	No Leadership and OD strategy in place across the trust resulting in failure to support our workforce	12	12	12	12	12

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

NHS
Gateshead Health
NHS Foundation Trust

Report Cover Sheet Agenda Item: 12

Report Title:	**Consolidated Finance Report – Part One**			
Name of Meeting:	Trust Board			
Date of Meeting:	25th May 2022			
Author:	Mrs Jane Fay, Assistant Director of Finance – Strategic Finance			
Executive Sponsor:	Mrs Jacqueline Bilcliff, Group Director of Finance			
Report presented by:	Mrs Jacqueline Bilcliff, Group Director of Finance			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☒	**Assurance:** ☒	**Information:** ☐
	The purpose of this paper is to provide assurance against priority objective 3.4 (develop an approved capital and revenue plan) and address risk 2874.			
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*	For the period April to March the Trust has reported a revenue surplus of £14.214m after adjustments for donated assets and gain/losses of asset disposal. This is an increase of £3.903m from the reported February surplus. For the same time period the Trust has spent £13.274m of its capital programme, £1.3m below its forecast outturn of £14.573m.			
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	This report seeks to provide assurance in respect of the priority objective 3.4 – develop an approved capital and revenue plan; addressing risk 2874 – risk that the Trust is unable to formulate a coherent financial plan due to the uncertainty surrounding the financial framework. To note the summary of performance as at 31st March 2022 (Month 12) for the Group (inclusive of Trust and QE Facilities, excluding Charitable Funds).			

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:	Priority objective 3.4 – develop an approved capital and revenue plan. Risk 2874 – risk that the Trust is unable to formulate a coherent financial plan due to the uncertainty surrounding the financial framework.				
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** ☒		

1. Introduction

1.1 The purpose of this report is to provide a summary of financial performance as at 31st March 2022 (month 12) for the Group (inclusive of the Trust and QE Facilities, excluding Charitable Funds).

2 2021-22 Financial Framework

2.1 Following on the from the financial framework implemented for the period 1st October 2020 to 31st March 2021 planning guidance issued in March 2021 confirmed a similar framework for the period April 2021 to September 2021 referenced in the guidance as 2021-22 H1.

2.2 The financial planning guidance for the period October 2021 to March 2022 referenced as 2021-22 H2 is underpinned by broadly the same principles as those in 2021-22 H1 as detailed below:

- A continuation of the block contract values agreed in 2021-22 H1 with an inflation uplift of 1.75% for pay award arrears for the period April 2021 to September 2021 and 1.16% inflation uplift inclusive of a 0.82% efficiency target
- Additional funding to support urgent care pathways
- Funding envelopes to be issued to Integrated Care System (ICS) with a requirement for each ICS to achieve a breakeven position
- Funding envelopes to be delegated to each Integrated Care Partnership (ICP) with a requirement for each ICP to achieve a breakeven position
- Additional funding streams defined as funding outside of the system envelope to continue including specific schemes for the Trust relating to COVID pathology testing and vaccination programmes
- The continuation of the elective recovery fund to support activity recovery in addition to system financial envelopes

2.3 The Trust's H2 financial plan reports a deficit totalling £2.588m for the period October to March 2022 to achieve an overall breakeven position for the 2021-22 financial year.

2.4 Reporting for March is against the Trusts H2 financial plan.

3 Income and Expenditure

3.1 The Trust has reported a surplus of £13.294 for the month of March 2022 and a 2021-2022 surplus of £22.436m prior to and £14.214m after an adjustment for donated assets, profit or loss on disposal of assets and the net impact of donated PPE from DHSC.

3.2 This is a positive variance of £16.802m against the 2021-2022 planned deficit of £2.588m as detailed on the Trust Statement of Comprehensive Income (SOCI) presented in Table 1.

3.3 For the month of March 2022 the Trust has reported actual income of £37.947m and £369.415m for the full financial year, resulting in an in month positive variance of £8.323m from the NHSEI plan and a full year favourable variance of £21.456m. Included in the income position is Elective Recovery Fund (ERF) income totalling £2.666m.

3.4 For the month of March 2022 the Trust has reported actual operating expenditure of £24.278m resulting in an in month positive variance of £4.236m with a full year positive variance of £3.906m. These figures include £9.370m of spend directly attributable to the Trusts response to the COVID-19 pandemic.

STATEMENT OF COMPREHENSIVE INCOME

March 2021-22	GROUP POSITION NHSI/E APRIL - MARCH 22 H1 + H2 REVISED PLAN			VARIANCE	
Red >100k over					
Amber <> (£50k) - £99.99k	Revised Covid Plan Total	Covid Plan to Date	Actual to Date	Variance (Actual - Budget)	Previous Month Variance
Green <(£50.1k)	£000's	£000's	£000's	£000's	£000's
Operating					
Operating Income from Patient Care activities					
Income From NHS Care Contracts	(321,438.8)	(321,438.8)	(339,629.0)	(18,190.2)	(8,833.1)
Income From Local Authority Care Contracts	(90.0)	(90.0)	(100.6)	(10.6)	(2.3)
Private Patient Revenue	(1,043.5)	(1,043.5)	(771.6)	272.0	245.2
Injury Cost Recovery	(300.0)	(300.0)	(377.4)	(77.4)	(19.7)
Other non-NHS clinical revenue	(414.0)	(414.0)	(770.1)	(356.1)	(347.6)
Total Operating Income From Patient Care activities	**(323,286.4)**	**(323,286.4)**	**(341,648.7)**	**(18,362.4)**	**(8,957.5)**
Other Operating Income					
Education and Training Income	(9,138.8)	(9,138.8)	(9,790.0)	(651.2)	(549.2)
R&D Income	(671.0)	(671.0)	(640.0)	31.0	1.3
Funding ouside of System Envelope	-	-	(3,277.3)	(3,277.3)	(3,172.5)
Other Income	(13,238.5)	(13,238.5)	(15,077.9)	(1,839.4)	(1,455.5)
Donations & Grants Received	-	-	(1,314.4)	(1,314.4)	(229.2)
Total Other Operating Income	**(24,673.3)**	**(24,673.3)**	**(27,766.5)**	**(3,093.2)**	**(4,175.1)**
Total Operating Income	**(347,959.6)**	**(347,959.6)**	**(369,415.2)**	**(21,455.6)**	**(13,132.6)**
Operating Expenses					
Employee Expenses - Substantive	210,655.4	210,655.4	205,258.0	(5,397.4)	(5,821.7)
Employee Expenses - Bank	8,276.3	8,276.3	12,374.7	4,098.4	2,912.4
Employee Expenses - Agency	4,259.7	4,259.7	5,980.1	1,720.4	992.4
Employee Expenses - Other	1,094.7	1,094.7	9,598.9	8,504.2	324.0
Total Employee Expenses	**224,286.2**	**224,286.2**	**233,211.8**	**8,925.6**	**(1,592.8)**
Purchase of Healthcare - NHS bodeis	5,736.7	5,736.7	6,709.0	972.3	458.6
Purchase of Healthcare - Non NHS bodies	2,630.6	2,630.6	2,958.4	327.8	176.7
Purchase of Social Care	-	-	540.0	540.0	-
NED's	185.2	185.2	183.9	(1.3)	(4.5)
Supplies & Services - Clinical	32,415.7	32,415.7	35,852.2	3,436.5	3,994.5
Supplies & Services - General	7,959.4	7,959.4	2,444.5	(5,514.9)	(2,491.7)
Drugs	17,804.4	17,804.4	19,116.7	1,312.3	1,021.2
Research & Development expenses	31.7	31.7	39.6	7.9	2.6
Education & Training expenses	2,170.9	2,170.9	1,119.0	(1,051.9)	(1,088.9)
Consultancy costs	340.1	340.1	548.2	208.1	47.0
Establishment expenses	6,217.2	6,217.2	3,561.9	(2,655.3)	(322.0)
Premises	18,525.6	18,525.6	18,682.2	156.6	1,297.4
Transport	1,207.4	1,207.4	1,304.4	97.1	60.0
Clinical Negligence	8,201.7	8,201.7	7,871.3	(330.5)	(258.1)
Operating Leases	1,020.0	1,020.0	1,705.0	685.0	836.6
Other Operating expenses	10,674.2	10,674.2	7,269.8	(3,404.4)	(967.3)
Operating Expenses included in EBITDA	**339,406.9**	**339,406.9**	**343,117.9**	**3,711.0**	**1,169.2**
Depreciation & Amortisation - Purchased / Constructed	6,962.0	6,962.0	7,278.3	316.3	354.8
Depreciation & Amortisation - Donated / Granted	429.0	429.0	361.7	(67.3)	(56.4)
Depreciation & Amortisation - Finance Leases	-	-	-	-	-
Impairment & Revaluation	(277.2)	(277.2)	(8,141.8)	(7,864.6)	59.0
Restructuring Costs	-	-	-	-	-
Operating Expenses excluded from EBITDA	**7,113.8**	**7,113.8**	**(501.9)**	**(7,615.6)**	**357.5**
Total Operating Expenses	**346,520.7**	**346,520.7**	**342,616.0**	**(3,904.7)**	**1,526.7**
(Profit)/Loss from Operations	**(1,439.0)**	**(1,439.0)**	**(26,799.2)**	**(25,360.2)**	**(11,605.9)**
Non Operating					
Non-Operating Income					
Finance Income	(56.0)	(56.0)	(87.5)	(31.5)	(13.9)
Total Non-Operating Income	**(56.0)**	**(56.0)**	**(87.5)**	**(31.5)**	**(13.9)**
Non-Operating Expenses					
Finance Costs	610.1	610.1	1,046.0	435.8	445.4
Gains / (Losses) on Disposal of Assests	(46.0)	(46.0)	131.5	177.5	177.5
PDC dividend expense	2,984.5	2,984.5	2,498.0	(486.5)	(568.6)
Total Finance Costs (for non-financial activities)	**3,548.6**	**3,548.6**	**3,675.5**	**126.9**	**54.3**
Other Non-Operating Expenses					
Misc. Other Non-Operating expenses	-	-	-	-	-
Total Non-Operating Expenses	**3,548.6**	**3,548.6**	**3,675.5**	**126.9**	**54.3**
(Surplus) / Deficit Before Tax	**2,053.6**	**2,053.6**	**(23,211.2)**	**(25,264.9)**	**(11,565.5)**
Corporation Tax	715.4	715.4	775.5	60.1	145.5
(Surplus) / Deficit After Tax	**2,769.1**	**2,769.1**	**(22,435.8)**	**(25,204.8)**	**(11,420.0)**
(Surplus) / Deficit After Tax from Continuing Operations	**2,769.1**	**2,769.1**	**(22,435.8)**	**(25,204.8)**	**(11,420.0)**
Remove capital donations / grants I&E impact	(429.0)	(429.0)	952.7	1,381.7	285.6
Gain on disposal of assets	46.0	46.0	46.3	0.3	46.3
Impairements - AME	-	-	8,325.0	8,325.0	-
Loss on disposal of DHSC assets	-	-	(177.8)	(177.8)	(177.8)
System envelope planning adjustment	202.0	202.0	-	(202.0)	
Remove net impact of consumables donated from other DHSC bodies	-	-	(924.6)	(924.6)	(913.4)
Adjusted Financial Performance (Surplus) / Deficit	**2,588.1**	**2,588.1**	**(14,214.1)**	**(16,802.2)**	**(12,179.2)**
Adjusted Financial Performance (Surplus) / Deficit	**2,588.1**	**2,588.1**	**(14,214.1)**	**(16,802.2)**	**(12,179.2)**

Table 1: Trust Statement of Comprehensive Income

4 Cost Reduction Programme (CRP)

4.1 Included in the Trusts 2021-22 H1 financial plans is an efficiency requirement of £2.225m and £2.100m for H2 totalling a required annual efficiency of £4.325m to achieve breakeven. Non-recurring schemes totalling £4.325m were achieved in 2021-2022.

5 Cash and Working Balances

5.1 The Trust opened the financial year with £43.862m of cash. The cash position of £55.586m as at 31st March is equivalent to an estimated 43.40 days of operating costs and represents a £1.982m decrease from February 2022.

5.2 The liquidity metric has improved by 7.22 days against February to +13.67 days driven by a £7.716m increase in the working capital balance.

5.3 The balance sheet is presented in Table 2.

Statement of Position - March 2022

	2021/2022 February 2022 Group	2021/2022 March 2022 Group	Movement from Prior Month	2021/2022 March 2022 QEF	2021/2022 March 2022 FT
	£000's	£000's	£000's	£000's	£000's
Assets					
Non-Current Assets					
Investments	80	80	0	80	16,824
Property, Plant and Equipment, Net	118,409	135,407	16,998	1,262	134,145
Trade and Other Receivables, Net	1,937	1,956	19	729	1,227
Finance Lease - Intragroup				42,047	0
Trade and Other Receivables - Intragroup Loan	0	0	0		11,668
Total Non Current Assets	120,425	137,443	17,018	44,117	163,865
Current Assets					
Inventories	4,329	4,577	248	2,565	2,013
Trade and Other Receivables - NHS	11,197	8,777	(2,420)	239	8,538
Trade and Other Receivables - Non NHS	5,108	5,426	318	1,816	3,609
Trade and Other Receivables - Other	0	0	0		0
Prepayments	3,991	4,347	356	554	3,793
Cash and Cash Equivalents	57,568	55,586	(1,982)	5,067	50,519
Other Financial Assets - PDC Dividend	0	488	488		488
Accrued Income	1,780	2,999	1,219	870	2,129
Finance Lease - Intragroup				697	0
Trade and Other Receivables - Intragroup Loan					4,121
Total Current Assets	93,990	82,200	(1,773)	11,808	75,209
Liabilities					
Current Liabilites					
Deferred Income	9,083	8,113	(971)	223	7,890
Provisions	5,554	4,660	(894)	320	4,340
Current Tax Payables	5,257	5,332	76	474	4,859
Trade and Other Payables - NHS	1,622	4,963	3,341	211	4,752
Trade and Other Payables - Other	9,314	10,375	1,062	3,328	7,047
Trade and Other Payables - Capital	135	463	327	0	463
Other Financial Liabilities - Accruals	41,399	31,587	(9,813)	10,357	21,229
Other Financial Liabilities - Borrowings FTFF	499	999	499	0	999
Other Financial Liabilities - PDC Dividend	767	0	(767)	0	0
Other Financial Liabilities - Intragroup Borrowings	0	0		4,121	0
Finance Lease - Intragroup	0	0		0	697
Total Current Liabilities	83,648	66,491	(7,139)	19,034	52,275
NET CURRENT ASSETS (LIABILITIES)	10,342	15,708	5,366	(7,226)	22,934
Non-Current Liabilities					
Deferred Income	2,124	2,044	(80)	1,719	325
Provisions	3,184	3,123	(61)	0	3,123
Trade and Other Payables - Other	0	0	0	0	0
Other Financial Liabilities - Accruals	0	0	0	0	0
Other Financial Liabilities - Intragroup Borrowings	0	0	0	11,668	0
Other Financial Liabilities - Borrowings FTFF	14,010	13,011	(999)	0	13,011
Finance Lease - Intragroup				0	42,047
Total Non-Current Liabilities	19,318	18,178	(1,140)	13,387	58,506
TOTAL ASSETS EMPLOYED	**111,450**	**134,973**	**23,523**	**23,504**	**128,293**
Tax Payers' and Others' Equity					
PDC	139,314	145,470	6,156	0	145,470
Taxpayers Equity	0	0	0	0	0
Share Capital	0	0	0	16,824	0
Retained Earnings (Accumulated Losses)	(34,574)	(20,391)	14,183	19,282	(39,673)
Other Reserves	0	0	0	0	0
Revaluation Reserve	6,611	9,795	3,185	0	9,795
Misc Reserve	99	99	0	0	99
TOTAL TAXPAYERS EQUITY	111,450	134,973	23,523	36,106	115,691
TOTAL ASSETS EMPLOYED	**111,450**	**134,973**	**23,523**	**36,106**	**115,691**

Table 2 – Statement of Position

6 Capital

6.1 The Trusts 2021/2022 CDEL limit had been set at £6.825m, with additional capital funding of £11.390m approved in the year to increase the Trust's CDEL to £18.215m as summarised in the below:-

CDEL	£000's
Net Depreciation*	6,213
Internal Cash	612
Accelerator Scheme PDC	1,050
Donation - Decarbonisation grant	1,528
Community Diagnostic Hub	5,329
TIF PDC	2,775
Cyber Security PDC	250
Digital Workstations PDC	198
Charitable Funds Donations	230
Maternity PDC	30
Total	18,215

* After Principal Loan Repayments of £1.178m

6.2 All new PDC awards are supported with additional external cash, with the Trust recently awarded PDC of £1.050m for the Accelerator Scheme which was previously to be funded via internal cash. An unconfirmed PDC award of £90k for oxygen infrastructure had been included in the annual CDEL, however as confirmation of the PDC has not been received these works will now be funded internally.

6.3 The Trust was issued Public Dividend Capital (PDC) in 2021/2022 to the value of £5.329m to commission and deliver a Community Diagnostic Hub. Third party delays in the fabrication and delivery of the respective modules, together with groundworks and power supply issues have resulted in only £1.915m being deliverable within 2021/2022.

6.4 The Trusts capital outturn totalled £13.274m against the CDEL of £14.573m, an underspend of £1.3m. This was funded as per the table below:-

Funding Source	Outturn £000's
Net Depreciation*	5,804
Internal Cash	0
Donation - Decarbonisation	1,100
Donated Assets	214
Accelerator Scheme PDC	1,050
Community Diagnostic Hub PDC	1,915
TIF PDC	2,775
Cyber Security PDC	250
Digital Workstations PDC	136
Maternity Diagnostics	30
Total	13,274

* After Principal Loan Repayments of £1.178m

7 Risk

7.1 The audit of the 2021-22 draft group accounts is on-going with all findings to be reported to the June 2022 Audit Committee.

Jacqueline Bilcliff, Group Director of Finance
18th May 2022

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Report Cover Sheet Agenda Item: 13

Report Title:	**Integrated Oversight Report**			
Name of Meeting:	Board of Directors – Part 1			
Date of Meeting:	25th May 2022			
Author:	Deborah Renwick and IOR Reporting Leads			
Executive Sponsor:	Joanne Baxter			
Report presented by:	Joanne Baxter			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☒	**Assurance:** ☒	**Information:** ☐
	To summarise performance in relation to key NHS standards, requirements and KLOE's to outline the risks and recovery plans associated with COVID -19. This report covers the reporting period of February and January.			
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*	Chief Operating Officer's Senior Management Team Trust Senior Management Team			
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*	An extremely pressured month for the Trust: High covid levels, staffing pressures and delayed discharges resulting in key issues: Pressures in UEC with the average time in department increasing, performance against the 4 hour standard (77%) remains static, ambulance handover delays increasing and an extraordinary 71 patients waiting longer than 12hrs to be admitted from ED. Flow and Bed availability pressures persist, with an average of 44 patients per day residing in hospital who no longer meet the criteria. 10% trust related delays, 90% related to LA pathways. Elective activity levels in April are under review. Indicative activity levels are below plan: • Daycases at 90%			

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

- Elective overnights at 71%
- New Outpatients at 88% and Follow-up at 83%
- All Diagnostics at 100%

Reduction in RTT waiters is in line with the plan. RTT performance above national average. Overall diagnostic performance continues to improve. Cancer backlog waiters has increased in month.

Workforce pressures continue although sickness absence levels improved to 5.3% (March).

Quality & Safety: 3 Serious Incidents were STEIS reportable in April and are currently under review.
</td></tr>
<tr><td>Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper</td><td colspan="6">This report seeks to provide assurance in respect of the priority objectives to 3.8 deliver operational transformation to improve productivity and efficiency.

The recommendations to the Committee are to receive this report, discuss the potential implications and record as partial assurance as a direct consequence of the impact on activity recovery, long waiting times and performance.</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:</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>Trust corporate objectives that the report relates to:</td><td colspan="6">3.8 (F&P) Deliver operational transformation to improve productivity & efficiency

3.9 (F&P) Develop smart integrated reporting framework</td></tr>
<tr><td>Links to CQC KLOE</td><td>Caring
☒</td><td>Responsive
☒</td><td>Well-led
☒</td><td>Effective
☒</td><td colspan="2">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 & Elective Recovery (2560, 2884,2869)
- Emerging increase in referrals rates – Breast, T&O and urology)
- UEC performance and flow
- Ambulance Delays
- 12 Hour Trolley waits
- Cancer rising referral rates (breast) Gynae transfers
- Workforce fatigue and health and well being
</td></tr>
</table>

	• Staffing and workforce gaps in key areas (2956, 2942, 2514, 2946, 2938, 2953, 1675) • Backlog reduction: Cancer – Urology, Gynaecology (2514), LGI Echocardiology (2730) • Outpatient capacity to see patients face to face • Maternity pressures (1675)		
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒

INTEGRATED OVERSIGHT REPORT – MARCH COMMITTEES

1. Introduction

1.1 This report summarises performance across key NHS standards, requirements and KLOE's outlining the risks and ongoing recovery plans associated with COVID -19. This report covers the reporting period of March and April, reporting performance predominantly where data is validated, signed off and submitted, as highlighted below.

Area	Data Item	Reporting Period	Data Quality Sign Off
Recovery	Activity	April: Draft reporting/baseline construction	**
Responsive	Community	April	**
	A&E	Submitted April	***
	2 week waits		**
	RTT	Provisional March	**
	Cancer		**
	Diagnostics		**
Safety	SI's	Reported April	***
	Open Safety alerts	March	***
	Reporting Safety incidents	March	***
Effective	HMSR	October 19 to Feb 22	***
	SHMI	August 19 to Dec 21	***
	Long Lengths of Stay	April CDS	***
	Criteria to reside	Daily Sit-Rep snap-shot	*
Well Led	People & Workforce	March	***
Maternity	All sub-set standards	April	***
*** Signed off Unlikely to change, ** Subject to validation * snapshot position			

1.2 Trust Corporate Objectives relating to this report and overseen by the following Committees are:

Quality Governance Committee:

- 1.2 Implementation of Board level reporting: Okenden and maternity services
- 1.8 Achieve accreditation of Nursing and Midwifery excellence programme
- 1.10 Supporting the route map to CQC Outstanding

People & OD:

- 2.5 Strengthen approaches to people related quality, performance & governance measures

Finance & Performance Committee:

- 3.8 Deliver operational transformation to improve productivity & efficiency
- 3.9 Develop smart integrated reporting frameworks

2. Key issues & findings

2.1 Covid Summary: In March the number of patients residing in hospital with a positive covid test increased rapidly to circa 80 patients per day and continued to rise into the high 90's during April, which is consistent with other Trusts in the Northeast and Cumbria. Whilst covid levels were rising in month, social distancing rules have been amended in line with the national direction, which increased capacity and ease some of the bed and accommodation pressures.

2.2 Flow and Discharge: The hospital and NENC remains under significant pressure with ED, Urgent and Emergency Care and Community continuing to care for patients with increased acuity. Delayed discharges constrained by (i) limited care packages in the community and (ii) reduced capacity in nursing homes, and (iii) limited access to residential homes has continued during March and April. Whilst some slight gains have been made in the average daily patient delay rate falling from 60.6 in March to 44.2 in April, there are still significant volumes of beds blocked, circa 2 General & Acute wards of patients residing in hospital who are medically optimised and are fit to go home. Just over 90% of the patients residing in hospital are awaiting Local Authority support or placement.

The number of patients in hospital with longer lengths of stay remains above average levels. Difficulties experienced in maintaining patient flow manifest in 'blockages' in the front of house and delays allocating specialty beds. In April there were 71 patients waiting more than 12 hours in ED for a hospital bed and ambulance handover delays increased to 72 delays between 30-60 mins and 62 handover delays greater than 1 hour.

Key contributing factors include: Closure of the winter Ward 4 (due to staffing pressures) and re-providing the acute winter ward across the existing bed base by enacting the full capacity protocol, moving to 6 beds in a bay where applicable. At times of extreme pressure, the Trust was pushing into 3 Covid wards, this combined with delayed discharges accounted for one third of the General and Acute Bed base out of circulation. The majority of the twelve-hour trolley delays follow the pattern of occurring on Tuesdays and Wednesday, when the Trust is recovering from weekend pressures where discharges drop off by 50%, In in the days preceding the unprecedented trolley waits, higher attendances in A&E (particularly Sun 3rd April) coupled with an increase in admissions over the weekend and following through into Monday & Tuesday contributed to 'the perfect storm' as full capacity had already been enacted with the via the closure of ward 4. All requests for mutual aid were declined and staffing levels/fill rates low in some key areas across the Trust.

2.3 Workforce: Sickness absence levels (in March) remained at 5.3%. Trust level appraisal compliance is at 61.8% and continues below the 85% target. Core training data also continues to display special cause variation and is outside of expected levels with performance at 70.7%.

2.4 Activity

2.4.1 April's (draft) combined **elective activity** is at 85% of 2019/20 baseline activity, below planned levels. Overnight elective activity is at 71% of baseline year. Daycase treatments are at 90% and Outpatient attendances are at 88% new and 83% follow-up. The expectation is to reach 104% of value of the plan, national concerns have been raised about the activity levels and pressures in April and May; pressures are also replicated across the ICS.

Patient Initiated Follow-up (PIFU) attendances are at 1.7% and the Trust reported 28% remote outpatient appointments against a transformational requirement of 25%.

Diagnostic activity levels continue along the same trajectory with total diagnostic activity at 100% of baseline year. Echocardiology activity is at 73%, and endoscopy at 98% of pre-covid levels.

2.4.2 Non-elective activity SDEC activity is captured within Non-elective activity as 'day beds' and continue to review 900 patients per month and continue to see and treat circa 80% of the patients in a day. Accounting for counting and coding changes overall non-elective admissions are below pre-covid levels.

2.4.3 Attendances through ED generally footfall remains circa 15% below pre-pandemic levels, although average daily attendances were 83 per day higher than March and 45 per day higher than last April.

2.4.4 Community Care continue to support secondary care services by keeping patients in their own home. Community teams saw 38,841 patients in April (averaging 1,295 per day). In total the rapid response team reviewed and or treated 4,161patients. Rapid Response achieved an indicative compliance rate of 65% for patients referred within 2 hours.

Winter bed escalation plans were instigated early this year and the Trust continues to operate with maximum winter escalation beds open at times alongside full capacity protocols.

2.5 Performance - Access and Recovery of Back-log Waiters

2.5.1 Urgent and Emergency Care: Remains under significant pressures. General winter pressures and barriers to discharging patients has put significant pressure on Trust services and continues to cause pressure across the wider local health system. Trust performance against the 4hr standard is at 75%, with bed pressures continuing to be main reason for delays from A&E. Ambulance delays at the front door are also triggering concern. The number of ambulance delays reported between 30-60 mins increased from 55 patients in March to 72 in April. Delays greater than 60 minutes increased from 10 in March to 62 in April. NEAS response times were not achieved for Cat 2, Cat 3 and Cat 4 patients, with cat 2 and cat 3 demonstrating particular pressure.
UEC measures demonstrate that patients are generally waiting longer in ED: There were 71 patients waiting longer than 12 hours before admission in April. As a comparison the Trust's 2022/23 average was 1.8 per month, reporting 5 in August 12 in January and then 5 in March. An initial site management debrief was undertaken with a full deep dive to review lessons learned.

Staffing levels in ED (and across the site) remain challenging with most departments carrying vacancies with additional pressures from absences due to covid, isolation guidance and annual leave.

Transformation work is on-going to prevent admission and improve discharge, ECIST are now providing focused support to the Trust.

The Trust's benchmarked position relates to March (not the current reporting month) and is placed 15th out of 139 providers**.** ECIST remains the Trust critical friend until the end of March in support of:

- Site management, reviewing systems and processes & practical support around use of BI data and operational intelligence to support flow
- Support in developing the Front Door assessment model – SDEC & frailty
- Frailty model and management exploring possible community options for care
- Discharge and expediting patients who no longer meet the right to reside

2.5.2 RTT: NHSE/I continue to focus on reducing patient backlog.
Reduced activity over the summer and increased referrals for surgical specialties coupled with reduced bed capacity has increased the number of patients awaiting treatment from 9,025 in July to 10,957 waiting at the end of March. Business Units continue to manage the backlog of long waiters: There were no patients waiting over 104 weeks, and there were 41 patients waiting over 52 weeks. 75% of our patients are waiting less than 18 weeks, with performance above the national trend of 62.4%.

Clinical prioritisation continues with a particular focus on patients with long waits or who continue to choose to wait longer for care, where offers for care and treatment have repeatedly been declined. The Trust is now following guidance which involves individualised patient level risk management involving joint reviews with GP's for on-going patient management and care. Weekly patient level reviews continue with a focus on long waiters and proactive care management.

2.5.3 Cancer: NHSE/I recognises the pressure in achieving this target across the NHS and focuses on backlog reduction whilst increasing capacity to treat patients. At the end of April, the Trust reported 74 patients waiting longer than 62 days, 16 patients waiting longer than 104 days and 58 patients were waiting longer than 62 days, (representing an in month increase of 12 patients overall). The Trust continues to support the ICS wide provision of cancer services and difficulties in gaining access to treatments across shared pathways.

Performance against the 2week standard remains stable at 85.7% in April albeit below the 93% target. Increases in breast referrals continue to cause pressure in this high-volume tumour group. Particular capacity pressures are evident in lung 2, accounting for 80% of the patients waiting 3 weeks or more.

The Trust achieved the **Faster diagnostic standard** in March with performance at 79.5% against the 75% target. ** Gynaecology, Upper GI, Lower GI and urological tumour sites are challenged.

Performance against **62 day cancer treatment** target is at 59.4% in March, Breast achieved the standard with performance at 93.3%. Service pressures continue across all other tumour sites.

2.5.4 Diagnostics Finalised Performance for the Trust improved from 77% in February to 80% in March, (CT achieved the standard).
Challenged modalities and pressures continue in: Audiology (63%) and echo-cardiology (32%).

2.6 Quality and Safety Effectiveness

2.6.1 Trust level SI's: 3 incidents have been reported in April, which is below average for the last 18 months. Themes include: falls, complication during surgical procedure and non-controlled drug incident.
There were no maternity SI's were reported in April.

2.6.2 Patient Safety Alerts: Eight safety alerts received in April, with one open patient safety alert.

2.6.3 Verbal Duty of Candour Displaying special cause variation. Current Trust processes for Duty of Candour require a review to ensure consistent compliance with defining notifiable patient safety incidents. There is potential (within the current process) for enacting Duty of Candour on non-notifiable incidents which should be managed under 'Being Open'. Process mapping is currently underway to re-define the process.

2.6.4 HMSR Continues to show more deaths than expected with an HSMR of 116.2 for the rolling period of Mar-21 to Feb-22. The **SHMI** is at 1.03 and is within expected range.

2.6.5 Informal Complaints The number of informal complaints is now triggering concern. Thematic analysis indicates Communications with families, staff carparking and privacy and dignity are the main areas to address. It should be noted that formal complaints have fallen.

2.6.6 Friends & Family Tests There is a noticeable drop in the score relating to patient feedback for inpatient and day case stays. Falling from 95.4% positive in March to 84.1% in April. Thematic analysis indicates the following areas scoring low: waiting times, discharge information, staffing related issues. This is an isolated month were the FFT score has dropped significantly below the mean, but given the low number of responses that contributed to this, these results should be taken with caution. We will review the results in conjunction with the results we receive in May and triangulate these with wider data such as complaints, incidents etc.

2.6.7 Maternity Total number of births continue within expected range. Smoking at time of delivery remains high at 10.4% against the 5% target and breast feeding at discharge remains a concern, although the trajectory is demonstrating early signs of improvement. Babies admitted directly to SCBU > 37 week gestation is at 2.2% and within normal range, whilst the pre-term birth rate at 4.9 % is within expected levels.
The current reporting arrangements are under review in line with Okenden 2 requirements.

2.6.8 Data Quality Maturity Index – Displaying special cause variation, caused by two fields in the mental health dataset. Further investigative work is underway to understand the issues and re-submit year to date activity. A business case is in the pipeline to support the Business Unit to proactively manage the data issues and waiting lists.

2.7 Benchmarking
The Trust remains in a relatively strong position against available benchmarking data:

Indicator	*QEH Performance*	*View*	*Position*
A&E 4 hour waiting time	77.3%	March	15th / 139 NHS Providers
Latest weekly PTL: patients waiting > 104 weeks	0	w/e 01/05/22	Joint 1st /8 Providers in ICS
Latest weekly PTL: patients waiting > 52 weeks	50	w/e 01/05/22	2nd / 8 Providers in ICS
Latest weekly PTL: patients waiting > 62 days for cancer treatment	74	w/e 01/05/22	1st / 8 Providers in ICS
62 day backlog as % of waiting on the list	8.7%	w/e 03/04/22	73 (top 20 under NHSE/I scrutiny

3. Recommendations

The Committees are recommended to note the content of this report, in summary:

3.1. An extremely challenging month for the Trust with pressures in rising covid levels in April coupled with the lack of usable beds.

3.2. Pressures in discharging patients safely are impacting on the Trust's ability to maintain patient flow, escalation beds are now open across the site, challenging the clinical operating model with staffing models stretched. There has been an unprecedented volume of 12 hour trolley waits in ED for an inpatient bed.

3.3. Indicative activity levels are below plan; this is replicated across the ICS. However, early indications via the weekly waiting lists now demonstrate improvements in our longer waiters (RTT) and the Trust remains a top performer in the ICS for reducing our backlog of longer waits. Diagnostic performance improves; however, the backlog of cancer waiters has more recently demonstrated a week-on-week increase.

Integrated Oversight Report: May 2022

Gateshead Health NHS Foundation Trust

Contents:

- Summary exception indicators KLOE
- COVID Status
- Activity & Recovery
- Exceptions by KLOE

Responsive:	UEC maximum waiting time of four hours & UEC measures
	Ambulance Handovers 30-60, 60+
	RTT/ Number of patient on Incomplete Pathways
	Cancer
	Diagnostics
	Verbal Duty of Candour
	Informal Complaints
Safe:	Serious incidents report to StEIS
	Patient Safety Alerts not completed by deadline
Effective:	HSMR (More deaths than expected)
	Spotlight slide – Criteria to Reside
	Long Length of Stay patients (LLOS)
Caring	Friends and Family Test – Inpatients and Day Cases
Well Led:	Sickness Absence
	Appraisals
	Core Training
	Data Quality Maturity Index (DQMI) – Mental Health S Dataset score
Maternity:	Births
	Smoking at time of delivery
	Breastfeeding at discharge
	Admitted directly to NNU (>37 weeks)
	Pre term birth rate <36+6 weeks

- Appendices (In reading room)

Benchmarking *(where available)*
Reporting Plans
Introduction to SPC

KLOE Summary: Indicators triggering concern or displaying Special Cause Variation

Indicators triggering variation or failing targets are summarised below – with spotlights referenced within the report. All indicators are now detailed in the appendices of this report.

Responsive 19 of 30 applicable indicators triggering SPC/underachieving against targets

Effective 1 of 5 applicable indicators triggering SPC/underachieving against targets

Caring 0 of 1 applicable indicators triggering SPC/underachieving against targets

Safety
1 of 8 applicable indicators triggering SPC/underachieving against targets

Well Led 10 of 13 applicable indicators triggering SPC/underachieving against targets

Maternity 4 of 5 applicable indicators triggering SPC/underachieving against targets

NHS
Gateshead Health
NHS Foundation Trust

KLOE Summary

Responsive

UEC: April 22 Performance against the 4 hour standard is at 75.28%. Overall activity remains (14.7%) below pre-covid levels. Footfall through UEC decreased from 9,153 in March to 8,754 attendances April. April activity is on average 45 attendances per day more than last year (18.5% increase). The latest national benchmarking data (March – performance of 77.25%) places the Trust at 15th of 139 Type 1 providers. The Trust reported 72 30-60 minute and 62 over 60 minute ambulance delays in April. The Trust also reported 71 12 hour waits from Decision to admit to leaving ED and 252 12 hour waits in the ED (from registration to left department)

RTT: March 22 Performance against the 18 week standard is 74.66% with an increase of patients on the RTT waiting list from 10,525 to 10,957, and a reduction to 41 patients waiting over 52 weeks.

Cancer: 2ww Cancer referrals remain higher than pre-pandemic levels which creates challenge in achieving the 2Week Wait Standard. The indicative Trust position against the target in April was 85.7%, below the 93% standard. In April 1,070 Two week wait referrals were received which shows a reduction of 4.5% in comparison to the same period last year and up by 25.4% on the same period in 2019.

Cancer: 62 day treatments The Trusts position against the 62 day standard showed a slight increase in performance in March reporting performance at 60.2% with Gynae, Haematology, Lower Gi, Urology and Lower GI tumour sites below the performance standard of 85%.

Diagnostics: The Trust failed the diagnostic standard in March however reporting a further improvement to 80.07% of patients seen with 6 weeks of referral. Echocardiography continues to be the main challenge at 31.84% and Audiology is also reported below target at 63.30% and highlighted as an area of concern.

Duty of candour: Verbal compliance with Duty of candour was 84.8% in April 2022. The Legal Services team are continuing to work with the business units with an aim to review all non-compliant incidents and to provide assistance with the outstanding Notification letters and Findings letters. However, current capacity issues within the team are impacting on the ability to efficiently monitor all incidents.

Informal Complaints: The number of Informal complaints (PALS) is triggering special cause variation for concern. The figure for April (90) has exceeded the control limit.

Gateshead Health NHS Foundation Trust

KLOE Summary

Safe

Total number of **Trust reportable SI's: 3** are reported in month, open and under investigation
No maternity **Serious Incidents** reported in April 2022
There is currently one **open patient safety alerts** not completed by deadline
No Never Events in the passed 18 months

Effective

The Trust **Hospital Standardised Mortality Ratio** (HSMR) continues to shows more deaths than expected for this indicator. The **Summary Hospital Level Indicator** (SHMI) shows deaths within the expected range.
The **stranded patient** indicator, or patients with a **Length of stay greater than 21 days** had previously triggered special cause variation. There was an improvement in the average number of Long stay patients (LOS 21+) from 92.3 in March to 79.9 in April.

Well Led

Core training performance remains broadly the same at 70.7%
Appraisals remain below the 18 month average at 61.8%
Sickness Absence rates 5.3% in April, above target but marginally below the 18 month average.

Caring

There are **no caring indicators triggering concern**.
A decrease in the Friend's and Family test score for Inpatient ad Day case areas is noted.

Maternity

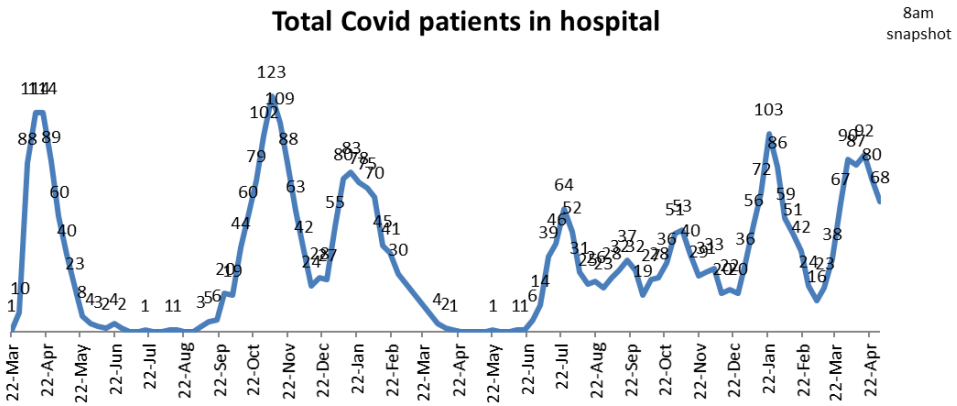
Includes a sub-set of indicators taken from the maternity dashboard.
Breast feeding at time of discharge and Smoking at delivery currently triggering concern as target consistently not achieved.

Gateshead Health NHS Foundation Trust

Covid-19: Statistical Update

The level of Covid-19 patients in the hospital is shown in chart (1). The Trust has treated more than 3,100 COVID cases.
This pattern is indicative across the NENC ICS patch. COVID positive patients are currently being treated according to NHSI/E, PHE guidelines. The Trust has mobilised a clinical model to accommodate COVID patient care safely.
The staff absences on chart (2) demonstrate the impact of track and trace and increase in COVID cases on staff absence. (Admin, clerical and nursing only).

1



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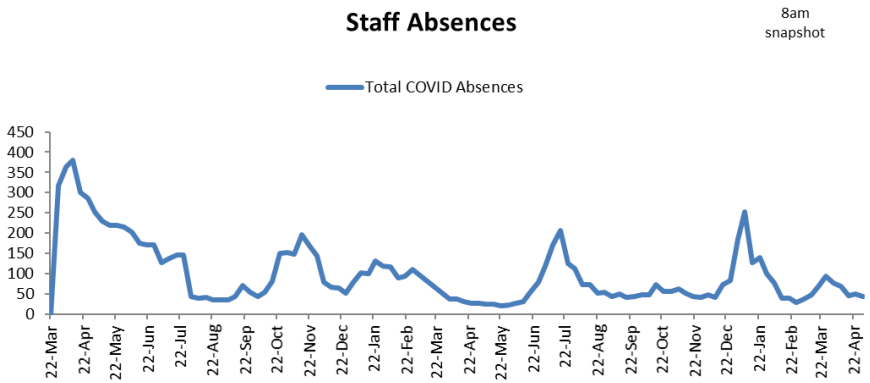
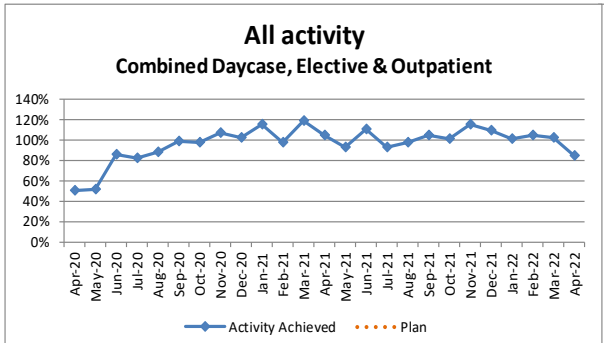
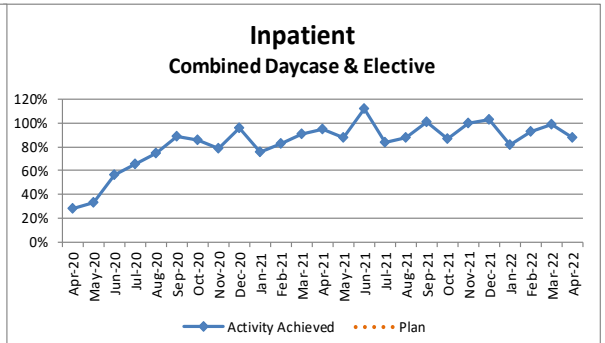


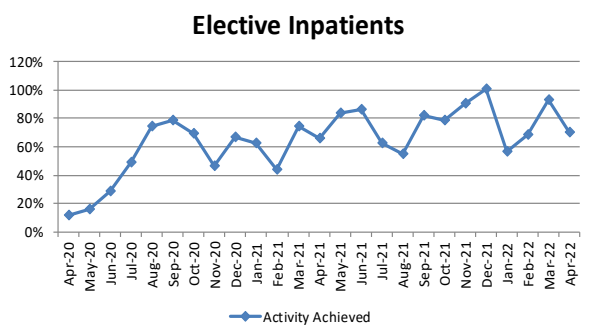
Activity & Recovery

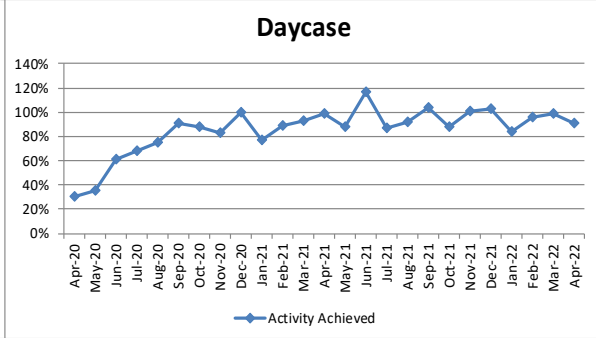
NHS Gateshead Health NHS Foundation Trust

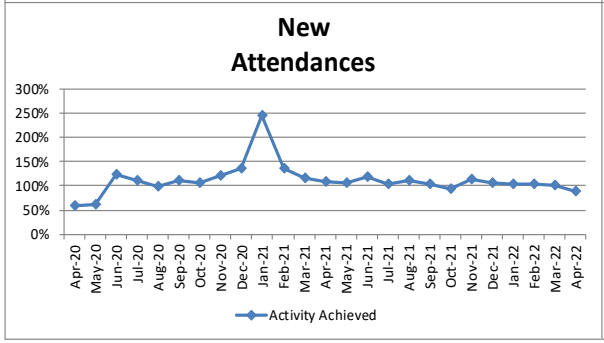
Trust's should deliver an activity plan to the value of 104% of pre-covid income generated from elective activity.
The Trust submitted 'a stretch' activity plan to deliver 100% over overnight Elective Activity, 103% Daycases with an Outpatient follow-up reduction plan to take full advantage of opportunities to transform the delivery of services. Moving away from non-value outpatient follow up activity and progressing clock stopping activity (predominantly inpatients) to reduce long waiters, Zero 52 week waiters by the end of March 2023.

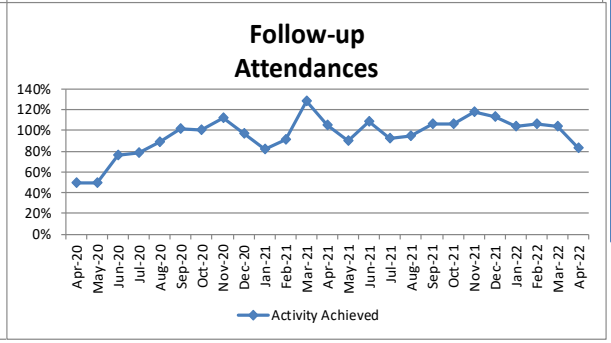












April Activity: (DRAFT)
Activity is below planed levels:

- **Combined elective activity 85%**
  - **Day cases 90%**
  - **Elective inpatients 71%**
  - **New Outpatients 88%**
  - **FU Outpatients 83%**

Other key requirements:

The Trust is reporting 28% of all outpatient attendances conducted remotely, which is in-line with 25% expectation.1.7% of all OP recorded as Patient Initiated Follow-Up – which is below planned levels and the expectation.

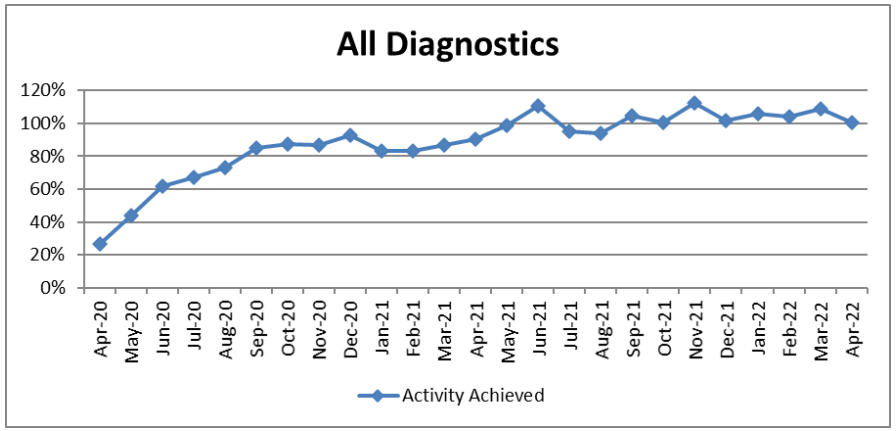
Nationally there are concerns re: activity levels and plans below 104% value and attainment of ERF. It is assumed, and to be confirmed that there will be a mid-June planning round with the opportunity rephase given the capacity pressures & constraints in April and May.

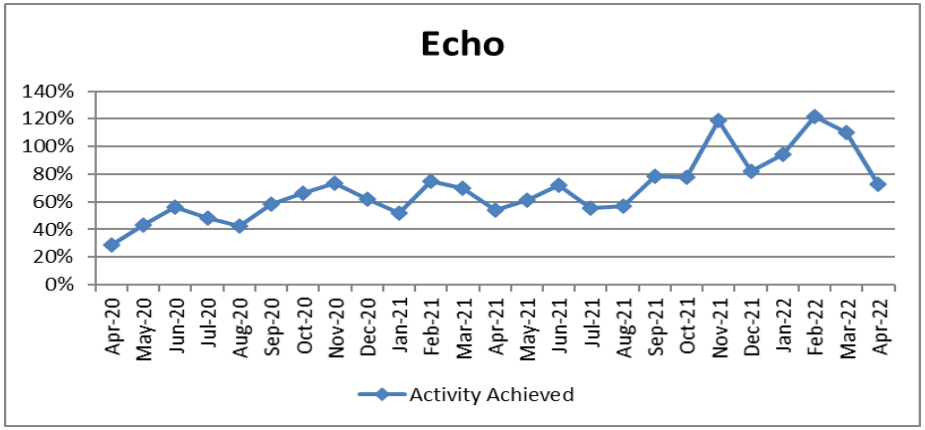
Locally as an ICS there are also concerns around plans not meeting the expectation.

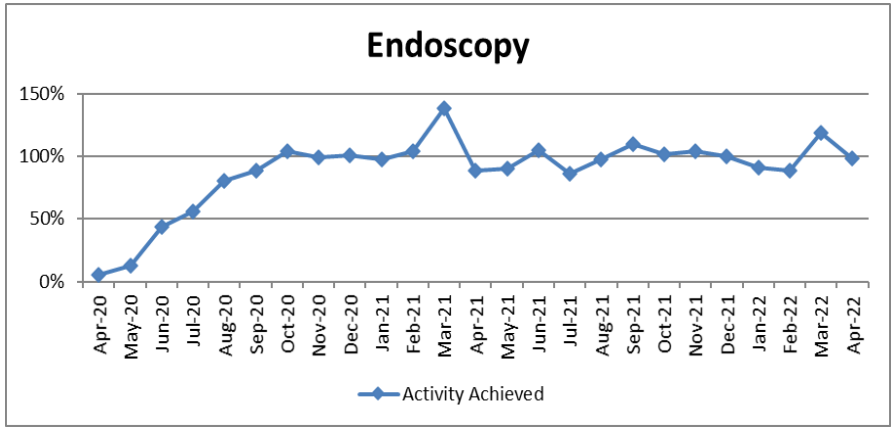
H2 Activity & Recovery

Gateshead Health NHS Foundation Trust

Whilst there are no specific planning thresholds for diagnostic delivery, Trusts are expected to deliver as much as they can to support elective recovery. **All Diagnostics**: 100% of activity in same period 19/20**, Endoscopy: 98**% of activity in same period 19/20**, Echocardiography: 73**% of activity in same period 19/20







As part of a national initiative to manage diagnostic risk, the Trust is required to review and clinically prioritise (as with inpatient waiters) all waiters over 6 weeks.

The diagnostic modalities most at risk are detailed below with % of the total wait over 6 weeks.

- Echocardiography accounts for 75.3% of the diagnostic waiters > 6 weeks with 68.2% of the echocardiography tests waiting longer than 6 weeks.
- Audiology accounts for 17.8% of the diagnostic waiters over 6 weeks with 36.7% of the audiology patients waiting longer than 6 weeks.

EXCEPTION REPORTING

Gateshead Health NHS Foundation Trust

This section covers detailed reports for:

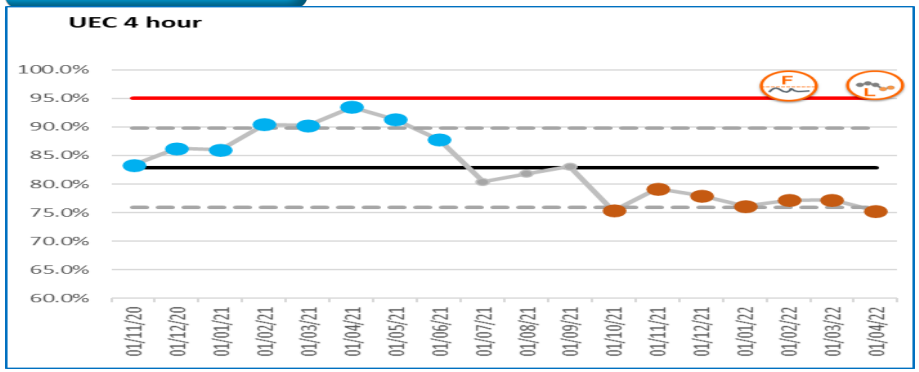
- **Indicators triggering concern or displaying Special Cause Variation**
- **Spotlights requested specifically by Committee or Board**

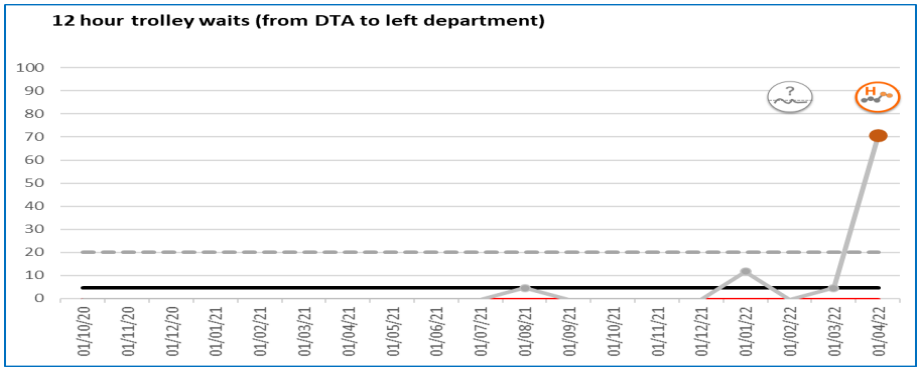
Report by exception: Responsive – UEC waiting times, 12 hour waits to be admitted and 12 hour in department

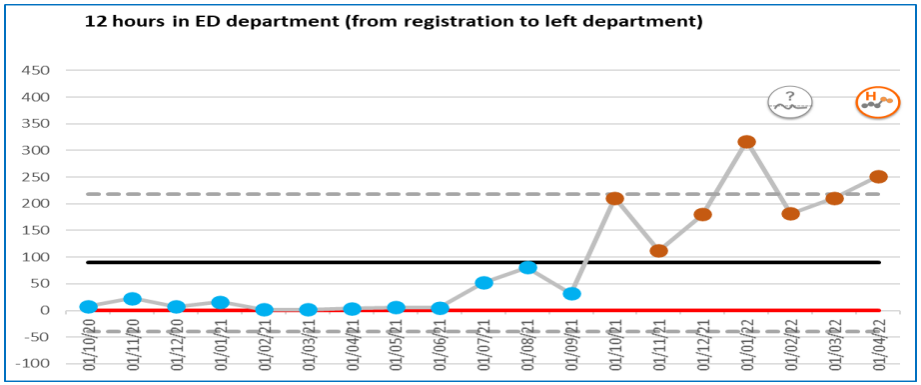
NHS Gateshead Health NHS Foundation Trust

4 hour standard has not been met since July 2020

Responsive







Performance Summary: APRIL 2022

- A&E 4hour performance at 75.28%
- Overall time in the department is beyond the upper control limits (non-admitted 3 hours, admitted 8 hours)
- Attendances below 2019/20 levels but higher than 2021/22 (growing trend since 2020)
- OPEL 3
- 12 hour trolley waits in month 71 (exceptional) majority taken place over two days (debrief undertaken and reported out)
- Bed occupancy levels are high averaging mid 90%
- Ambulance delays are higher: 72 at 30-60 mins and 62 > 60 mins (highest ever been)
- Volume of patients in the department who are in longer than 12 hours is high 250 (pre-pandemic levels were at zero or the exception)
- Adjusting for SDEC - Non elective admissions are 17% down on 2019/20 levels

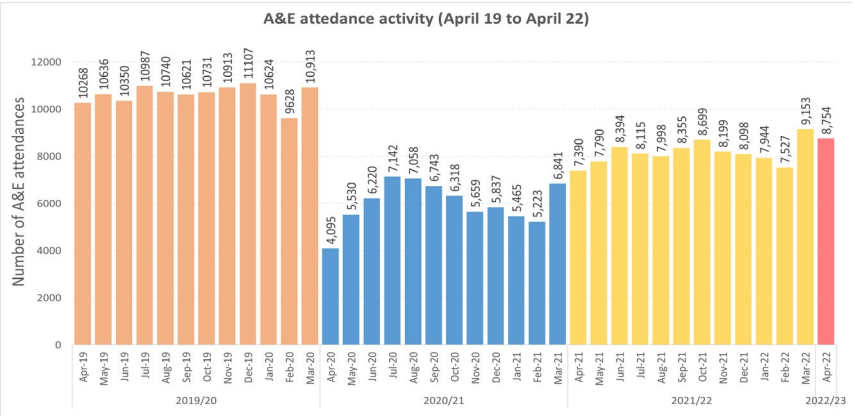
Contributing Factors

Closed the winter Ward 4 and re-provided Acute beds (38) on existing wards (as boarding beds) Increasing to 6 beds in a bay where possible which enacted the full capacity protocol. Levels of Covid in hospital were high, peaking in the 90's and occupying 3 wards. Staffing levels across the board were compromised with covid and sickness absence resulting in low fill rates in key areas. An average of 44

patients per day were 'bed blocking'; 10% of the bed base.

The trolley delays predominantly occur on the Tuesdays and Wednesday, following weekend pressures, where weekend discharges drop off by 50%. In the days preceding the trolley waits, higher attendances in A&E (particularly Sun 3rdApril in particular) couples with an Increase/higher than average admissions on Monday / Tuesday (with all escalation beds used to accommodate the closure of Ward 4)

All requests for mutual aid were declined.



NHS
Gateshead Health
NHS Foundation Trust

Report by exception: Responsive UEC Heat Map

Responsive

Gateshead Activity - mapped against No. of waits for admission from DTA over 12 hours

	Fri-01/04/2022	Sat-02/04/2022	Sun-03/04/2022	Mon-04/04/2022	Tue-05/04/2022	Wed-06/04/2022	Thu-07/04/2022	Fri-08/04/2022	Sat-09/04/2022	Sun-10/04/2022	Mon-11/04/2022	Tue-12/04/2022	Wed-13/04/2022	Thu-14/04/2022	Fri-15/04/2022	Sat-16/04/2022	Sun-17/04/2022	Mon-18/04/2022	Tue-19/04/2022	Wed-20/04/2022	Thu-21/04/2022	Fri-22/04/2022	Sat-23/04/2022	Sun-24/04/2022	Mon-25/04/2022	Tue-26/04/2022	Wed-27/04/2022	Thu-28/04/2022	Fri-29/04/2022	Sat-30/04/2022	Sun-01/05/2022	Mon-02/05/2022	Tue-03/05/2022	Wed-04/05/2022	Thu-05/05/2022	Fri-06/05/2022	Sat-07/05/2022	Sun-08/05/2022	Total April	Total period
															Easter																										
No. of A&E Attendances	261	269	358	334	322	312	289	299	300	255	312	304	266	297	317	245	273	289	324	302	261	299	260	270	317	280	284	277	293	285	291	318	312	315	283	272	285	360	8754	11190
No. A&E attendances (19/20)	363	329	317	329	309	325	356	362	327	324	306	306	309	322	378	340	322	311	341	366	317	395	419	392	364	317	329	339	385	369	326	336	324	349	371	379	406	369	10268	13128
Diferrence	102	60	-41	-5	-13	13	67	63	27	69	-6	2	43	25	61	95	49	22	17	64	56	96	159	122	47	37	45	62	92	84	35	18	12	34	88	107	121	9	1514	1938
No. of admissions	108	72	72	105	104	98	110	99	66	47	91	112	100	101	80	54	57	64	86	103	109	86	64	59	108	109	91	120	99	66	55	66	98	106	96	94	60	67	2640	3282
No. of admissions (19/20)	86	103	77	80	84	66	69	84	89	91	87	76	55	59	84	83	76	84	74	54	62	72	90	100	87	103	70	51	75	87	101	84	95	71	74	72	96	87	2358	3038
Difference	-22	31	5	-25	-20	-32	-41	-15	23	44	-4	-36	-45	-42	4	29	19	20	-12	-49	-47	-14	26	41	-21	-6	-21	-69	-24	21	46	18	-3	-35	-22	-22	36	20	-282	-244
No. of discharges	107	59	49	91	105	104	106	106	59	37	107	101	94	127	78	62	44	47	86	98	87	113	62	54	104	114	114	105	107	60	52	48	86	121	87	107	65	37	2587	3190
No. of discharges (19/20)	94	75	80	84	111	62	44	85	68	107	77	99	59	36	83	95	84	105	65	56	47	61	73	89	81	114	67	31	112	77	102	89	97	72	60	53	86	94	2321	2974
Difference	-13	16	31	-7	6	-42	-62	-21	9	70	-30	-2	-35	-91	5	33	40	58	-21	-42	-40	-52	11	35	-23	0	-47	-74	5	17	50	41	11	-49	-27	-54	21	57	-266	-216
No. of emergency admissions	81	71	67	92	86	80	92	85	66	46	75	98	85	89	79	54	56	61	74	89	90	79	60	55	94	94	83	96	87	66	55	64	86	93	77	86	60	65	2330	2916
No. of emergency admissions (19/20)	69	68	60	60	68	61	63	63	65	70	63	61	52	55	72	71	67	72	71	52	59	67	71	81	69	67	68	47	56	66	75	68	78	65	72	68	76	63	1934	2499
Difference	-12	-3	-7	-32	-18	-19	-29	-22	-1	24	-12	-37	-33	-34	-7	17	11	11	-3	-37	-31	-12	11	26	-25	-27	-15	-49	-31	0	20	4	-8	-28	-5	-18	16	-2	-396	-417
No. of emergency admissions via A&E	51	53	54	66	56	56	60	53	52	41	56	68	52	59	59	45	42	52	48	62	65	47	48	43	59	47	49	66	58	55	44	52	80	63	56	55	50	53	1622	2075
No. of emergency admissions via A&E (19/20)	57	53	56	52	54	58	58	51	58	57	55	54	48	50	61	61	60	57	65	47	53	62	59	70	56	55	58	44	52	55	66	58	63	58	68	63	62	60	1676	2174
Difference	6	0	2	-14	-2	2	-2	-2	6	16	-1	-14	-4	-9	2	16	18	5	17	-15	-12	15	11	27	-3	8	9	-22	-6	0	22	6	-17	-5	12	8	12	7	54	99
No. of patients arriving by Ambulance	50	54	62	52	59	43	44	50	54	51	49	59	49	64	73	35	60	60	51	56	55	48	47	43	62	50	47	67	60	65	58	56	55	52	58	58	61	76	1619	2093
No. of 4 Hour Wait Breaches	46	74	104	88	100	74	76	77	68	37	71	96	67	79	66	27	80	75	72	80	66	75	57	47	64	57	84	85	82	86	36	49	71	84	77	91	101	82	2160	2751
No. of waits for admission 4-12 hours from DTA	23	36	24	35	13	12	31	34	30	17	24	48	31	30	31	6	26	27	24	30	47	35	26	28	32	20	28	32	41	25	18	13	25	31	36	35	31	20	846	1055
No. patients waiting over 12 hours in department	1	1	1	16	34	31	9	6	5	0	9	13	8	10	4	0	0	1	11	23	23	13	4	0	13	5	2	9	0	0	0	0	1	14	2	8	6	0	252	283
No. of waits for admission from DTA over 12 hours	**0**	**0**	**0**	**1**	**23**	**21**	**4**	**3**	**1**	**0**	**2**	**0**	**0**	**2**	**1**	**0**	**0**	**0**	**5**	**8**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**71**	**71**
No. of patients who do not meet the criteria to reside	66	54	55	56	56	52	51	48	39	44	42	38	35	31	47	40	33	34	34	36	30	37	39	48	43	46	48	45	53	46	44	43	43	51	54	63	66	63	1326	1753
% Beds Occupied	90.3%	93.3%	96.2%	99.1%	96.4%	95.5%	96.8%	93.8%	94.4%	96.2%	93.8%	95.0%	96.1%	90.8%	90.7%	90.1%	93.9%	96.8%	97.8%	97.8%	97.7%	93.4%	94.4%	95.7%	95.7%	95.1%	91.8%	92.4%	89.2%	91.9%	92.5%	95.9%	95.3%	93.5%	93.0%	92.5%	91.0%	95.5%		

UEC measures

NHS Gateshead Health NHS Foundation Trust

Responsive

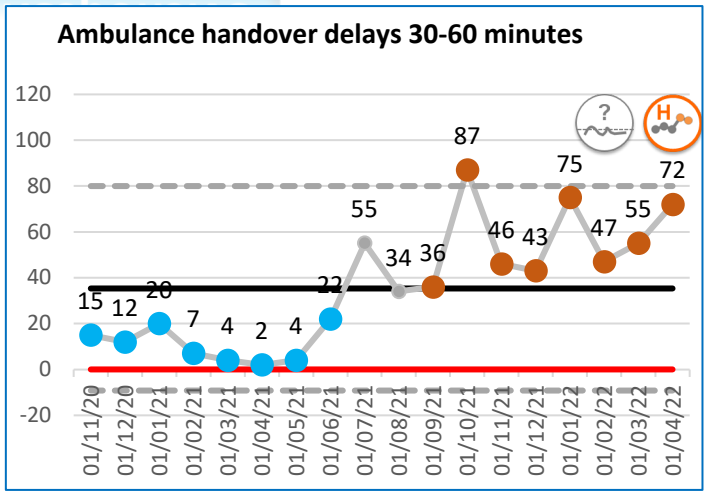
Waiting Times			Quality Access & Outcomes											
Quality Access & Outcomes	Requirement	Target	May	June	July	August	September	October	November	December	January	February	March	April
UEC Shadow Performance Measures	95 % Target	95%	91.30%	87.78%	80.69%	81.78%	83.08%	75.32%	79.14%	77.96%	76.15%	77.15%	77.25%	75.28%
	QEH ED Total Attendances		7790	8394	8115	7998	8355	8699	8199	8099	7944	7527	9153	8754
	(Activity levels 2019/20)		10636	10350	10987	10740	10621	10731	10878	11107	10624	9628	7571	10268
	Activity as proportion of base year		73%	81%	74%	74%	79%	81%	75%	73%	75%	78%	121%	85%
	Type 1 Attendances		5205	5556	5555	5404	5614	6132	5593	5598	5214	4870	5779	5431
	Type 3 Attendances		2585	2838	2560	2594	2741	2567	2606	2501	2730	2657	3374	3323
	No Attendances Assessed within 15 mins		2310	2895	2883	2593	3241	3642	3249	2882	2977	2853	4044	3719
	Attendances Assessed within 15 minutes		5480	5499	5232	5405	5114	5057	4950	5217	4967	4674	5109	5035
	Percentage Assessed within 15 minutes		70.35%	65.51%	64.47%	67.58%	61.21%	58.13%	60.37%	64.42%	62.53%	62.10%	55.82%	57.52%
	30 minute Ambulance Breaches		4	22	55	34	36	87	46	43	75	47	55	72
	Total patients spending > 12hrs in Dept.		6	5	52	81	32	211	112	180	317	182	211	252
	No of patients with TCI > 12 hours		0	0	0	5	0	0	0	0	12	0	5	71
	Average Time in Dept - Non-Admitted		130	135	147	145	142	160	150	149	152	148	150	154
	Average Time in Dept - Admitted		264	293	363	354	339	417	384	410	465	429	447	482
SDEC	% of 0 LOS Admission as proportion of total NEL Activity		22.36%	20.80%	19.97%	19.13%	34.45%	36.98%	35.63%	37.15%	40.54%	40.76%	42.85%	39.88%
Supplimentary Information	Ave Time in Dept in Hours - Non-Admitted		2.17	2.25	2.45	2.42	2.37	2.67	2.50	2.48	2.53	2.47	2.50	2.57
	Ave Time in Dept in Hours - Admitted		4.40	4.88	6.05	5.90	5.65	6.95	6.40	6.83	7.75	7.15	7.45	8.03

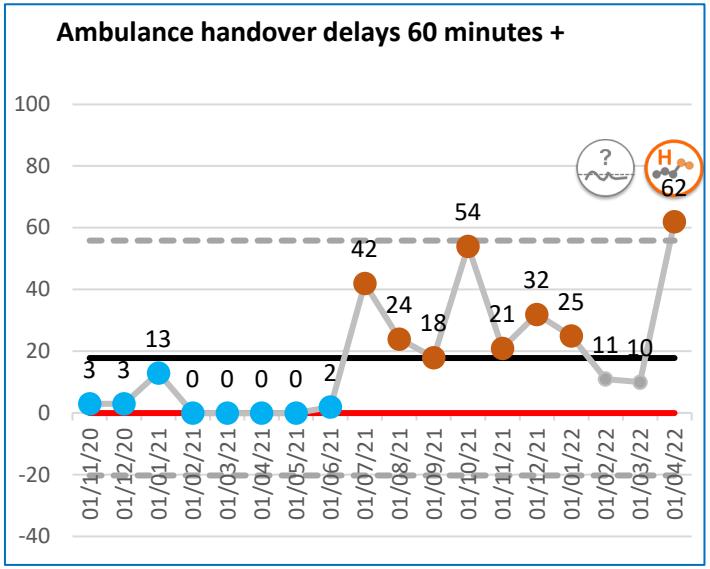
Report by exception: Responsive - UEC Ambulance Handover Delays

Gateshead Health NHS Foundation Trust

Detail on this measure is included as delays have increased and special cause variation (concern) triggered in recent months and the national focus on zero tolerance to ambulance delays.

Responsive





Background

The NHS Long Term Plan set out a vision to reduce Ambulance delays. Ambulance delays are risky as they delay assessment and treatment for those waiting in an ambulance queue. Delays can compromise safety in the community by reducing the number of ambulances available to respond to emergencies.

There is now greater focus on reducing ambulance delays following AACE publication of clinical review (15/11) which states that the review should take 15 mins with no patients waiting more than 30 minutes. In 2022/23 an expectation of 65% of handovers should take place within 15 minutes, 95% within 30 minutes and 100% within 60 minutes.

Situation

A noticeable increase in handover delays can be observed from July 2021
Special cause variation is observed for 30-60 minute delays with the number of delays above the mean for eight consecutive months. Over 60 minute delays is triggering special cause variation with 62 delays in Apr-22

The upper process s limit was breached for 30-60 minute delays in Oct-21 and and for over 60 minute delays in Apr-22

Actions taken to Mitigate Risk & Accept ambulance transfers rapidly

- Implementation of 10 point UEC action plan ongoing via Urgent Care Board
- Direct referrals to SDEC for GP/111/999
- SDEC provision in place for 7/7 – 12 hours per day
- Flexible FOH surge capacity: Enhanced discharge lounge – space to accommodate 4 front of house arrivals
- Access to Clinical Decision makers: Front of House frailty provision 70 hrs+ (work with geriatric team underway)
- CRtP recorded to support onward timely care
- Fit to Sit implemented
- Community Discharge capacity to support flow and prevent admission via rapid response team – rapid response team reviewing access to P3 & P4 activity with NEAS.
- Community are reviewing gap analysis re: community support and pathway operating model
- Utilising HALO support in handover of care

Recommendation

Finance & Performance Committee to receive updates from service and feedback from ECIST findings.

Report by exception: SDEC Spotlight

Responsive

Background

Same day emergency care means that patients are assessed, diagnosed, treated and then sent home the same day with ongoing clinical follow-up as required, avoiding an emergency admission if appropriate. Examples of patients who might be referred to same day emergency care include:

- Patients who require a brief period of observation prior to safe discharge
- Patients who require a specific test prior to safe discharge
- Patients who are waiting for a social or psychiatric assessment or intervention prior to discharge

Situation

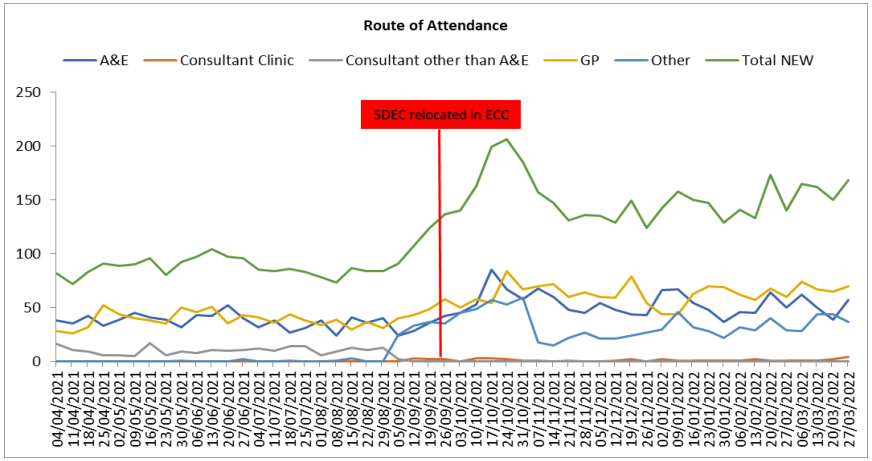
New Operating Model: Sept 2021 SDEC transferred from Old Ambulatory Care to ECC. Doubled capacity from 16 to 30 spaces , operating 8am to 9pm, 7 days per week with a 'Lift & Shift' model of care.

Summary of Change :

- Increased patient through-put in the unit (GP* & A&E)
- Revised data capture from Outpatient to Inpatients
- In April 22 39.88% of all non elective admissions were zero LOS
- In April 22 79.17% of attendances at SDEC were discharges on the same day
- The Business Case savings will not be realised on the 'lift and shift model – this requires further development of the model of care and expansion of pathways (and flow)

Further Development :

- Increased opening hours to 11 pm subject to Business Case – in line with ECIST recommendations.
- Workforce developments through Advanced Care Practitioner framework
- LMC links to keep GP's appraised of changes whilst building relationships



Recommendation

Finance & Performance Committee to receive updates from service and feedback from ECIST findings and Operational Board.

Community teams

Gateshead Health NHS Foundation Trust

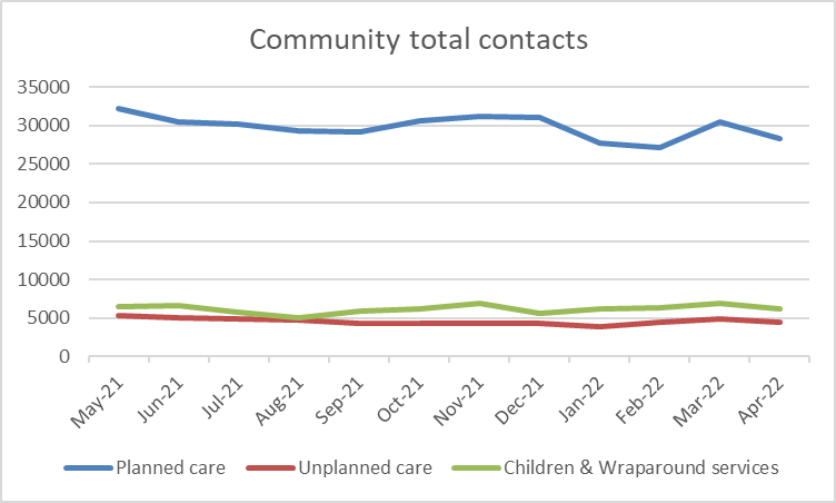
Responsive

Community teams work with patients from birth to end of life to provide care to patients in their place of residence, clinic or education setting. The aim is to provide care close to home, avoiding admission, support early discharge and support patients to reach their maximum potential and independence in all areas of life. Services are split into 3 areas

Planned Care- Locality Nursing and community COVID vaccination teams

Unplanned Care - Rapid Response, Community Stroke Rehabilitation team and Falls team plus Strength and Balance and Pulmonary Rehabilitation

Children and Wraparound Services
- Children's Community Nursing and Therapy teams (Occupational therapy, Physiotherapy and Speech and Language), Continence team, Podiatry and Adult Speech and Language



Indicator	Team	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
Total contacts	Planned care	32159	30417	30183	29247	29181	30548	31232	31055	27739	27134	30418	28227
	Unplanned care	5256	4966	4829	4799	4364	4375	4302	4332	3945	4492	4878	4428
	Children & Wraparound services	6484	6602	5731	5056	5877	6243	6962	5620	6239	6370	6907	6186

Rapid Response
Rapid Response is a 24/7 service providing a nursing and therapy service who require unplanned and rehabilitation assistance in Gateshead. The aim is to supports patients in the community to prevent admission with the 2 hour crisis response service, facilitate early discharge and promote independence in activities of daily life

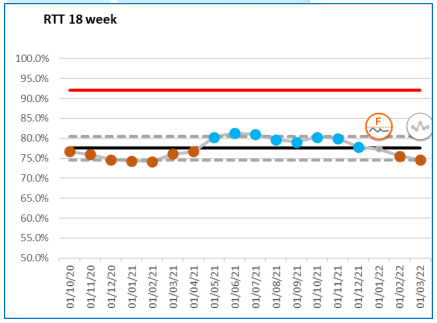
NHS E/I has implemented the following Community health services Two hour crisis response standard:
Improve outcomes through reaching patients in crisis in under 2 hours where clinically appropriate. Providers will be required to achieve, and ideally exceed in the majority of cases, the minimum threshold of reaching 70% of 2 hour crisis response demand within 2 hours from the end of Q3.

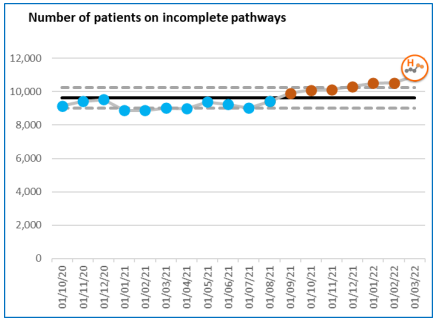
Indicative data shows the Rapid Response team responded to 29 Two hour crisis response referrals in April, 19 of which met the 2 hour response time, an compliance rate of 65.63%

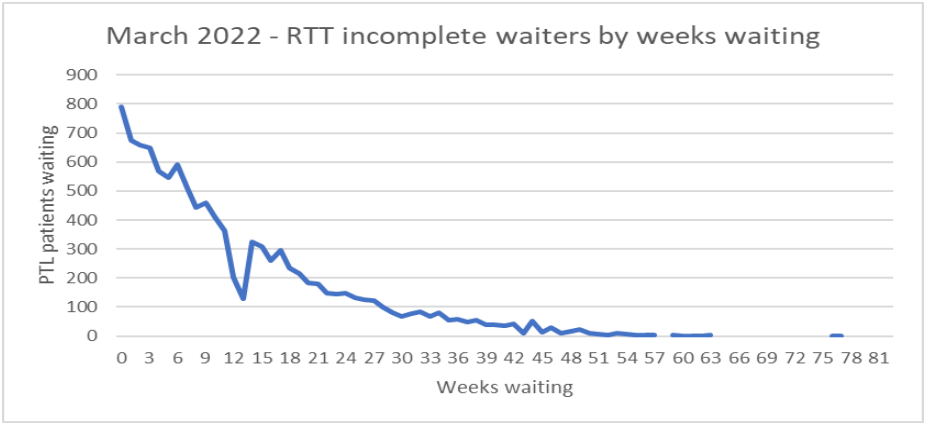
Report by exception: Responsive – Maximum time of 18 weeks from point of referral to treatment (RTT) 92%

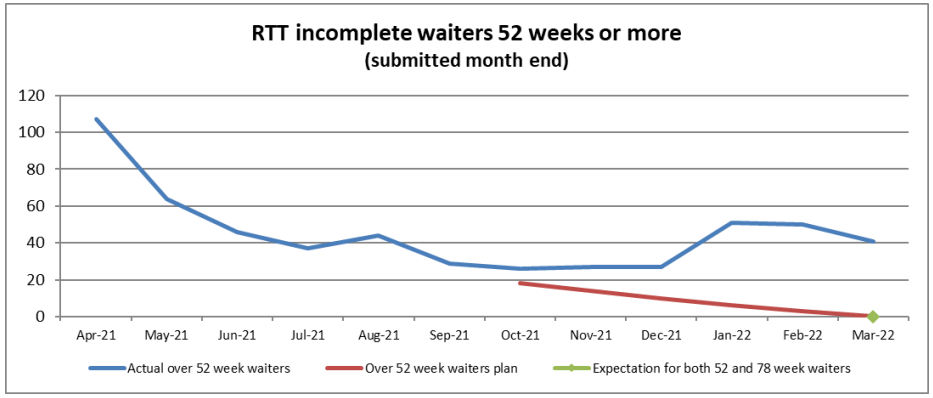
Gateshead Health NHS Foundation Trust

Responsive









Situation

The planning guidance recognises the challenges faced by the NHS in achieving this target and had introduced the expectation to remove all 104 week waiters and manage the backlog of over 52 week waiter to zero by March 2023.

The Trust is still reporting no over 104 week waiters, and the number of over 52 week waiters has decreased to 41 over 52 week waiters in March.

The Elective Programme Board continues to provide leadership and oversight on all stages of treatment in RTT: Outpatients, diagnostics and inpatients.
The priority for the Trust is to make sure all patients have TCI dates and to limit cancellations where possible, whilst prioritising out P2's and cancer patients. Clinical prioritisation is ongoing and centralised scheduling supports reducing long waiters and booking patients in clinical priority then longest waits.

The main areas of risk now are recovering from the impact of the current covid wave and reinstating the elective programme to catch up on lost elective capacity to reduce the waiters. Areas of risk continue to include workforce staffing in theatres and reduced staffing across a number of surgical specialties. Agency staffing and WLI continue to support areas of workforce pressures.

The total numbers of patients reported on the PTL has increased in month – major increased in referrals have been seen in Breast, T&O General Surgery and Urology.

Actions

- Business Units are managing the risk to long waiters by continuing to clinically prioritise with weekly prioritisation of available capacity.
- Principles of Maximising Day case potential & working through additional capacity plans to deliver the gateway criteria at ICP/ICS levels.
- Plans to deliver zero >52 week waiters are now at risk, compounded by constraints in outpatient capacity.
- Technical validation of the waiting list to be repeated to understand patients' treatment options and refresh those choosing to delay treatment but remain on the waiting list, supporting the removal of P5's classifications on the waiting list.

Recommendation

Finance & Performance Committee are to note that the orthopaedic programme commenced w/c 14th February. Although operational delivery has been impacted by staff testing positive.

Report by exception: Responsive – Maximum 6-week wait for diagnostic procedures

Detail on this measure is included as the standard has not been met and special cause variation triggered.

Gateshead Health NHS Foundation Trust

Responsive

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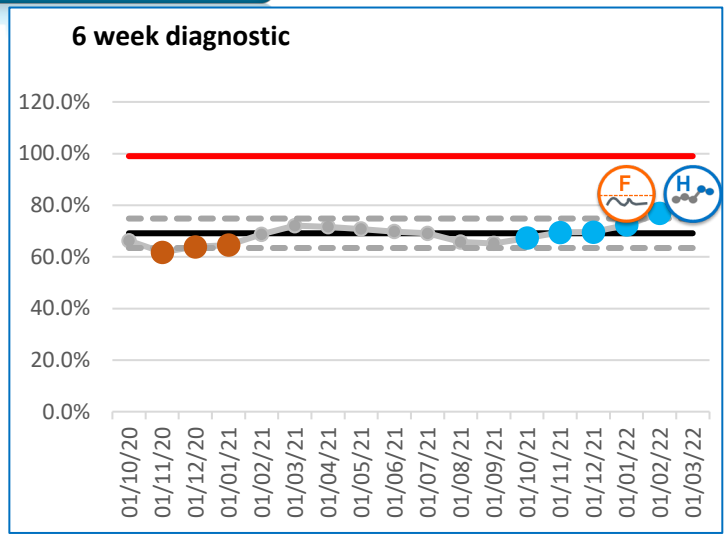

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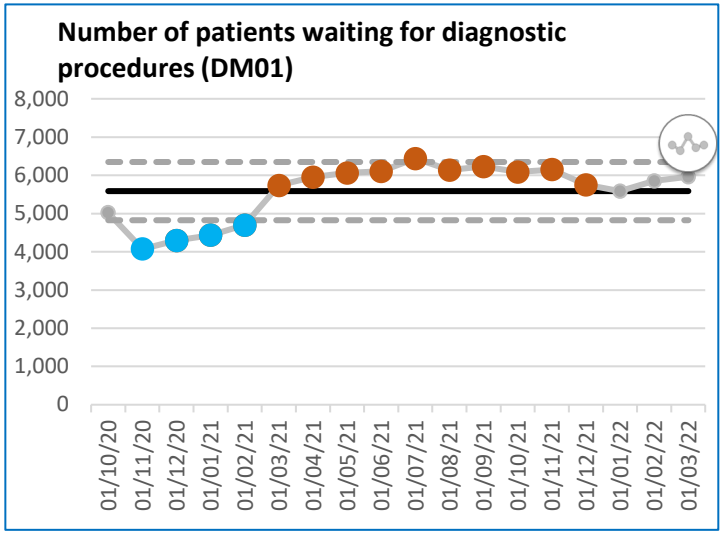


Background

1. This indicator measures, at the end of each month, the percentage of patients waiting less than 6 weeks for specified diagnostic tests and the number of patients waiting for those specified diagnostic tests.
2. The volume of patients waiting for a diagnostic procedure

Assessment

Recovery plans are in place to re-instate additional capacity, Echocardiography still remains a particular area of concern accounting for 68.2% of the patients waiting over 6 weeks. Activity levels for echocardiography decreased in April to 73% (March 2020 will have been affected by COVID activity).

In Audiology more than 37.6% were waiting more than 6 weeks. Capacity is now being reviewed on a weekly basis, along with service reprovision. However, performance continues to improve as indicated through Aprils early indicative data.

Actions

- Risks continue with Service Line Management pressures in Clinical Support & Screening
- Weekly management of Audiology performance continues to be in place
- Following support to proceed by the March F&P Committee, a business case for additional resource that will improve audiology performance is being constructed.
- The Endoscopy service is currently working with insourcing companies with a view to contracting for weekend working in June to reduce the waiting list size and waiting times
- Endoscopy Strategy/Vision Planning session scheduled for 16/05
- Echocardiography action plan includes estates work for additional room and also using external resource to meet the capacity gap - Backlog recovery of all long waits revised to end of August 22.
- Echo - Business case to provide a fourth Echo room and equipment is ongoing. Continue to scope/utilise insourcing and outsourcing companies and validate all echo referrals which come into the department, i.e. duplicates.

Recommendation

Progress with business cases with regards Audiology recovery, and fourth Echo room. And continue working with companies for insourcing of additional Endoscopy capacity.

Report by exception: Responsive – Maximum 6-week wait for diagnostic procedures (supplementary monitoring)

Gateshead Health NHS Foundation Trust

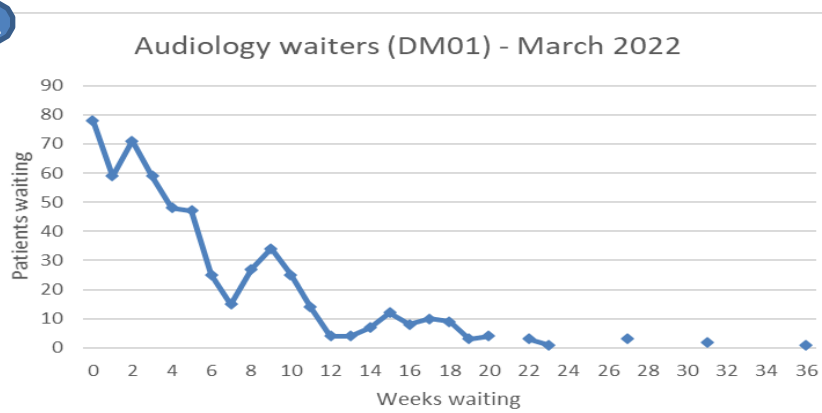
Responsive

Audiology patients waiting and also those waiting more than 6 weeks has been steadily increasing this financial year, Chart 1 shows the number of patients waiting by week band with the longest wait at 36 weeks.

Endoscopy waiters have increased in March to 679 from 616 in February and are currently showing a longest wait of 12 weeks Chart 2

Charts 3 and 4 demonstrate the total waiters with the recovery trajectory and delivered activity levels.

1



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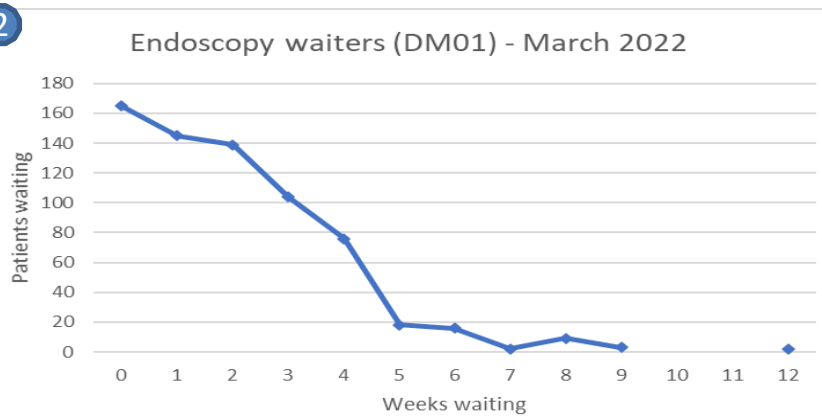

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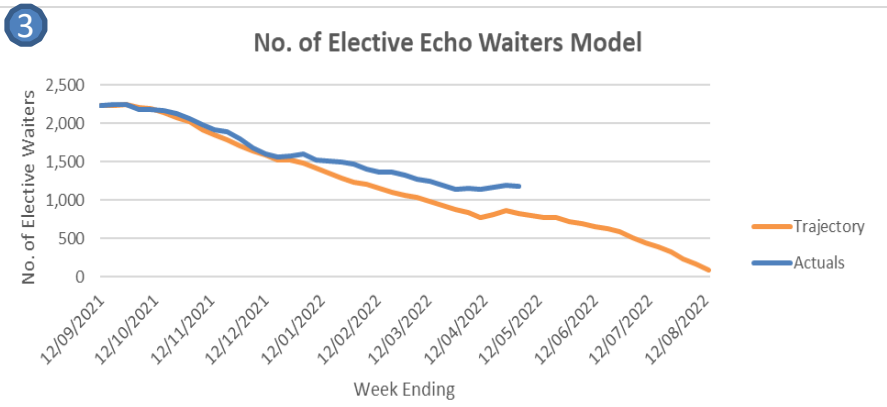

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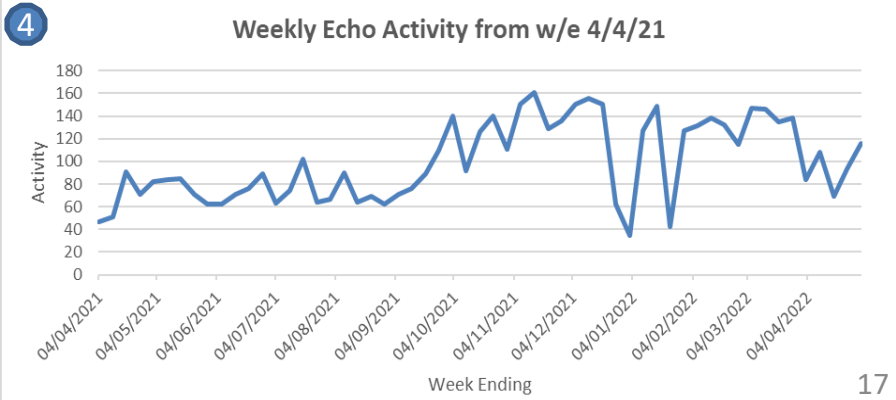

Report by exception: Responsive – Cancer Standards Summary

Gateshead Health NHS Foundation Trust

Responsive

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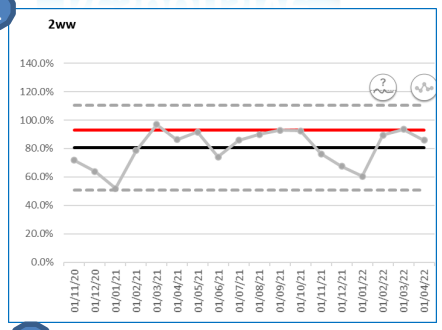

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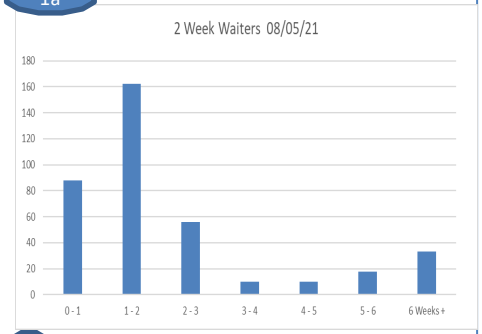

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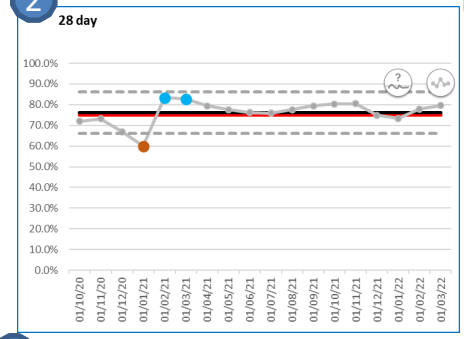

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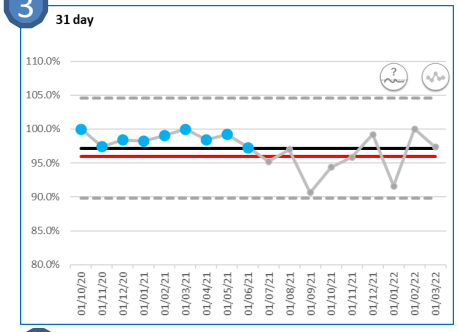

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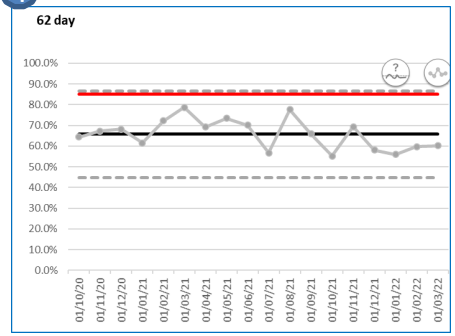

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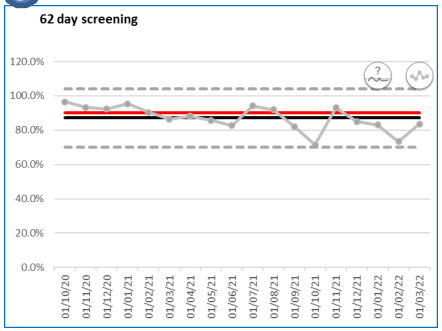


1. **2 Week Waits – 85.73% April** performance is below to the 93% threshold.

There were pressures in March in all tumour sites with only Haematology exceeding the 93% target.

Clinic attendances in April dropped below pre COVID levels and capacity issues still prevail related to rising demand, infection control measures and workforce pressures across the services.
Marked deterioration in 2ww performance in lung to 21.4% in April which is directly related to consultant staffing pressures within the respiratory team. The Lung pathway is particularly pressured –accounting for 80% of the waiters longer over 3 weeks.

2. 28 Day Faster Diagnostics March: 79.59% The target has been achieved in March and continues to improve . This measure will replace the 2 Week wait in the new system oversight framework.

3. 31 Day Diagnostic Standard – performance 97.4% Breast & Gynae tumour sites below the standard

4. 62 Day Treatment March: 60.2% Gynae, Haematology, Lower GI, Lung and Urology tumour sites were below standard.

Whilst the national target is set at 85%, the planning guidance recognises the challenges faced by the NHS and has set a recovery trajectory based on the volume of patients waiting over 62 days.
At the end of April the Trust reported 74 patients waiting over 62 days on a 2ww classic pathway (155 on all pathways).

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 80 at April 2022, reporting 74 for the month of April 2022 the plan has been met.
The number of long waits (> 104 days) on a 62 day (2ww) pathway at the end of April was 16 patients (44 on all pathways).

5. 62 Day Screening March: 83.6% Performance is below the 90% standard both tumour sites with activity; Lower GI and breast were below the standard.

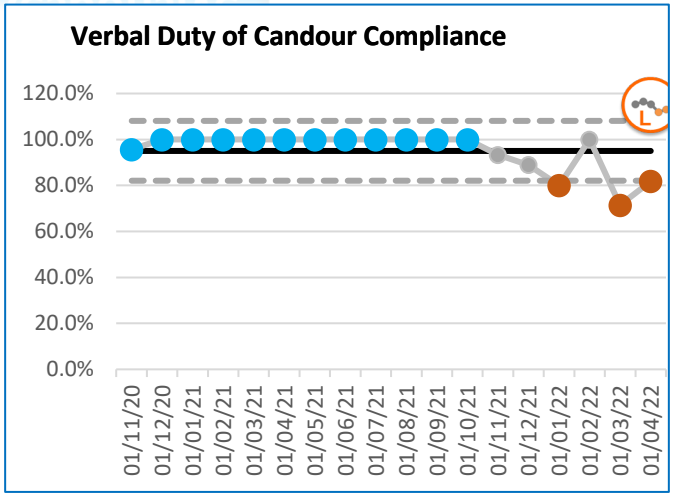
Actions
Respiratory consultants workplan reviewed to allow capacity for cancer work
Additional locum support agreed to support within gynaecology early diagnostics
Ongoing liaison with specialist commissioning to develop a funding model to support our development as lead provider for gynae-oncology surgery.
Ongoing discussion with NUTH to provide extra consultant support to increase capacity for TP biopsies and cancer diagnostics.
Weekly endoscopy capacity meetings cognisant of increasing demand on service and plan to provide outsourcing of routine work which will increase onsite capacity for delivery of cancer work.

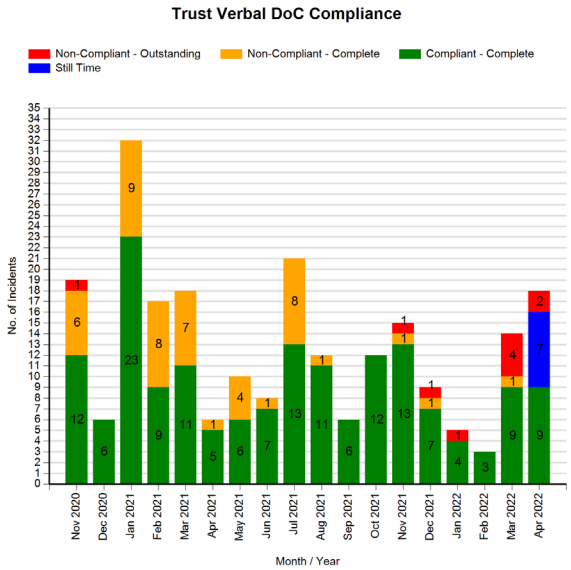
Report by exception: Responsive – Duty of Candour Verbal Compliance

Detail on this measure is included as special cause variation (low) is identified in January, March, and April 2022.

NHS Gateshead Health NHS Foundation Trust

Responsive





Situation

Verbal Duty of Candour compliance is displaying special cause variation for concern in January, March, and April 2022.

Background

Duty of Candour 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 Duty of Candour require review to ensure consistent compliance with defining notifiable patient safety incidents, as within the current process there is potential for enacting Duty of Candour on non notifiable incidents which should be managed under 'Being Open'

The Trust also records the remaining two requirements of the Act , which are written notification and Final investigation findings reports. These two areas have not been presented in this report, however performance for these elements is sadly lower that verbal enactment, and it is recommended that these are included going forward.

Assessment

The reduction in verbal Duty of Candour compliance from January to March 2022 is likely to be multi-factorial in cause. The most recent spike in covid-19 causes and resulting hospital acuity will have an impact on Trust staff's ability to carry out the Duty of Candour in a timely manner.

It may also be that housekeeping on the DATIX system by staff following verbal may not have occurred, affecting data. The Legal Services team are continuing to work with the business units with an aim to review all non-compliant incidents and to provide assistance with the outstanding Notification letters and Findings letters. However, current capacity issues within the team are impacting on the ability to efficiently monitor all incidents.

Actions

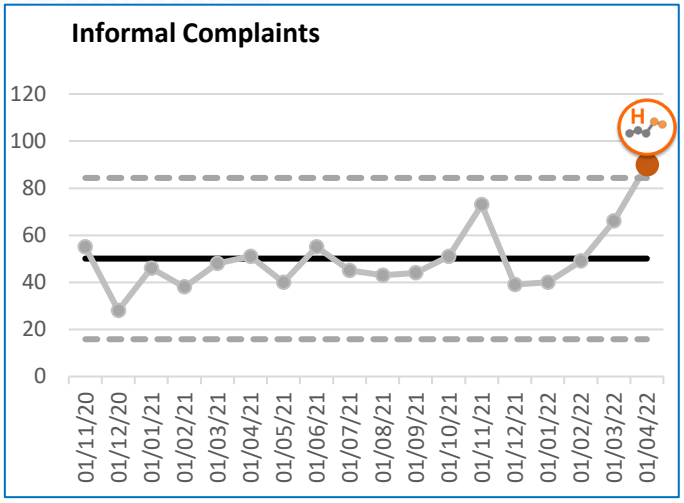
Process mapping work is currently underway, which seeks to make a new proposal on how we ensure only notifiable patient safety incidents have DoC enacted. This has been discussed and agreed at QRG. Further, the introduction of a week multidisciplinary triangulation meeting, which once fully established, will seek to determine cases where duty of candour legally applies and work in partnership with the business units to define a process that aligns this to current practices and reduces unnecessary workloads created through enactment based on the subjective reported harm levels.

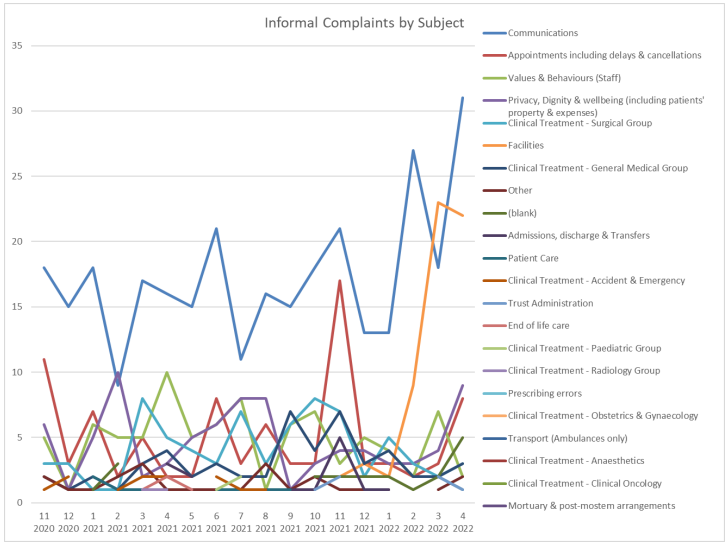
Report by exception: Responsive – Informal Complaints

Detail on this measure is included as special cause variation (high) is identified in April 2022.

Gateshead Health NHS Foundation Trust

Responsive





Situation

The number of Informal complaints (PALS) is triggering special cause variation for concern. The figure for April (90) has exceeded the control limit.

Background

The Patient Advice and Liaison Service (PALS) offer confidential advice, support and information on health-related matters. They provide a point of contact for patients, their families and their carers and facilitate the resolution of informal complaints.

Assessment

A general upward trend has been observed in informal concerns and formal complaints across Q3&4 of 21/22 and has been reported bimonthly via the Safecare/Risk and Patient Safety Council. This increase was to 90 informal concerns raised in the month of April and the top themes for these were:

- Communications (31)
- Facilities (22)
- Privacy, Dignity & wellbeing (including patients' property & expenses) (9)
- Appointments including delays & cancellations (8)

The theme of communication relates to a number of areas but predominantly is around ward staff are not keeping family members as updated as they would like around their loved ones care (note information would only be divulged with the consent of the patient and many patients do have mobile phones are keep their family members updated themselves). The theme of facilities largely relates to Parking Eye concerns, and with this accessibility and signage around Parking Eye. The PALS team have approached QEF to discuss signposting complainants directly to QEF rather than logging as an informal concern for management via PALS (with the suggestion that QEF provide the PALS team with information around concerns that have been raised via QEF which can be triangulated with Trust data).

It must be noted that formal complaints dipped to 9 received in April, therefore some of the concerns that may have been logged as formal complaints have instead been processed via the informal PALS route following this decision by the patient/family member.

Actions

We welcome all feedback, whether positive or negative and will continue to monitor the number of informal concerns received. Volunteers will continue to visit ward areas to support with virtual visiting via iPad for those patients who do not have a smart phone device/do not have family members visiting.

Recommendation

To be reviewed and discussed at the Quality Governance Committee.

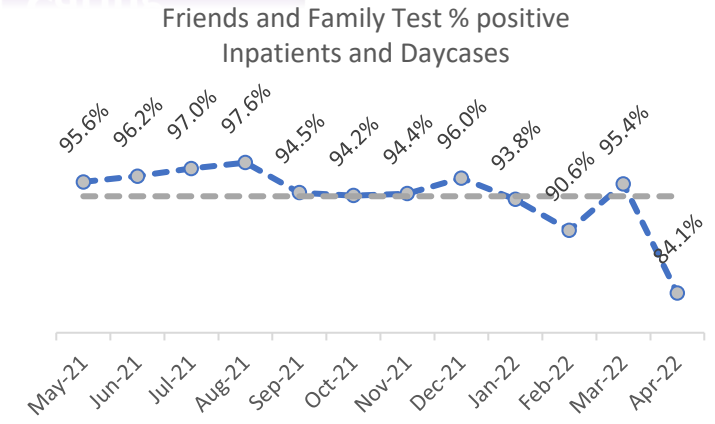
Report by exception: Caring

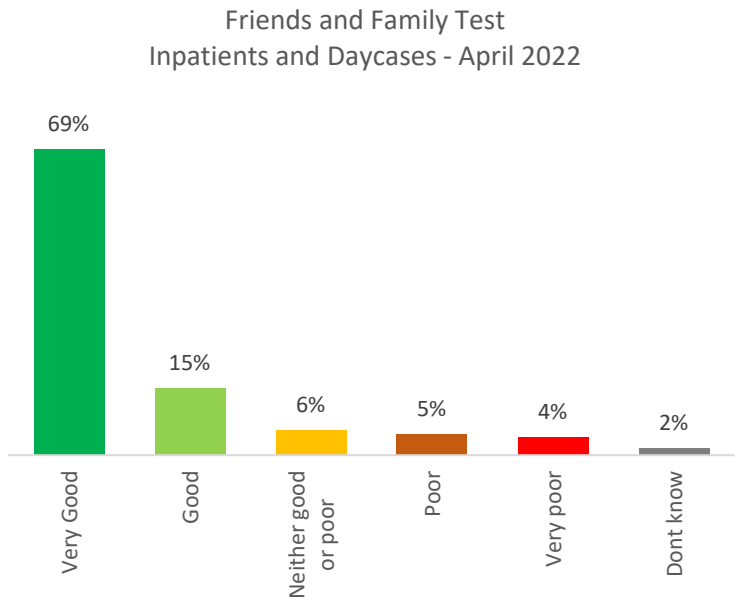
Friends and Family Test – Inpatients and Day cases

Detail on this measure is included as a reduction is observed in April 2022

Gateshead Health NHS Foundation Trust

Caring





Situation

A noticeable drop is observed in the Friends and Family score for Inpatients and Day cases in April 2022.

Background

The questions that form the basis of the Friends and Family Test (FFT) were amended by the national team early in the pandemic, followed by a national pause in FFT collection (new key question of "overall, how was your experience of our services?). We used the time of the national pause to develop and introduce a digital FFT solution which went live across the Trust early 2021 with the exception of the Community and Maternity. The FFT is now an automated text message service system, this is an 'opt out' process – there is a tick box on patient administration system with the patient contact details for this to be amended should the patient does not want to take part in test message FFT. Where patients do not have access to a smart phone, they still can provide real-time feedback on wards using Friends and Family cards, which is by exception only. The cards are collected from each ward/area's FFT box at the end of each month.

Assessment

Since introducing FFT via the text message service (with FFT cards by exception), the number of patients providing responses has significantly reduced.

In April the Trust's score was 84.1% for the questions "overall, how was your experience of our services" was 10 percentage points below the mean. There were 20 patient responses that contributed negatively to the score. Contributing reasons are not specific to a isolated ward areas but were noted to be across inpatient stays and day cases and include the following themes:

- Waiting times
- Discharge information / aftercare
- Staffing
- Staff behaviour / attitude

Actions

This is an isolated month were the FFT score has dropped significantly below the mean, but given the low number of responses that contributed to this, these results should be taken with caution. We will review the results in conjunction with the results we receive in May and triangulate these with wider data such as complaints, incidents etc.

As the number of patients completing FFT via text message is reducing we will deep dive into this area and this will inform an action plan as needed.

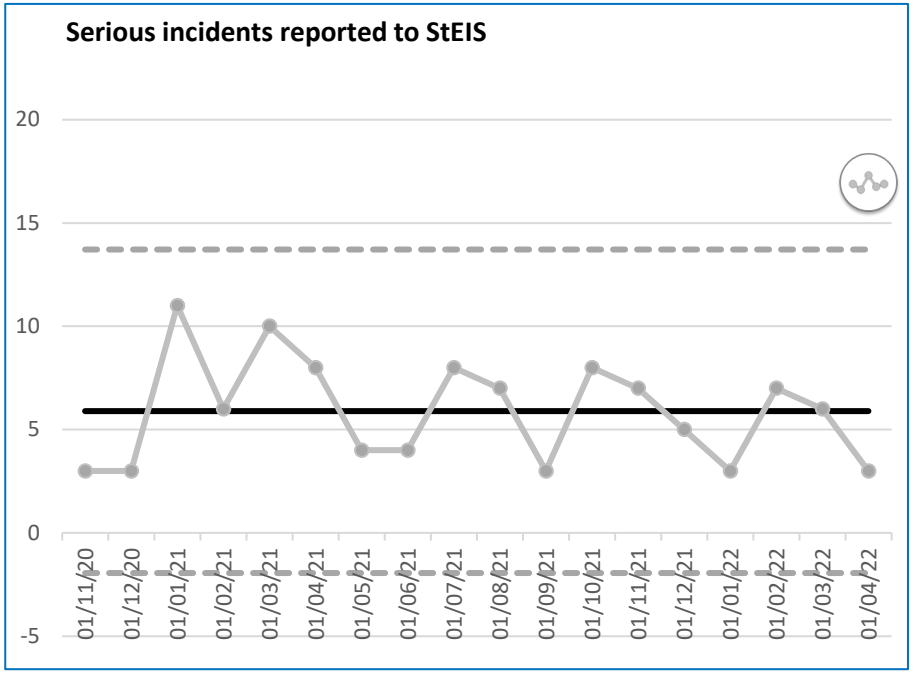
Recommendation

To be reviewed and discussed at the Quality Governance Committee

Report by Exception: Safe - Serious Incidents reported to StEIS

Gateshead Health NHS Foundation Trust

Safe



Serious Incidents in health care are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is justified. Serious Incidents include acts or omissions in care that result in; unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm - including those where the injury required treatment to prevent death or serious harm, abuse, Never Events, incidents that prevent (or threaten to prevent) an organisation's ability to continue to deliver an acceptable quality of healthcare services and incidents that cause widespread public concern resulting in a loss of confidence in healthcare services.

This indicator is included as trending information only – there is no trigger raising a cause for concern, and is included at the request of the Board for information only.

Severe / Major Harm
1 x Complications During Surgery or Procedure
1 x Fall on same level - cause unknown
1 x Non-controlled drug incident

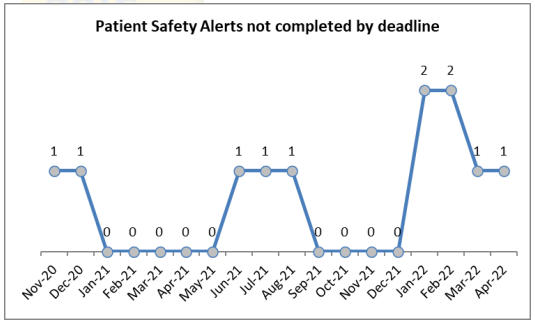
Thematic analysis Over the last 18 months reveals 34 SI's have been reported Falls (34) and it is also he highest volume of patient safety incident type reporting in the Trust.
Delay / failure to treat / monitor (19). Most of these (10) are Diagnosis / delay / failure – 10 over the 18-month period (5xDeath Catastrophic; 3x Severe Harm; 2x Low harm)
18 SI's are related to IPC incidents. The bulk are related to incidents associated with Hospital Acquired Covid. (15 x Death Catastrophic; 1 Severe Harm; 1x Moderate Harm, 1x Low Harm)
Discharge or Transfer (8). Five of these relate to delay in transfer of patient in August 2021.

Report by exception: Safe – Patient Safety Alerts not completed by deadline

Detail on this measure is included as there are patient safety alerts currently open which were not completed by the deadline in the last 18 months

Gateshead Health NHS Foundation Trust

Safe



Combined impact analysis

Financial impact

Quality impact

Workforce impact

Operational performance impact

Situation

There have been 8 alerts received in April 2022. One of these necessitated removal of all stock from shelves and cupboards and this is now due for completion, with only one area awaited for assurance of removal.

Background

National patient safety alerts are received into the organisation via the patient safety team and then forwarded to the Medical Director to be forwarded to appropriate identified leads to determine actions required. These may also be added to a risk register depending upon the significance for the organisation when actions are overdue to enable monitoring of actions through the agreed governance groups.

Assessment

There has been no closures of alerts related to the Trust in April 2022

Actions

A review of the Ulysses system and simplification of recording monitoring and closing incidents in underway. The system requires simplification to easily see overdue actions and progress towards completion.

Recommendation

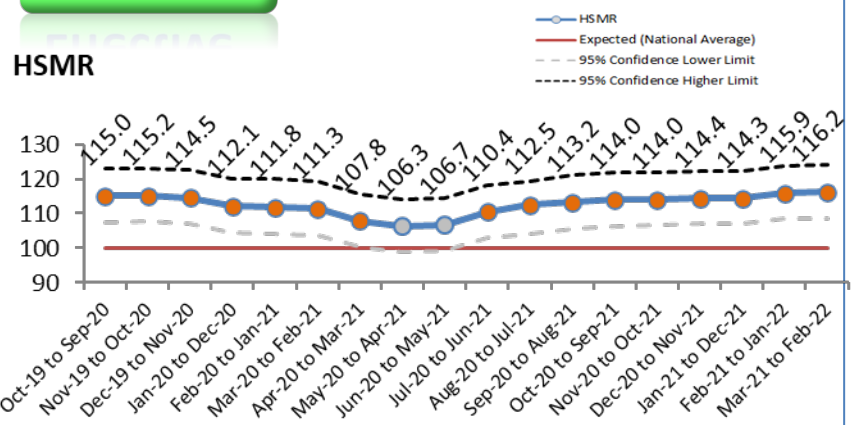
To evaluate the effectiveness of the current process and Ulysses system to minimise organisational risk.

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

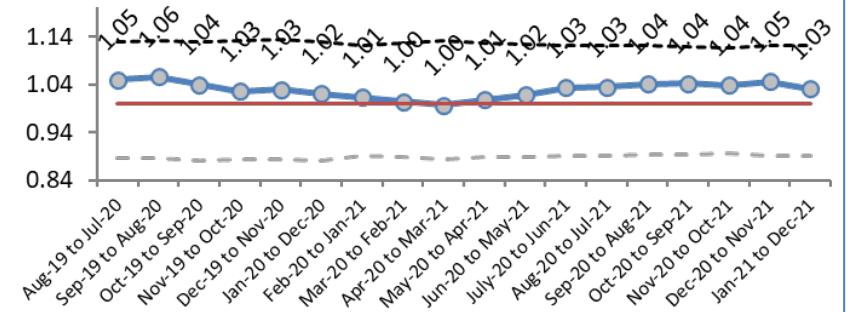
Gateshead Health NHS Foundation Trust

Effective

HSMR



SHMI



Mortality Review

Period: March-2021 – February 2022

	Deaths in period	Deaths reviewed	%	Hogan 1	Hogan 2	Hogan 3	Hogan 4	Hogan 5	Hogan 6	Potentially Avoidable Deaths
All Deaths	1188	585	49.2%	96.4%	3.2%	0.3%	0.0%	0.0%	0.0%	0.0% (0)
Learning Disability Deaths	18	11	61.1%	81.8%	18.2%	0.0%	0.0%	0.0%	0.0%	0.0% (0)

Situation – The Trust HSMR is 116.2 and remains with a banding of 'More Deaths than Expected' for the most recent available period. The SHMI is 1.03 and remains with a banding of 'As Expected'

Background - The HSMR and SHMI are measurement tools that considers 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 - Mortality indicators show the Trust deaths relative to the expected deaths per the statistical models for HSMR and SHMI. The HSMR is showing 'More Deaths than Expected whereas the SHMI is showing deaths are within the expected range. The Trust continues to trigger for Congestive Heart failure

Mortality review data for the last 12 months demonstrates that 96.4% of deaths reviewed were definitely not preventable. 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, they review all deaths and escalate cases for additional investigations i.e. Mortality Council, patient safety investigation.

Analysis of the HSMR by deprivation quintile identifies that more deaths than expected are observed within the two highest deprivation quintiles with average and affluent areas observing deaths within the expected range. Analysis by fiscal quarter shows a reducing pattern in the HSMR. Q1 124; Q2 118; Q3 113; Q1 111.

Actions

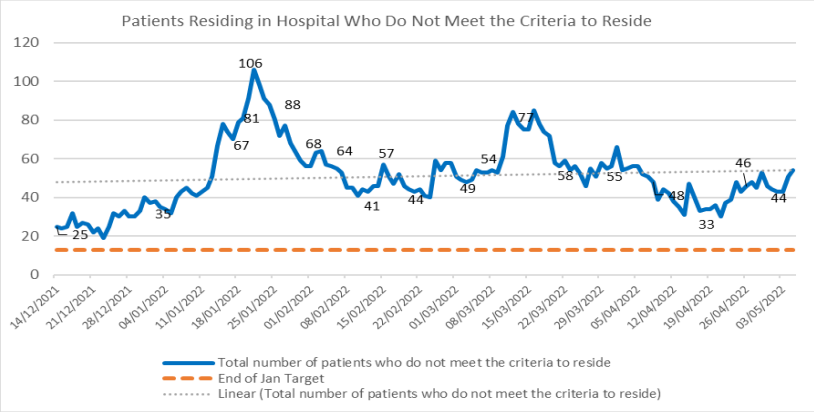
- Two additional Mortality Council meetings have been scheduled to review heart failure deaths – 15 cases have been reviewed 12 x Hogan 1 and 3 x Hogan 2. 7 x NCEPOD 1, 4 x NCEPOD 3 and 4 x NCEPOD 4. Learning identified in terms of NCEPOD 3 and 4's was 1) delays in discharges as a result of delays in obtaining social care packages, 2) recognition of patient dying, 3) reduced access to obtaining ECHOs and telemetry and appropriateness of placing patients in wards were there is limited access to monitoring 4) ECGs not documented within patient notes 5) Senior decision making and handover 6) Referrals to heart failure team 7)
- Task & Finish Group set up to incorporate the Medical Examiner Review into the level 1 process. A large proportion of deaths are expected and well managed, particularly in the Medical Business Unit. Changing the process will release capacity and allow the ward teams to concentrate their efforts on reviewing the deaths where is the most learning and areas for improvement. First meeting took place on 16th February, very well attended, agreement to change process and action plan development to achieve this. Action plan is on track, work ongoing with the systems to ensure capture of data and allow for reporting. Medical Examiner reviews will now be reported in terms of level 1 reviews.
- Explore the use of HIE to ensure all comorbidities are captured more efficiently in the initial clerking document in order to be coded appropriately, lead for Great North Care Record, he is going to take it back to the HIE – completed full access to HIE is available
- Review the admission document to ensure all differential diagnoses can be added and coded appropriately. Completed September 2021

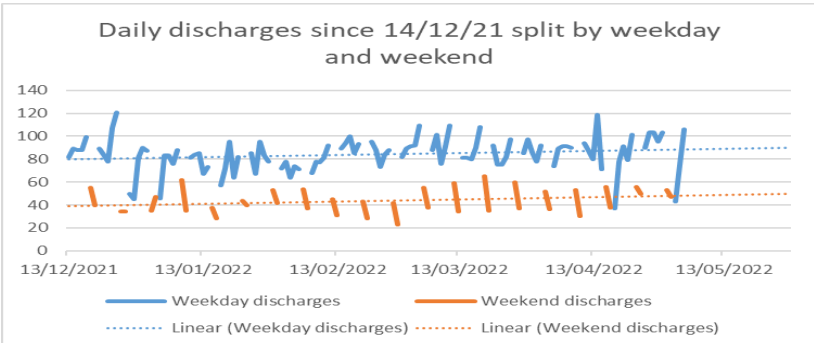
Recommendation - Continue to inform & note actions undertaken at Mortality and Morbidity steering group and Quality Governance Committee via the Integrated Oversight Report and Mortality Paper.

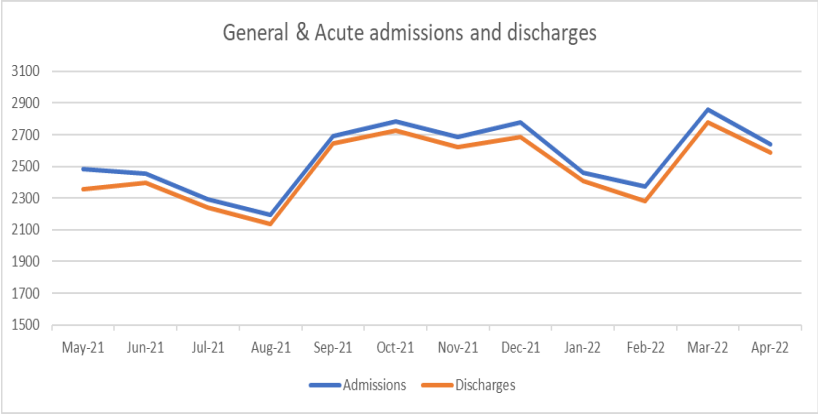
Report by exception: Flow & Discharge

Gateshead Health NHS Foundation Trust

Effective







Assessment
To achieve flow, daily discharge volumes need to exceed daily admissions (minimum 5%). Expediting discharge to create flow remains a priority for the Trust. Improving the Patient Journey T&F group meets weekly to provide focus in the following areas to support the discharge.

- Developing and standardising Ward and Board Round processes
- Developing processes to support the implementation of 7 day discharges, including criteria led discharge as a specific workstream
- Implementation and monitoring of CtR to support the patient discharge
- Developing and enhancing the Discharge Lounge pathway to support timely discharges
- Developing standardised operational procedures that will support the effective and efficient use of IT Systems leading to a standard way of working

Admission and Discharges
Creating flow where discharges exceed admission: There is no change to date, admissions still exceed discharges indicating a process under pressure.

Criteria to Reside: there have been some small improvements in the average daily patient delay rate improving from an average of **60.6 patients** per day in March **to 44.2 patients** per day in April. Despite these improvements April's delays equate to a significant volume, circa 2 wards of bed capacity lost or 'blocked' each day.

- Trust internal delays – 9% of patients in April
- Local Authority delays – 91% of patients in April

Discharge Lounge: Utilisation of the facility indicates improvement from October from 3.8 to 9.4 patients per day. Despite ongoing challenges with the estate and staffing. A full evaluation has been undertaken and is due to be reviewed at the improving the patient journey task & finish group to understand next steps (May 22).

Discharges Before 5pm: Demonstrate a slight improvement in the averages of 47.8% (Dec) to 50% in April, Remain static circa 50% below the 70% target.

Patients Length of Stay The volume of patients with longer lengths of stay (+21 days) is above the recommended ECIST level and Bed occupancy levels remain in the high 90%'s.

Risks & Mitigating Actions

- Ongoing daily review & progression of Criteria to Reside patients
- Ongoing discharge lounge utilisation / evaluation
- Implementation of ward discharge focus to guide wards on achieving earlier discharges
- ECIST work – continue working through ECIST recommendations
- Nerve Centre amendments in data capture to support refinement of delays

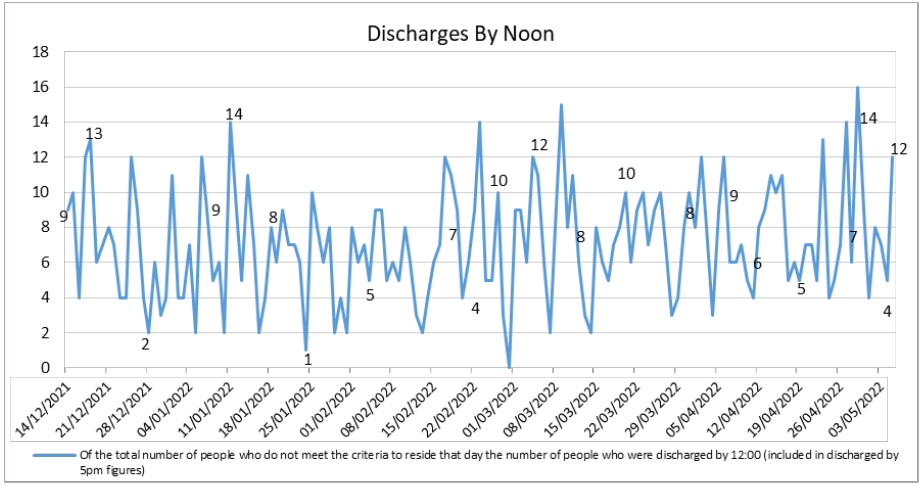
Bed Model review: Beds adequate for activity levels but if delays /criteria to reside patients are not resolved & length of stay continues to rise the Trust will need to review the original model and rebase the beds accepting the delays as the new normal operating model with higher lengths of stay.

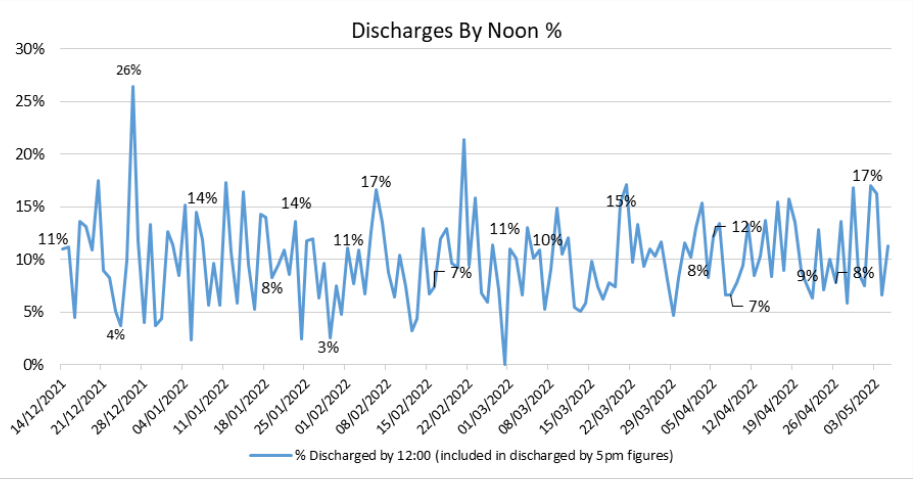
Recommendation
Review plans actions and expedite discharge as part of Daily operational oversight at Emergency Care Board & COO Meetings.

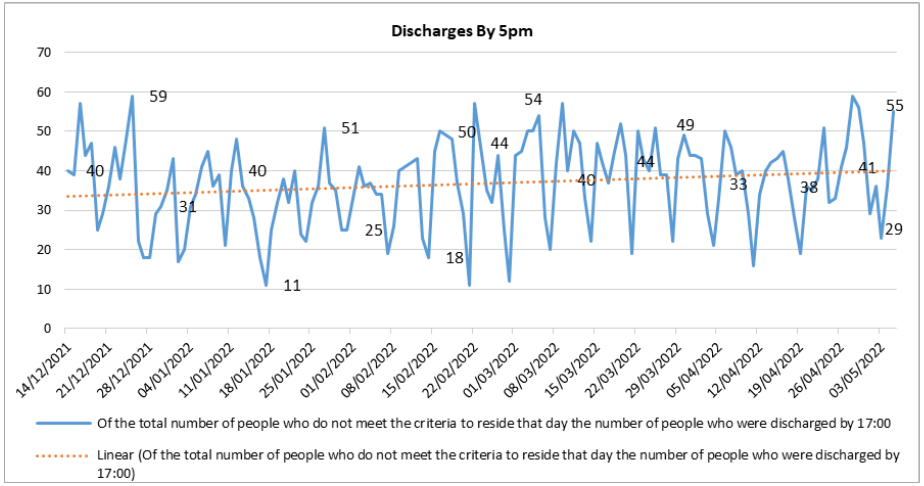
Report by exception: Discharge

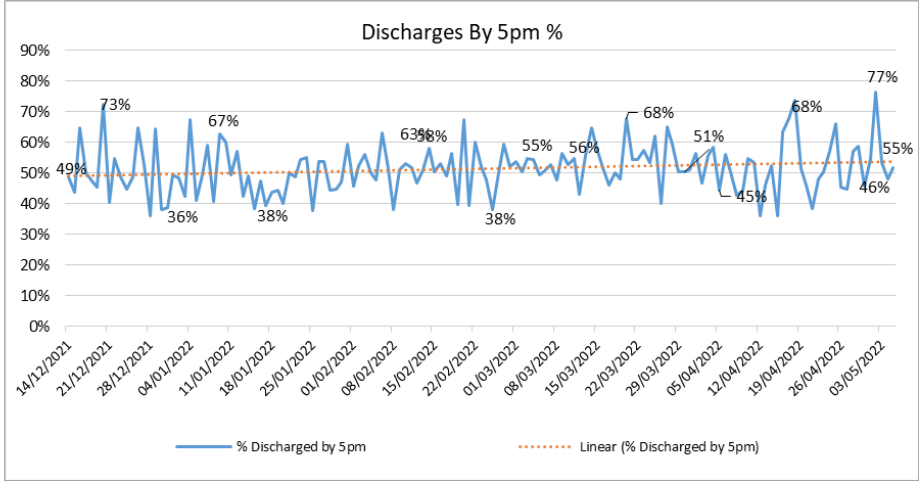
NHS
Gateshead Health
NHS Foundation Trust

Effective





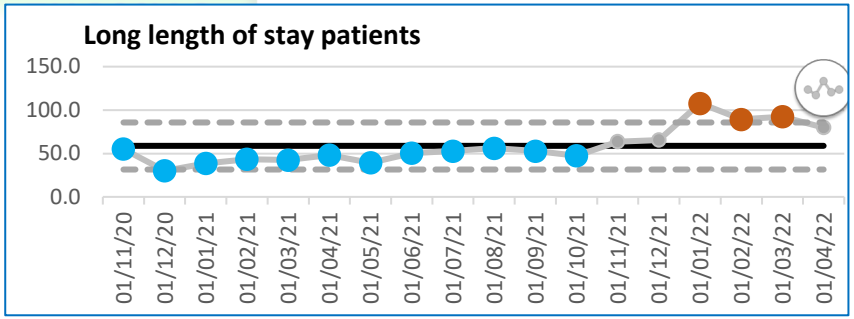


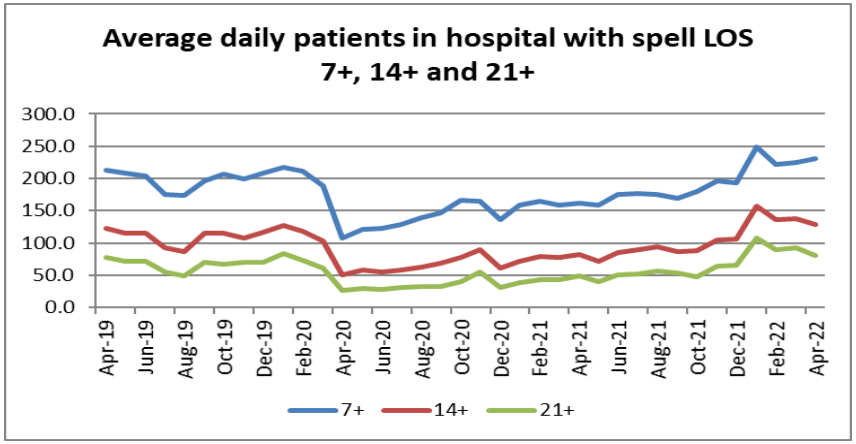


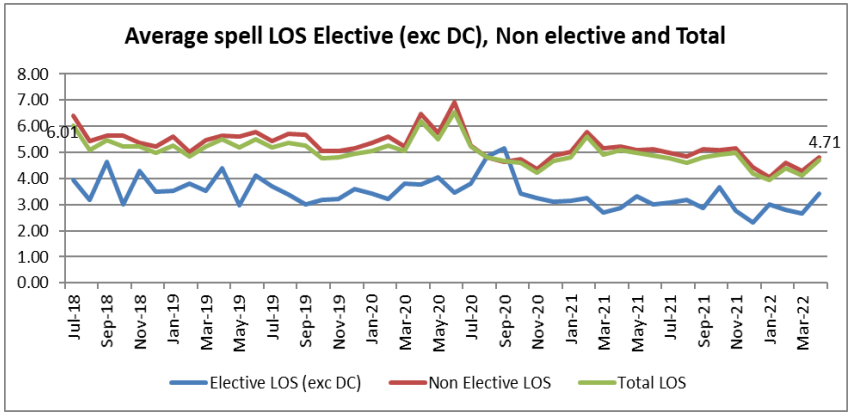
Report by exception: Effective – Long Length of Stay Patients

Gateshead Health NHS Foundation Trust

Effective







Situation The average number of patients in hospital with 21+ days LOS is currently in normal variation however had triggered special cause variation (concern) for the previous 3 months. A general upward trend is observed and the 2022 figures are above the upper process .

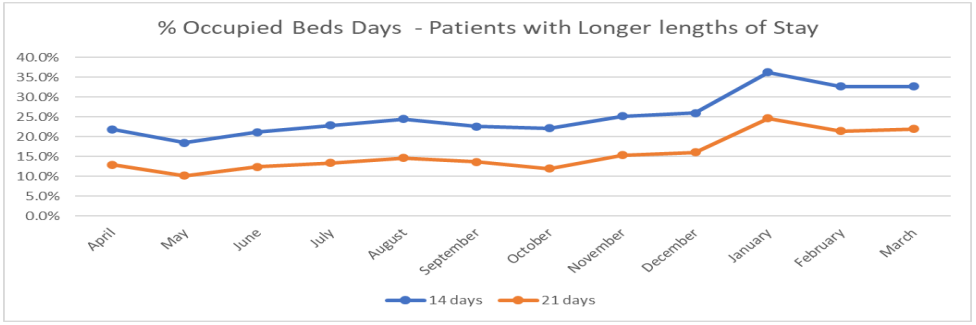
The ECIST existing target of 59 is subject to either pass or fail based on common cause variation.

Background
An expectation that the daily average number of patients staying 21+ days would not exceed 59.

Assessment
Complex high acuity patients requiring multi faceted treatment plans genuinely do require longer lengths of stay in hospital – these patients are deemed as meeting the right to reside in hospital criteria. However, patients who no longer meet the criteria to reside (and are medically optimised) are usually more complex discharges where external delay factors such as limitations on packages of care and the ability to place patients into a care homes are the usual reasons behind the delays.

Long lengths of stay patients continue to be reviewed as part of the Improving the patient journey task & finish group as a number of workstreams are affected. A specific workstream to review the super stranded patients - length of stay over 21 days as part of the second priority.

Recommendation
Review as part of Discharge workstream under the Urgent and Emergency Care Board

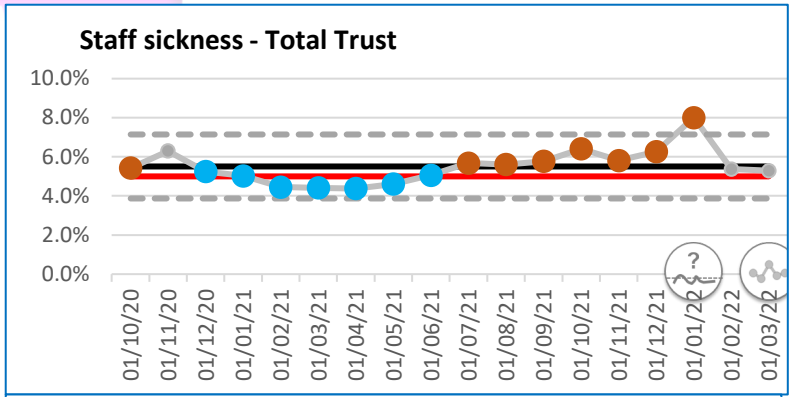


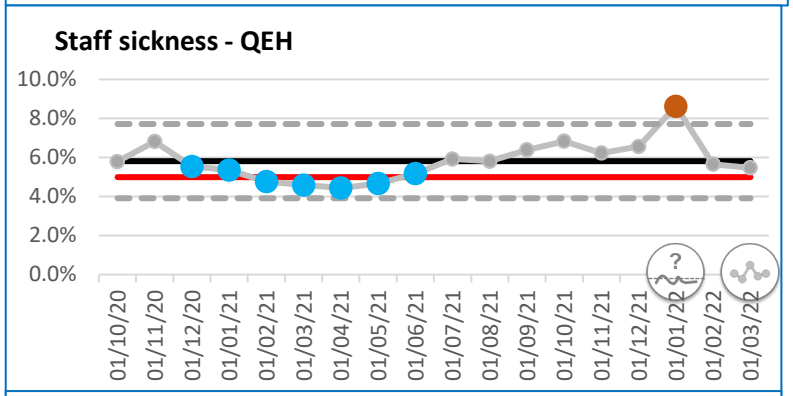
Report by exception: Well led – Sickness Absence

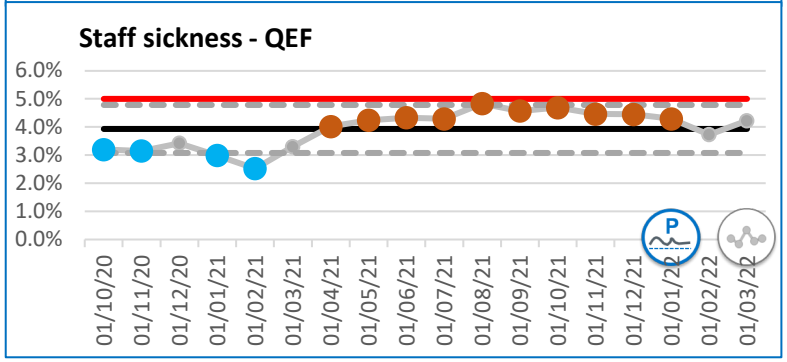
Detail on this measure is included because the target will either be achieved or failed based on variation within the performance and special cause variation identified.

Gateshead Health NHS Foundation Trust

Well Led







Situation Common cause variation displayed for the Trust overall and both QEH and QEF for the latest month

Current performance of 5.3% represents a fail of the Trust target.

Background
Absence levels continue to contribute to the overall pressures in relation to supply and as such the focused management of sickness absence has become a strategic priority.

Assessment
Whilst we have seen a small decrease in sickness absence levels we continue to see a fail against the Trust target.

Actions
During May a number of presentations will be given across business units and corporate departments highlighting the absence pressures, cost and impact. These presentations and discussions will be followed by targeted actions within each area to reduce the impact of short and long term absence.

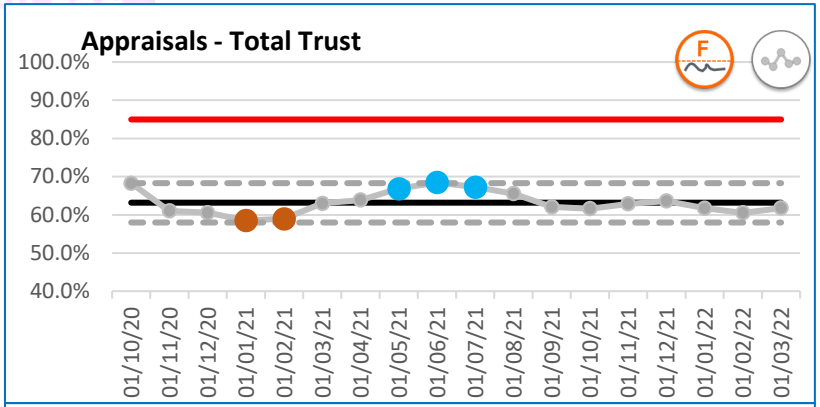
Recommendation
Review, management and oversight by Senior Team and continued management by operational teams with support from the People Services Team.

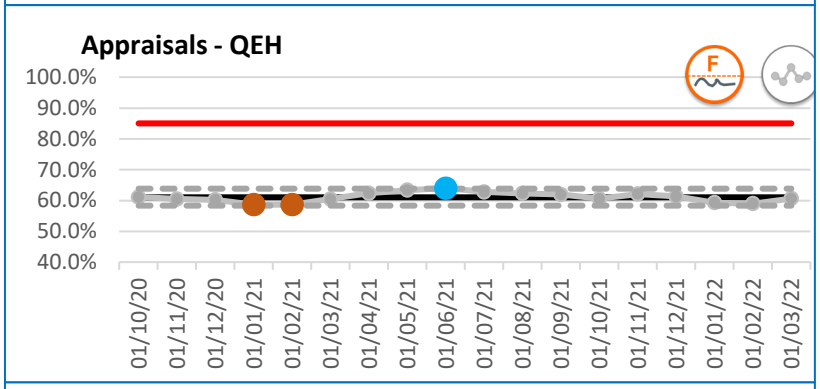
Report by exception: Well led – Appraisals

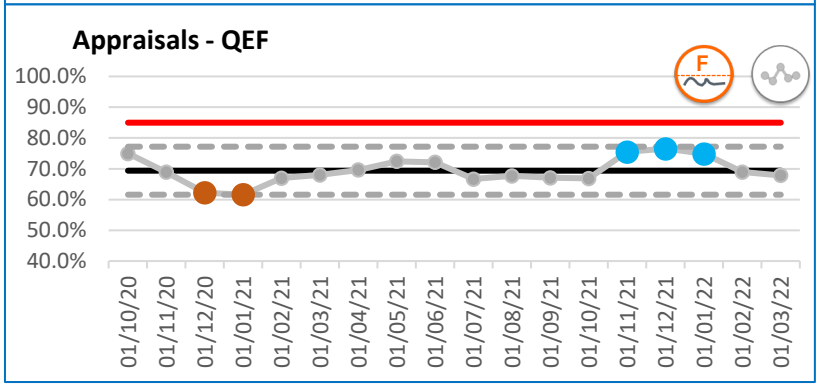
Detail on this measure is included because the target is consistently not met

Gateshead Health NHS Foundation Trust

Well Led







Situation
Appraisal compliance consistently fails the 85% target, with this target not being achieved during the past 18 months.

Background
Rates of Appraisal in operational business units remain at a lower compliance than corporate services, with Ward based services such as Medicine and Surgery having the lowest rates of appraisal compliance.

Assessment
Compliance rates are monitored via ESR and reported to business units as part of the suite of workforce metrics that are produced. Current compliance is 61.8% against an 85% target. Services remain under significant pressures from staffing, however work to improve compliance continues, with support from the POD teams.

Actions
POD continue reporting monthly to line managers, with the aim of reducing the volume of information, and include additional data about appraisals due in the next 90 days. The aim is to encourage managers to make realistic plans for the coming months. Work continues to provide support by updating ESR on behalf of managers and the new Education, Learning & Development Group, which has now been established, will oversee a wider review of the process, with an aim to launch a new document and process by the end of July 2022.

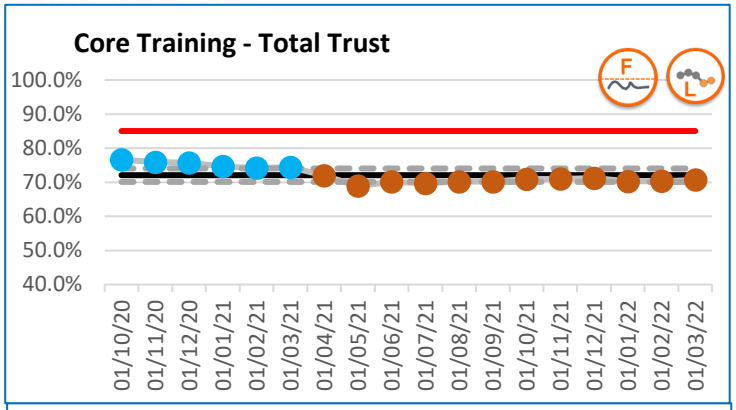
Recommendation
Review, management and oversight at Senior Leadership Team and continued management by operational teams.

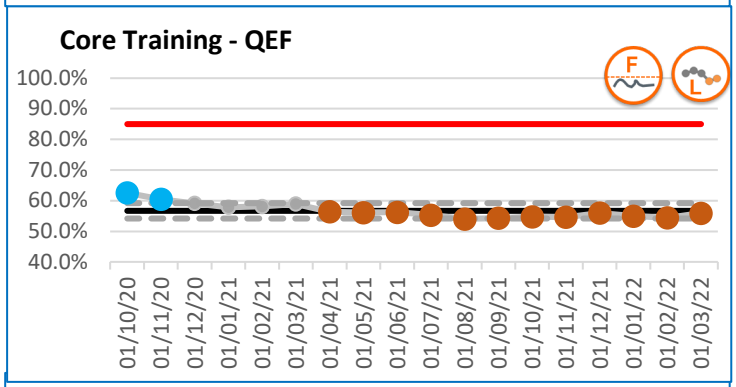
Report by exception: Well led – Core training

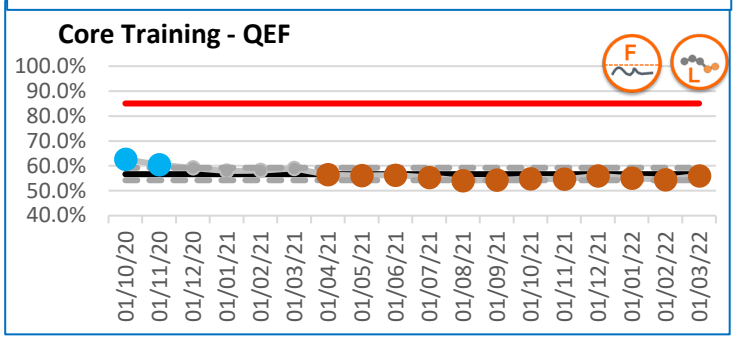
Gateshead Health NHS Foundation Trust

Detail on this measure is included because the target is no longer being met and special cause variation indicates a shift in performance.

Well Led







Situation

A shift in core skills compliance is observed from April 2021 with special cause variation (deterioration) triggering with the latest twelve months below the 18 month mean.

QEH and QEF figures are both currently triggering special cause deterioration. The indicator is flagging to consistently fail the target based on current performance and monthly variation.

Background

Core training covers those programmes which are recognised as core or essential training for all employees. However the need to respond to the significant demands on staff and services as a result of the pandemic and recovery, has meant this was not as high a priority in some services. In addition it was necessary to cancel attendance at a number of taught core skills courses; capacity on taught courses is still reduced as a result of social distancing measures; and difficulties to source other suitable accommodation. This inevitably affects capacity to improve certain core skills performance.

Assessment

Current compliance is at 70.7% against an 85% target

Actions

A core skills review is nearly complete, which will ensure that the training aligned to staff is appropriate.

Recovery plans have been requested for business units to ensure there is plan to improve compliance. This project will be overseen by the newly formed Education, Learning & Development Group and will include BU recovery planning in partnership with POD Leads. As social distancing measures have been reviewed within the trust, face to face teaching can increase where required and this will support an increase in compliance.

Recommendation

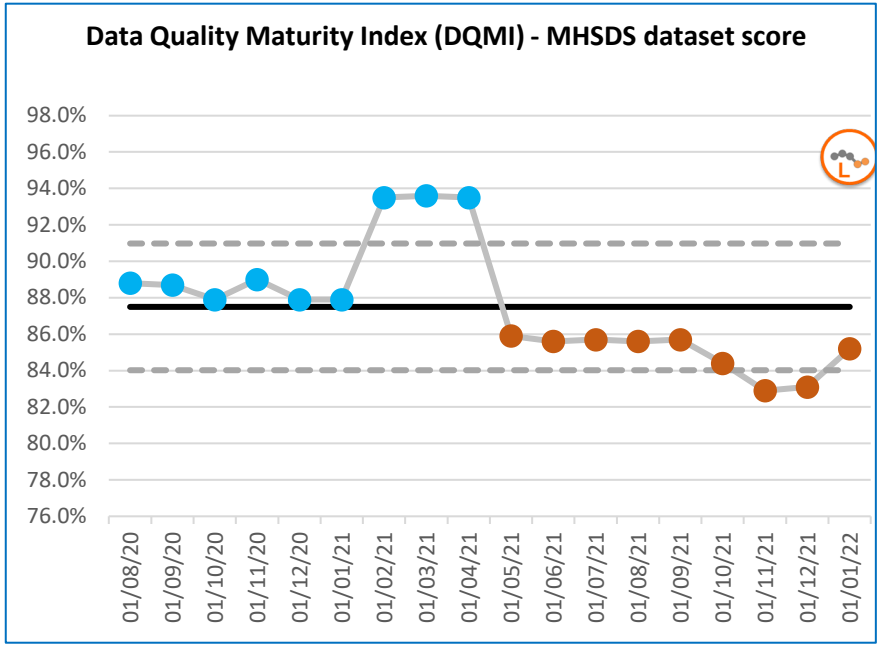
Review, management and oversight at Senior Leadership Team and continued management by operational teams.

Report by exception: Well led – Data Quality Maturity Index (Mental Health Services Dataset)

Gateshead Health NHS Foundation Trust

Detail on this measure is included because special cause variation indicates a shift in performance.

Well Led



Situation

A shift in the data quality maturity index for Mental Health Services Data Set observed from May 2021 with special cause variation (deterioration) triggering with the latest nine months below the 18 month mean.

Background

The Data Quality Maturity Index (DQMI) for the Mental Health Services Dataset is a monthly publication intended to highlight the importance of data quality in the NHS. It provides the Trust with timely and transparent information about their data quality.

Assessment

The current DQMI score is 85.2% for the most recent available data (January 2021).

The remedial actions below have been introduced however will not be visible until the March publication

- Investigation identified that for a number if records the 'Primary Referral Reason' field was missing at the time of the original submission. This data is now populated and is being submitted retrospectively to improve the Trust's score.
- There may be potential to improve the 'Activity Type Location Code' within the dataset. This again could improve the Trusts score if any missing data can be sourced. Resubmissions can be made for any records dated October 2021 to March-22

Actions

- Resubmission of records where the data is now available
- Investigate further opportunities to improve the Trusts score and resubmit where possible.
- As part of a review of the Single Point of Access review, to clarify the process with the admin team to ensure that the primary referral reason is captured.

Recommendation

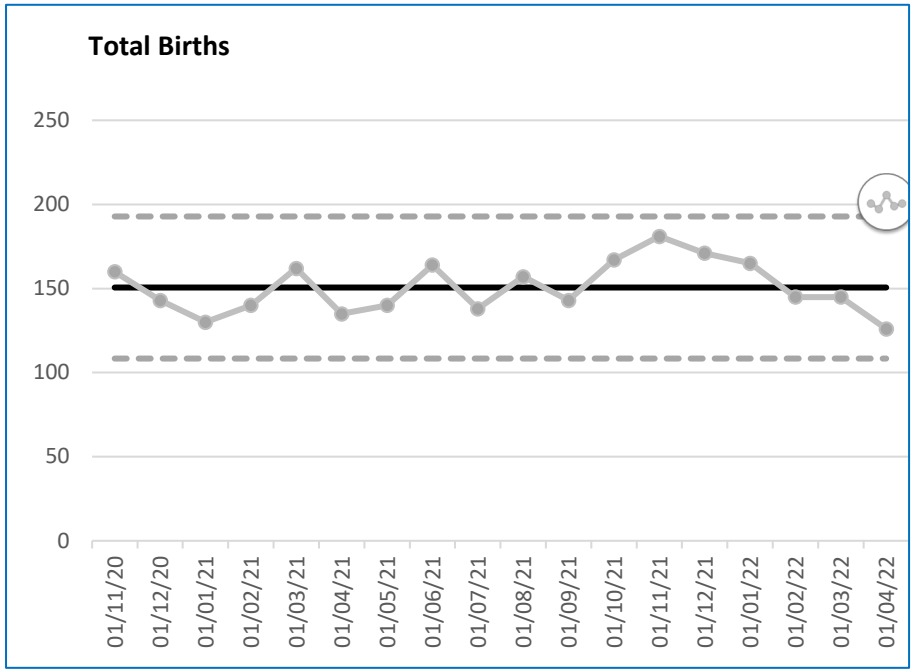
To review the score following the actions above.

Report by exception: Maternity – Total births

Detail on this measure is included because the target will either be achieved or failed based on variation within the performance.

Gateshead Health NHS Foundation Trust

Maternity



Combined impact analysis

Financial impact

Quality impact

Workforce impact

Operational performance impact

Situation Common cause variation displayed
126 births in April represents birth rates within expected range.

Background
The birth thresholds are used to monitor staffing ratios on the delivery suite and the capacity of the unit. Birth rates consistently above 170 would flag a significant increase and a review of staffing levels would be required.

Assessment

The variation in total number of births shows common cause variation and does not indicate a sustained increase in births, however the comparison with the 20/21 number of births which was 1757 and the 21/22 total births which was 1848 shows a 5% increase. The increase in acuity continues to have a significant impact on the input required from the Obstetric, midwifery and Anaesthetic teams, due to increased levels of intervention.

Actions
The acuity of mothers is recorded on a four hourly basis on the delivery suite and postnatal ward. This is reviewed daily and weekly and informs the HOM staffing review and report to the Chief Nurse.

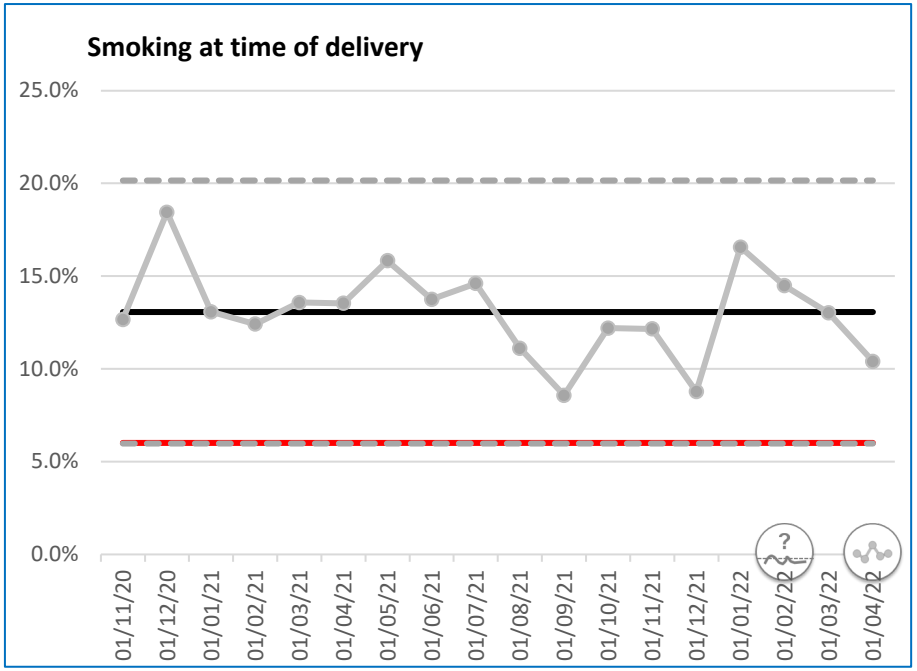
Recommendation
Continue to monitor intervention rates and discuss whether additional medical/theatre staffing is required. There are added pressures due to covid sickness absence as with all staffing.

Report by exception: Maternity – Smoking at time of delivery

Detail on this measure is included because the target will either be achieved or failed based on variation within the performance.

Gateshead Health NHS Foundation Trust

Maternity



Combined impact analysis

Financial impact

Quality impact

Workforce impact

Operational performance impact

Situation Common cause variation is displayed
The target has not been achieved in the last 18 months
Current performance of 10.4% is above the Trust target.

Background
Strategic/LTP aim to achieve 5% or less women tobacco dependant at time of birth by 2025.
Embed enhanced stop smoking support and NRT as per ambitions of the NHS LTP through maternity provision. Support and enhance the ICS Tobacco Dependency in Pregnancy pathway to maximise support to those with highest health inequalities.

Lead Midwife and MSW in post to target mothers who smoke and their partners in high risk clinics in WHC.

Improvement seen in CO monitoring at booking and 36 weeks following pathway lauch

Assessment
Working towards compliance with Saving Babies Lives Care bundle and compliance with MIS year 4 which includes access to smoking referral pathways and improved training and dedicated smoking cessation leads. Public health action plan agreed with NENC/ICS leads. 20/21 overall performance 13.52% and 21/22 overall performance at the end of the financial year 12.99%.

Monthly reporting of CO monitoring shows month on improvement.

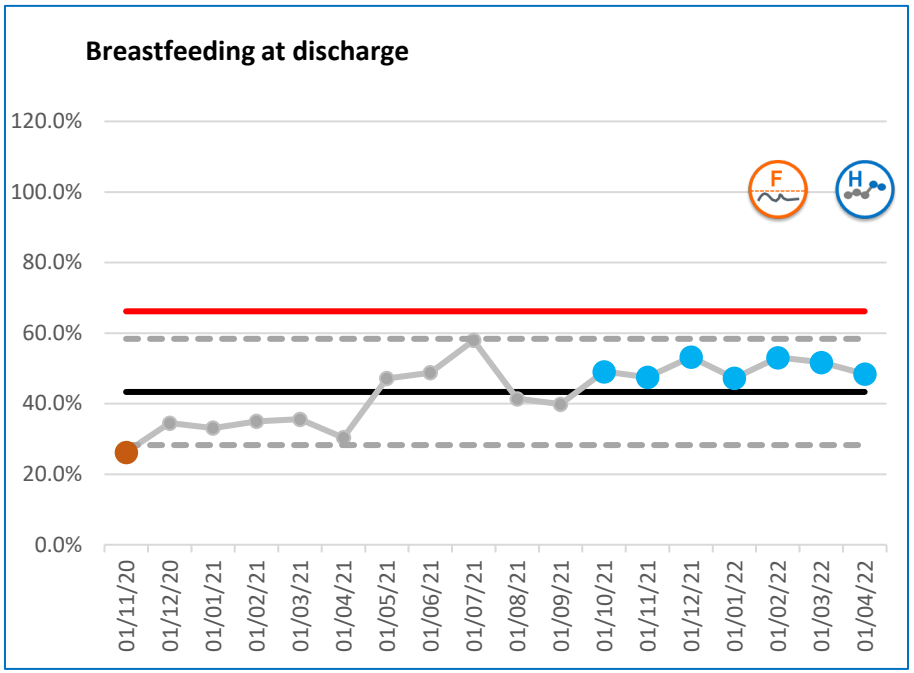
Recommendation
PH plans in place to address KPI's

Report by exception: Maternity – Breastfeeding at discharge

Detail on this measure is included because the target will be consistentlyfailed based on variation within the performance.

Gateshead Health NHS Foundation Trust

Maternity



Combined impact analysis

Financial impact

Quality impact

Workforce impact

Operational performance impact

Situation

Better Births (2016), the Maternity Transformation Programme and the NHS Long Term Plan (2019) highlight the importance and benefits of breastfeeding. There is a regional breastfeeding target to achieve of 72% by 2025, currently the department initiation rate 48.0% in April 2022.

Background

As part of the NHS's ongoing vision to improve postnatal care, the Long Term Plan includes a commitment to support maternity services to deliver an accredited, evidence-based infant feeding programme (such as the UNICEF UK Baby Friendly Initiative.)
The targets are set as:
100% of units at UNICEF level 2 by 2020
100% of units at UNICEF level 3 by 2025

Assessment

Gateshead Health NHS Foundation Trust is accredited at Level 1 and is eligible for Level 2 support: accreditation assessment costs and additional support. UNICEF Breastfeeding & Relationship Building Course facilitated - March, meetings in progress to discuss commencing the relevant UNICEF audits.

The maternity infant feeding guidelines were assessed as part UNICEF stage 1 accreditation in September 2019 and will be due to be reviewed again in the summer. SCBU planning for level 1 accreditation will start with review of infant feeding guidelines to review.

Actions

Monthly face to face UNICEF staff training and Practical Skills Review's re-commenced from October 2021.
Planning meeting arranged with Unicef 28 June 2022
Working towards stage 2 accreditation July 22.
Part of regional maternal breast milk in preterm infants QI group

Recommendation

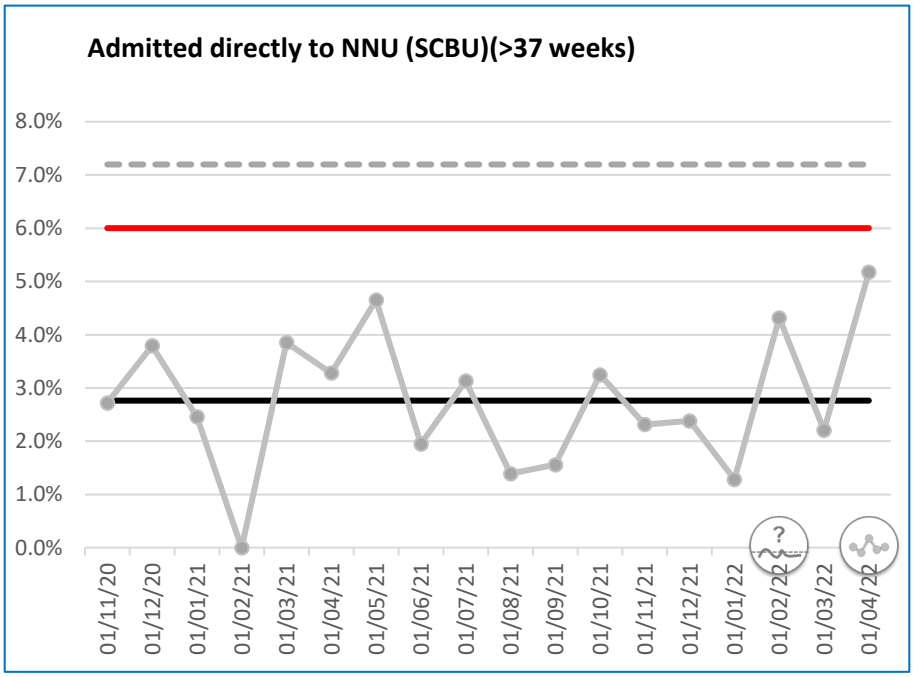
There will always be some mothers who do not continue to fully breast feed for various reasons. A full review of target indicators will be part of Maternity Sub group reporting and benchmarked regionally with the NENC Infant feeding leads.

Report by exception: Maternity – Admitted directly to NNU >37 weeks

Detail on this measure is included because the target will either be achieved or failed based on variation within the performance.

Gateshead Health NHS Foundation Trust

Maternity



Combined impact analysis

Financial impact

Quality impact

Workforce impact

Operational performance impact

Situation Common cause variation displayed
The target has been achieved for every month in the last 18 months .
Current performance of 5.2% represents an achievement of the Trust target. End of financial year total 2.6% performance well below target.
On target to achieve Year 4 MIS safety action.

Background
Our transitional care model enables babies who would have once been admitted to SCBU to remain with their mothers and be supported on the postnatal ward with input from the Neonatal nurse practitioners and maternity support workers. This reduces SCBU admissions and enables mother and baby bonding.

Assessment
KPI set at 6% for direct term admissions to SCBU by NE&Y Regional Perinatal Quality Oversight Group. Local dashboard amended to reflect this and targets continue to be met.

Actions
Quarterly audit of all term admissions ongoing and themes and trends reviewed at Perinatal Mortality meeting.
This KPI is also reported as compliance with Safety Action 3 of MIS year 4 and the Maternity service declared compliance with Year 3 in July 2021.
Working towards Year 4 and on target for compliance.

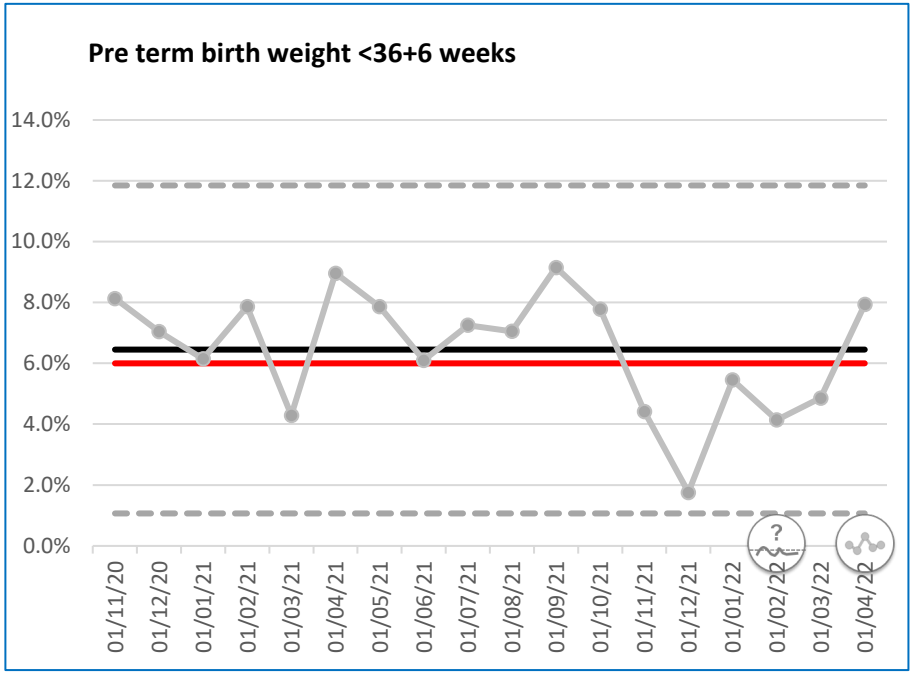
Recommendation
Review of transitional care staffing and succession planning for development of the ANNP role as without this the model will not function. Quarterly audit of term admissions to be reported on IOR as exception.

Report by exception: Maternity – Pre term birth rate <36+6 weeks

Detail on this measure is included because the target will either be achieved or failed based on variation within the performance.

Gateshead Health NHS Foundation Trust

Maternity



Combined impact analysis

Financial impact

Quality impact

Workforce impact

Operational performance impact

Situation Common cause variation displayed
The target has been achieved in six of the last eighteen months.

Current performance of 7.9% represents a fail of the Trust target.

Background
The DoH report "Safer Maternity Care" (2017) set a target to reduce the national rate of pre-term birth from 8% to 6%

Assessment
Data capture of any pre-term births (definition; delivery prior to **37 weeks gestation) is monitored and reported. This has been added to the clinical dashboard.**

Actions
Engagement with regional preterm birth network including allocated funding to provide specialist pre-term birth clinic – metrics to be reported to NENC LMNS
Engagement with MatNeoSIP national pre-term birth optimisation pathway
Implementation of Saving Babies Lives v2 care bundle (element 5 relates to preterm birth)
Trust preterm birth quarterly meetings commenced, lead midwife & HCA in post & additional fetal fibronectin machine to be purchased utilising LMNS funding
Recommendation
Continue to engage & monitor outcomes following full implementation of these work streams. Reported to the Neonatal Network.
Need to identify funding for sonographer to support preterm birth pathway

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 14i

Report Title:	**Annual Nurse Staffing Capacity and Capability Report**			
Name of Meeting:	Board of Directors			
Date of Meeting:	Wednesday 25th May 2022			
Author:	Gill Findley, Chief Nurse			
Executive Sponsor:	Gill Findley, Chief Nurse			
Report presented by:	Karen Roberts, Deputy Director of Nursing			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
	This report provides the required annual assurance that nurse staffing levels have been evaluated and assessed using a nationally agreed staffing measurement tool. The paper gives an assessment of the staffing establishment against the tool and provides assurance that the Trust is meeting the requirements for a safe staffing establishment. This paper should be read in conjunction with the monthly staffing exception reports, which demonstrate areas where teams have been unable to fill shifts to this set level of establishment.			
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*	No previous consideration, but it will also be discussed at Quality Governance Committee			
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 Chief matrons and Deputy Director of Nursing have reviewed the staffing establishments for the acute medical wards and emergency assessment areas using the safer nursing care staffing tool (SNCT). The SNCT is a recognised, evidence based tool approved by the National Institute for Health and Care Excellence for calculating staffing establishments. The use of SNCT has shown that the majority of wards have an appropriate level of staffing when all posts have been recruited to. The wards are feeling ongoing pressure			

	due to supply gaps, short and long term sickness and covid isolation. A review of headroom for staff absences has been undertaken and it is recommended that this increases to 23%. A separate business case will be presented to SMT to cover this change. The Trust is taking part in the testing for a tool for emergency department staffing and for community nursing. Once these data are available a paper will be presented to the Board of Directors for those areas. The next SNCT review is due to start in June 2022 and continues on a 6 monthly cycle.				
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	The Board of Directors is asked to note that completion of the Safer Nursing Care Staffing tool for the acute wards and Emergency Assessment unit and that the majority of wards are have an appropriately funded establishment. A business case will be presented to SMT for any required changes.				
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:	*List corporate objective reference and headline – e.g. 1.4 Maximise the use of Nervecentre to improve patient care*				
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)	POD 2764 - Workforce - Risk of not having the right people in right place at the right time with the right skills. (16)				
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒		

Gateshead Health NHS Foundation Trust

Nurse Staffing SNCT Review

1. Introduction

This detailed report provides a comprehensive review of nurse staffing for Gateshead Health NHS Foundation Trust. It is in line with the requirements set out by the National Quality Board (NQB): *Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time- safe, sustainable and productive staffing* (July 2016).

This guidance is supported by a further publication from NHSI *'Developing Workforce Safeguards: Supporting providers to deliver high quality care through safe and effective staffing'* which was published in October 2018. It supports providers to use best practice in effective staff deployment and workforce planning.

A detailed review of nursing and midwifery staffing led by the Chief Nurse, the Clinical Lead for Healthroster, Information Analyst, Business Unit Finance partner and Chief Matron took place in January 2022 for the acute inpatient areas.

2. Right Staffing

National guidance recommends that inpatient ward staffing is determined using evidence-based workforce planning. The Trust has an embedded review process for nurse staffing establishment for acute inpatient wards which are undertaken utilising the following:

- NQB/NICE guidance
- Safer Nursing Care Tool (SNCT) - a NICE endorsed evidence-based tool, which uses acuity and dependency to support workforce planning
- Quality indicators
- Professional judgement
- Review of agreed staffing levels and establishment

This process triangulates the evidenced based methodology (SNCT) with professional judgement of experienced ward managers, matrons, and chief matrons to ensure wards are safely staffed and that the skill mix is balanced. The triangulation also includes patient safety data and adjustments for the care environment.

3. Safer Nursing Care Tool

The SNCT is a NICE endorsed evidence-based tool, which uses acuity and dependency to support workforce planning. Originally developed by the Association of United Kingdom University Hospitals (AUKUH), it is now hosted by and endorsed by the Shelford Group. SNCT has been endorsement by NICE since 2014 acknowledging that it meets the requirements set out in the NICE guideline "Safe staffing for adult in-patient wards" (NICE, 2014).

The Developing Workforce Safeguards (NHSI, 2018) guidance states that to use SNCT, the Trust must sign a license to ensure the tool is used appropriately and is free from local manipulation. There is also a requirement to evidence compliance with this guidance as part of the Trust single oversight framework submission.

Gateshead Health NHS FT has secured the Shelford group SNCT licence and senior nurses involved in this review have been trained in the inter-rater reliability assessment process.

In addition to the methodology from the SNCT, Gateshead's system enables staff to input data and present the results in graphical and numerical form for each ward (appendix 1 and 2). The uplift figure (for annual leave (13%), sickness cover (4%), training (4%) equating to 21% is then added to the required numbers to set the final establishment). When setting establishments the SNCT tool assumes headroom of 22%, whereas the Trust currently applies 21% for in-patient areas. For comparison an uplift of 23% has also been applied for in-patient

wards and 25% for EAU. This means for EAU, the SNCT comparator used in the Trust aligns to our establishment uplift but may generate a slightly higher figure. This is well known and understood and is not viewed as a risk as SNCT metrics are always triangulated in conjunction with professional judgement and other safe staffing metrics, and patient outcomes to inform establishment setting.

The Ward Manager supervisory time is also included within this headroom calculation. We ask Ward managers to take the lead in the following areas:

- Sickness reviews
- Appraisals
- Oversee core skills delivery
- Ensure daily ward checks and audits are carried out
- Manage budgets
- Prepare rotas to ensure adequate cover
- Manage gaps in staffing
- Recruit
- Oversee quality and safety
- Do exit interviews
- Manage day to day issues on ward
- Have H&WB conversations
- Offer staff support
- Carry out ward and board rounds
- Along with all of the other tasks that comes with managing a ward like ensuring high quality effective care

The ward managers nominally have 1 day per week allocated to complete this work. This is insufficient time and currently most of the Ward Managers are working clinically to cover unfilled shifts. A discussion paper and business case will be brought to SMT for discussion in the next few months.

For one week each month every ward collects SNCT data, which involves scoring each patient to an acuity and dependency care level. Staffing multipliers are applied at each acuity and dependency care level. These multipliers factor in nursing time spent on:

- Direct and indirect care
- Ward management
- Education/training
- Staff performance review
- Staff breaks
- Associated work such as administration and clerical
- Bed occupancy

These results are then considered alongside the current establishments and nurse quality indicators.

4. Collaborative Approach to Safer Staffing

Staffing review meetings were held with ward sister/charge nurses, matrons and chief matrons to review a range of information that included the previously agreed staffing levels in 2019, SNCT data and quality indicators. The meetings involved detailed discussions and challenge to enable robust decisions to be made regarding staffing levels moving forward. Meetings were then held with the Chief Nurse and Deputy Director of Nursing, Midwifery and Quality and Chief Matrons to finalise the staffing levels to ensure the continuity of safe patient care.

As part of the review, once any new staffing levels are identified the required establishments are calculated and compared to the current funded establishments to determine whether any adjustments to skill mix and funding are required. Where this is the case a business case will be produced.

a. Acute medical inpatient wards

The agreed staffing levels are detailed in appendix 1 for each medical inpatient ward along with the SNCT data. The staffing levels have been set using the described methodology and are based on the ratio of 1:8 qualified nurse to patient (plus the co-ordinator for an early shift) and a ratio of 1:8 for the late shift; the ratio for EAU is 1:4.

b. Surgical wards

The agreed staffing levels for the surgical units are shown at appendix 2. The staffing levels have been discussed with the ward managers and Chief Matron. The only area of concern is ward 27 where the funded establishment is consistently less than the staffing suggested by the SNCT. This could be because the CEV patients are currently housed on this ward and are more complex than the usual caseload. It is suggested that this ward is given a temporary uplift until the position for CEV patients is resolved.

Improving recruitment and retention among the nursing workforce is a local priority for Gateshead Health NHS Foundation. A Recruitment Council has been established to maintain a focus in this area and chaired by the Head of Nursing. It should be noted that despite ongoing and continued recruitment, there are still a significant number of vacancies. It has therefore been difficult for staff to experience their wards with all posts fully recruited.

5. Capability and Quality

It is important for any staffing review to take into consideration the quality of the care provided, patient experience and capability of the work force as well as the capacity. The appendices provide a breakdown by ward of the following information:

- Patient experience – the Friends and Family Test
- Patient Experience- Your care your voice (Oct 2020)
- Percentage of harm free care – the Safety Thermometer
- Patient safety incident (excl. community acquired pressure damage)
- Validated Category 2 Pressure Damage (Monthly Average
- Staffing Incidents (insufficient nurses)
- Falls
- Complaints
- Medication errors

NHSI and NQB guidance indicate that Trusts must ensure that three components are used in safe staffing processes: evidence-based tools (where they exist), professional judgement and outcomes. The Trust provides a monthly staffing report to board where wards reporting less than an 75%-day RN fill rate in month are consider as an exception and undergo a review. Any area of concern has been reported to the board.

In line with planned levels of staffing on a shift-by-shift basis both planned and actual nurse staffing levels are publicly displayed on all wards across the Trust.

All nurse staffing issues on the risks register are regularly reviewed and staffing incidents are review by matrons and at the Nursing and Midwifery Professional Forum.

6. Developing Workforce Safeguards Guidance

NHSI *'Developing Workforce Safeguards'* was published by NHSI in October 2018 to support organisations to use best practice in effective staff deployment and workforce planning. It offers advice on governance issues related to redesigning roles and responding to unplanned changes in workforce and describes NHSI's role in helping providers achieve high quality, sustainable care by assessing the effectiveness of workforce safeguards annually, which includes new recommendations on workforce safeguards to strengthen the commitment to safe, high-quality care in the current climate.

NHSE/I will assess Trusts' compliance with the 'triangulated approach' to deciding staffing requirements described in National Quality Board (NQB) guidance. This includes the requirement to complete a Quality Impact Assessment (QIA) for all skill mix changes across the workforce. NHSI will measure compliance using information collected through the Single Oversight Framework (SOF) and will also ask Trusts to include a specific workforce statement in their annual governance statement.

From a nursing and midwifery perspective, all the required data is available to inform board reporting and provide assurance to the Board that we are meeting the standards and recommendations. As a Trust we have assessed ourselves against the recommendations of the workforce safeguards to understand our current level of assurance and we report we are fully compliant and have relevant policies in place.

7. Conclusion

Due to the COVID 19 pandemic this has been another unprecedented year for the NHS, however we have also maintained a focus on ensuring the safe levels of staffing for our patients. This report provides assurance to the Board on staffing capacity planning and capability. It provides a clear methodology for agreeing nursing staffing numbers and establishments. It provides information on the agreed number of staff needed on a shift-by-shift basis on each ward and meets the requirement set out in expectations set out by the NQB and provides assurance that the Trust has robust systems in place to safeguard the quality of care provided to patients.

Following their review, for the medical business unit, most ward managers concluded the planned staffing levels for their ward areas were correct once the teams were fully established. The exception to this was Ward 11, (gastro) the ward manager felt the need for three qualified nurses on night shift (i.e. one additional Registered Nurse) to support this difficult client group, however, the SNCT data would suggest an HCA is required. The Care of the Elderly (COTE) ward managers agreed their ward areas would benefit from an extra HCA on a late shift/ long day. All ward managers agreed it would be beneficial to repeat this review in 6 months' time after achieving their planned establishment as per the operational plan. The proposal would be to leave the establishment as is and review in 6 months, once the recruitment and supply issues have hopefully eased.

For the surgical wards, there was a similar response that the main aim should be to recruit to all the vacant posts and reassess the staffing position in June 2022. The only exception to this is ward 27, where the CEV patients are currently housed. It is suggested that there is a temporary uplift of 2.0 WTE until the final arrangements for these patients are agreed.

This report will be published on the Trust website for our patients and the public.

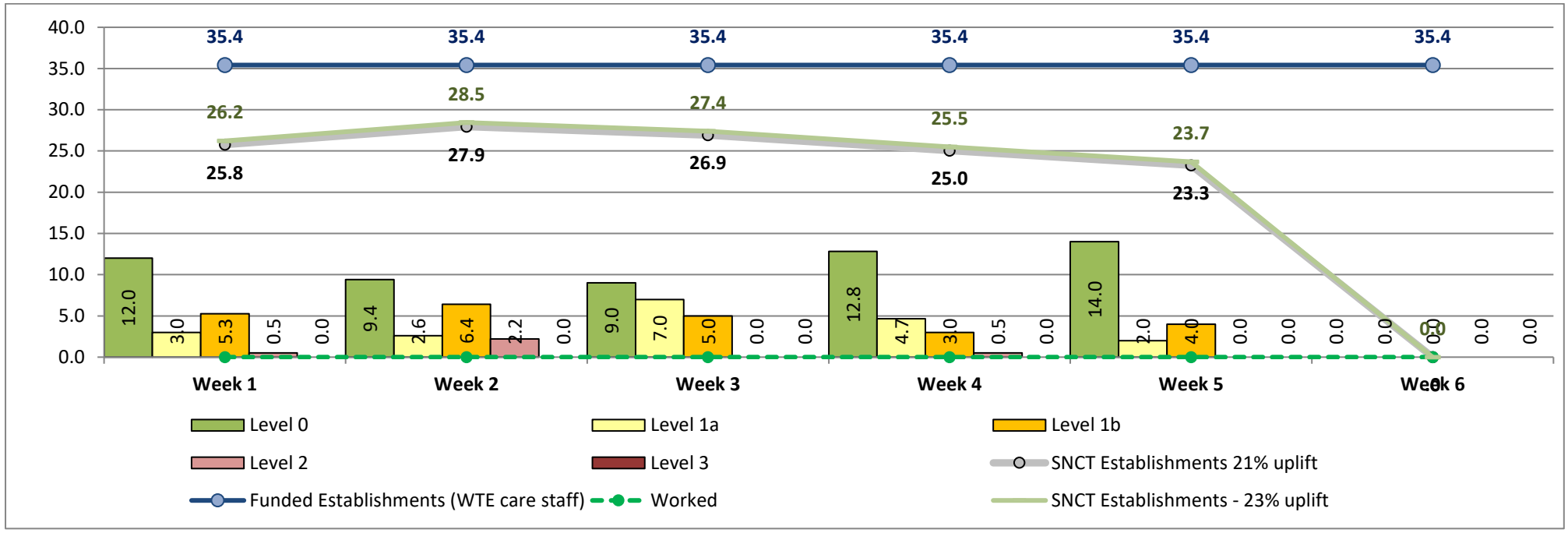
8. Recommendations

The Board is asked to receive this report for information and assurance.

Appendix 1 – Medical Wards Staffing Review

Ward 8 Cardiology

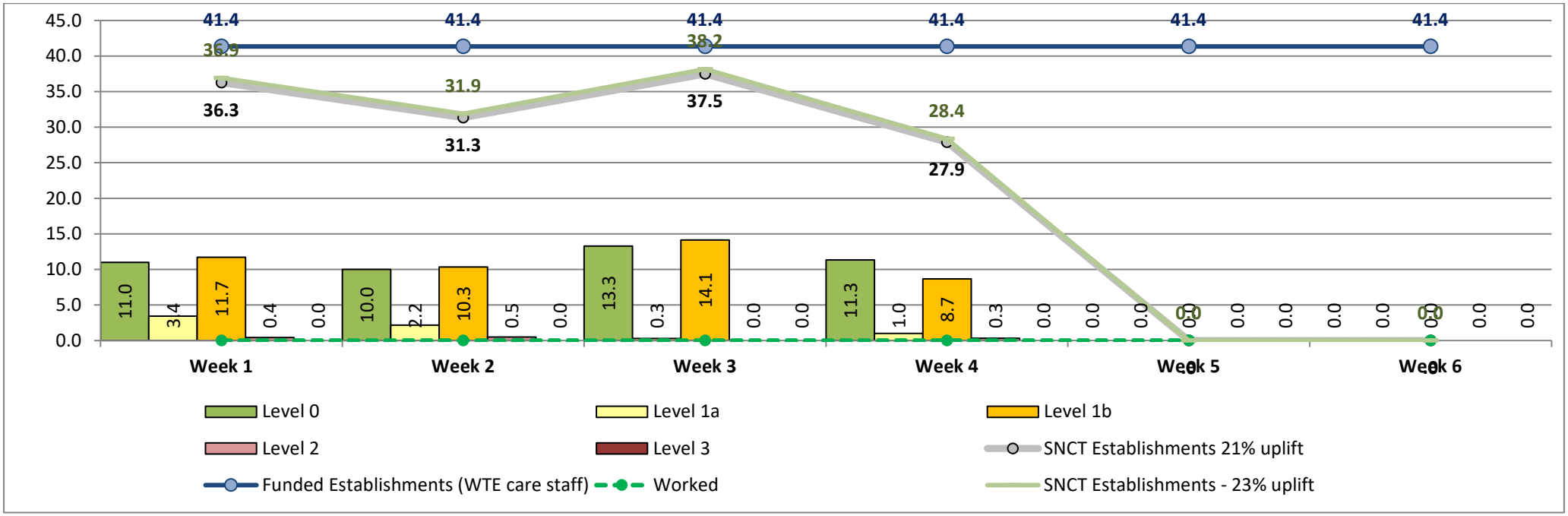
Number of Beds	Current Funded Establishment			Staffing Levels		
	Total	Qualified	Nursing Assistant	Early Q/NA	Late Q/NA	Night Q/NA
21	35.4	20.6	14.8	4 + 3	4 + 3	2 + 2
Comment: WTE Staff include specialist nurses and cover catheter lab and chest pain assessment services including 24hour cardiac arrest bleep cover. 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.						



Quality Outcomes April 2021- November 2021 -monthly average in (brackets)			
Friends and Family Test - Recommend Rate	100%	Staffing Incidents (insufficient nurses)	1
Your care your voice survey score (Oct 20)	100%	Falls (Monthly Average)	5
Patient safety incident (excl. community acquired pressure damage)	71 (9)	Complaints	4
Validated Category 2 Pressure Damage (Monthly Average)	1	Medication errors	11 (1)

Ward 9 Respiratory

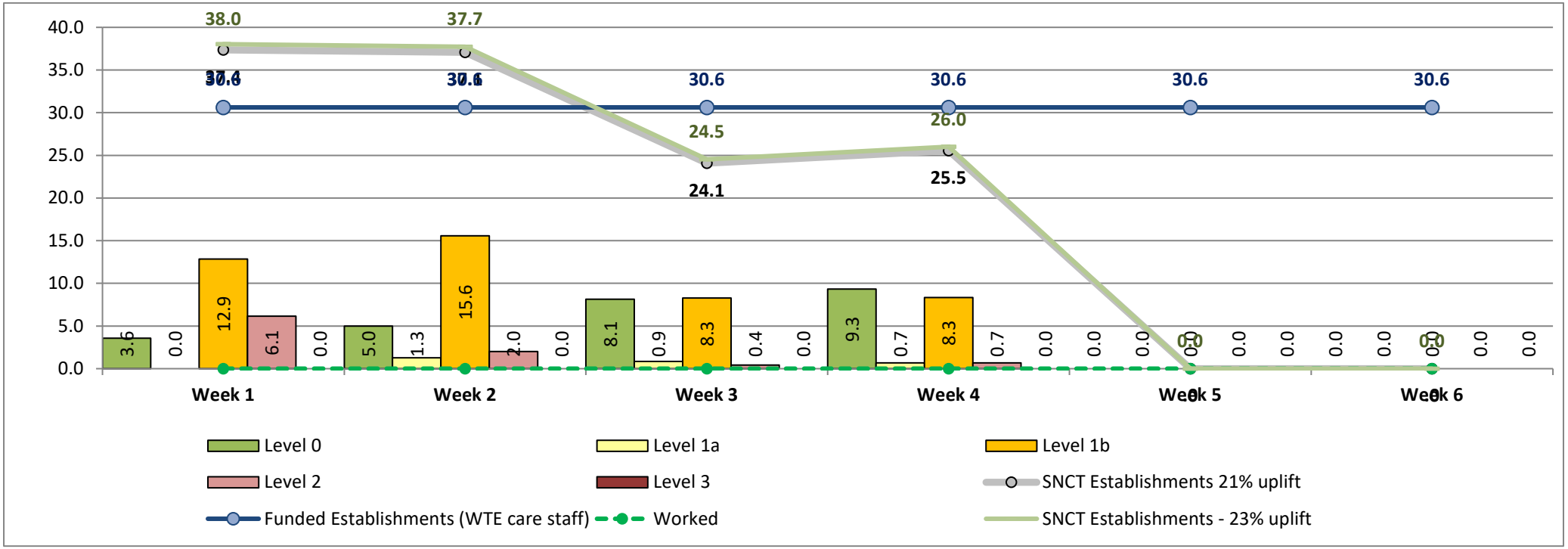
Number of Beds	Current Funded Establishment			Staffing Levels		
	Total	Qualified	Nursing Assistant	Early Q/NA	Late Q/NA	Night Q/NA
22	41.4	25.5	15.9	5/3	5/3	3+2



Quality Outcomes April 2021- November 2021 -monthly average in (brackets)			
Friends and Family Test - Recommend Rate	95%	Staffing Incidents	0
Your care your voice survey score (Oct 20)	97.6%	Falls (Monthly Average)	31 (4)
Patient safety incident (excl. community acquired pressure damage)	76 (10)	Complaints	2
Validated Category 2 Pressure Damage (Monthly Average)	3	Medication errors	6

Ward 10 Respiratory

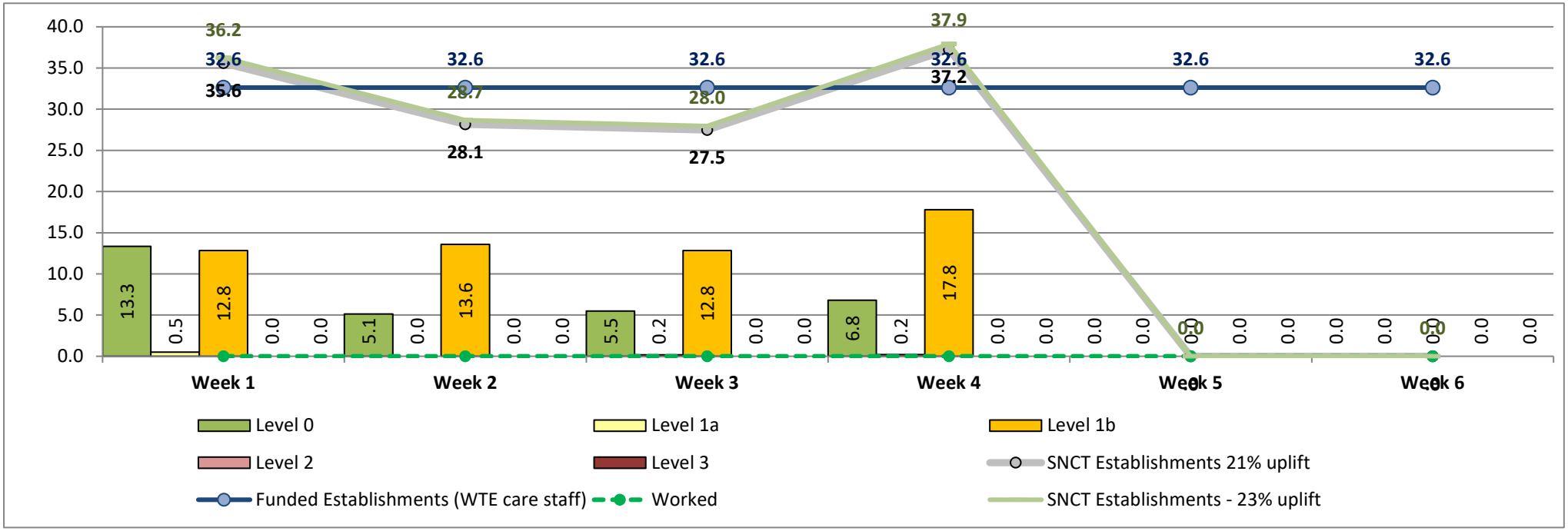
Number of Beds	Current Funded Establishment			Staffing Levels		
	Total	Qualified	Nursing Assistant	Early Q/NA	Late Q/NA	Night Q/NA
20	30.6	16.6	14	4 + 3	4 + 3	3 + 2 (Includes NIV nurse).
Comment: SNCT recommends an uplift of 1.0 wte to overall budget						



Quality Outcomes April 2021- November 2021 -monthly average in (brackets)			
Friends and Family Test - Recommend Rate	83.3%	Staffing Incidents (insufficient staff and nurses)	6
Your care your voice survey score (Oct 20)	-	Falls (Monthly Average)	45 (6)
Patient safety incident (excl. community acquired pressure damage)	88 (11)	Complaints	4
Validated Category 2 Pressure Damage (Monthly Average)	0	Medication errors	12 (2)

Ward 11 Gastroenterology

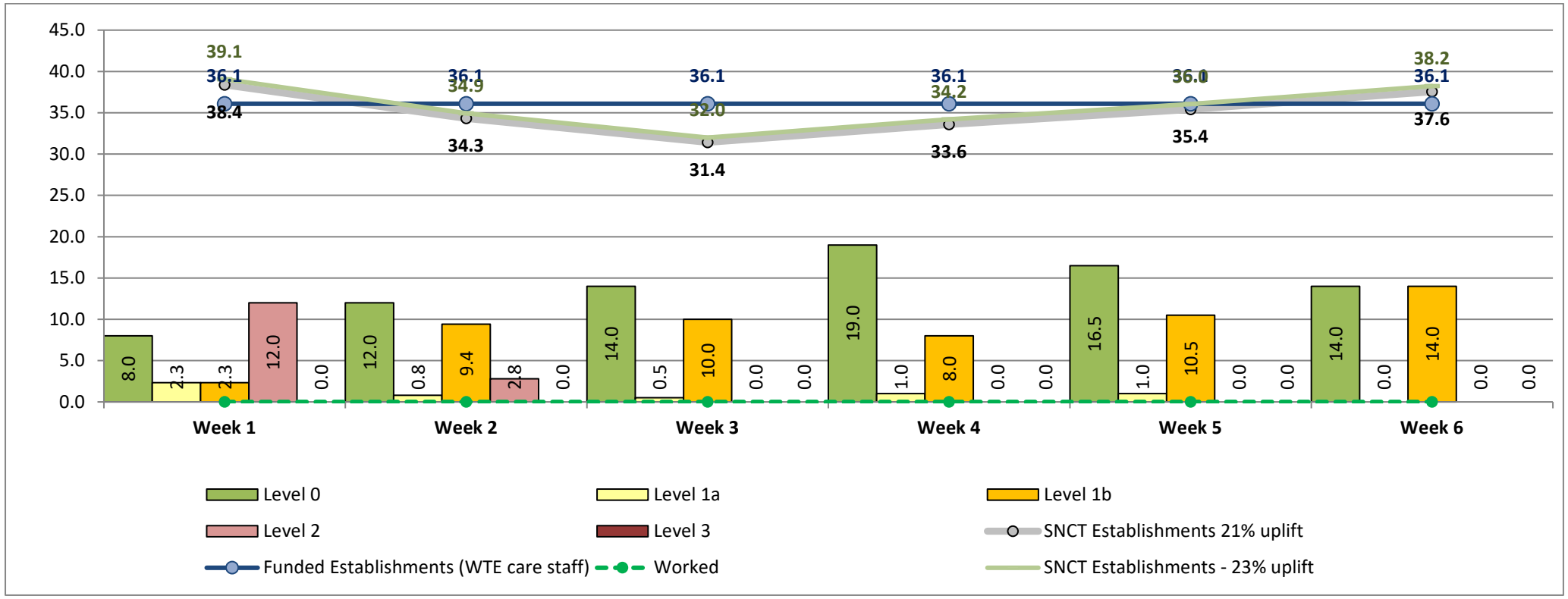
Number of Beds	Current Funded Establishment			Staffing Levels		
	Total	Qualified	Nursing Assistant	Early Q/NA	Late Q/NA	Night Q/NA
21	30.6	16.6	14	4/3	4/3	2/2
Comments: SNCT has identified seasonal variation June/Jan data sets, in general gastro patients tend to have higher acuity. Ideally ward manager would like to have 3Q on nights to support this client group however, the SNCT data below would suggest a HCA.						



Quality Outcomes April 2021- November 2021 -monthly average in (brackets)			
Friends and Family Test - Recommend Rate	91.7%	Staffing Incidents (insufficient nurses)	2
Your care your voice survey score (Oct 20)	94.4%	Falls (Monthly Average)	45 (6)
Patient safety incident (excl. community acquired pressure damage)	119 (15)	Complaints	4
Validated Category 2 Pressure Damage (Monthly Average)	0	Medication errors	15 (2)

Ward 12 General Medicine (Escalation)

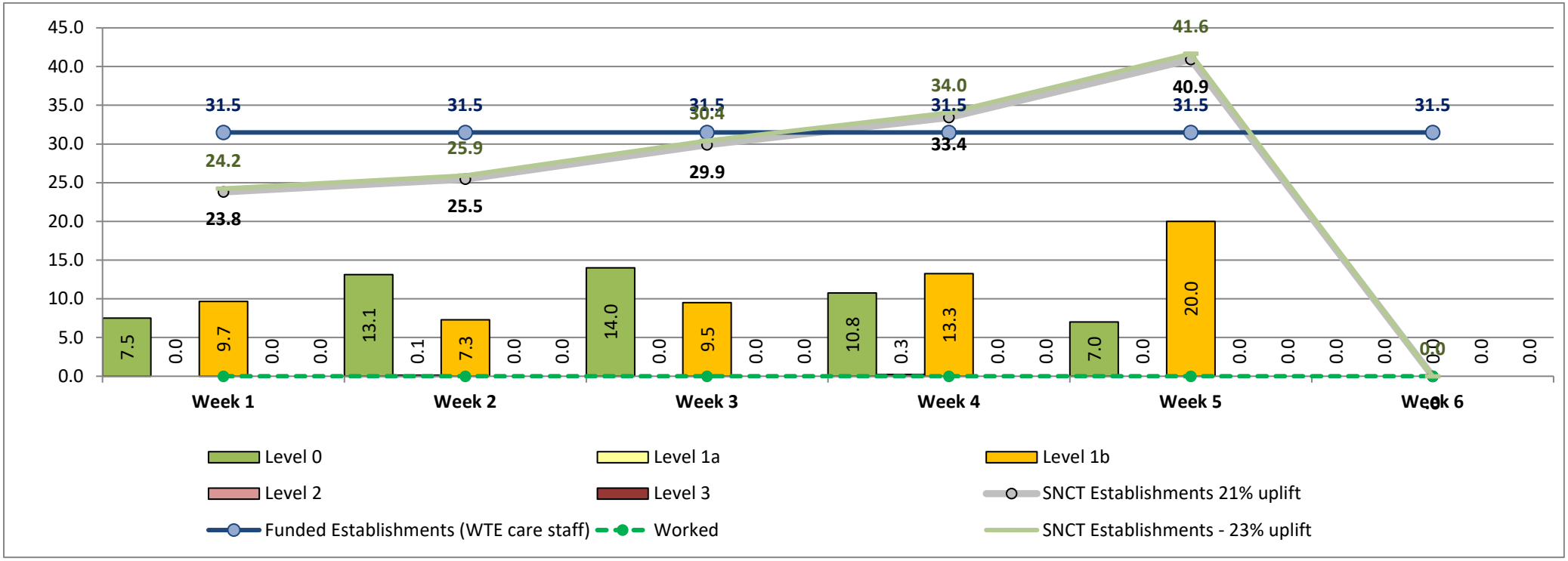
Number of Beds	Current Funded Establishment			Staffing Levels		
	Total	Qualified	Nursing Assistant	Early Q/NA	Late Q/NA	Night Q/NA
23	36.1	22.1	14	5/3	5/3	3/2
Comment: If all Q vacancies were filled the establishment would feel correct (from ward manager). The ward has been heavily reliant on bank and agency usage.						



Quality Outcomes April 2021- November 2021 -monthly average in (brackets)			
Friends and Family Test - Recommend Rate	91.7%	Staffing Incidents (insufficient staff and nurses)	2
Your care your voice survey score (Oct 20)	-	Falls (Monthly Average)	17 (2)
Patient safety incident (excl. community acquired pressure damage)	49 (6)	Complaints	0
Validated Category 2 Pressure Damage (Monthly Average)	1	Medication errors	5

Ward 14 General Medicine

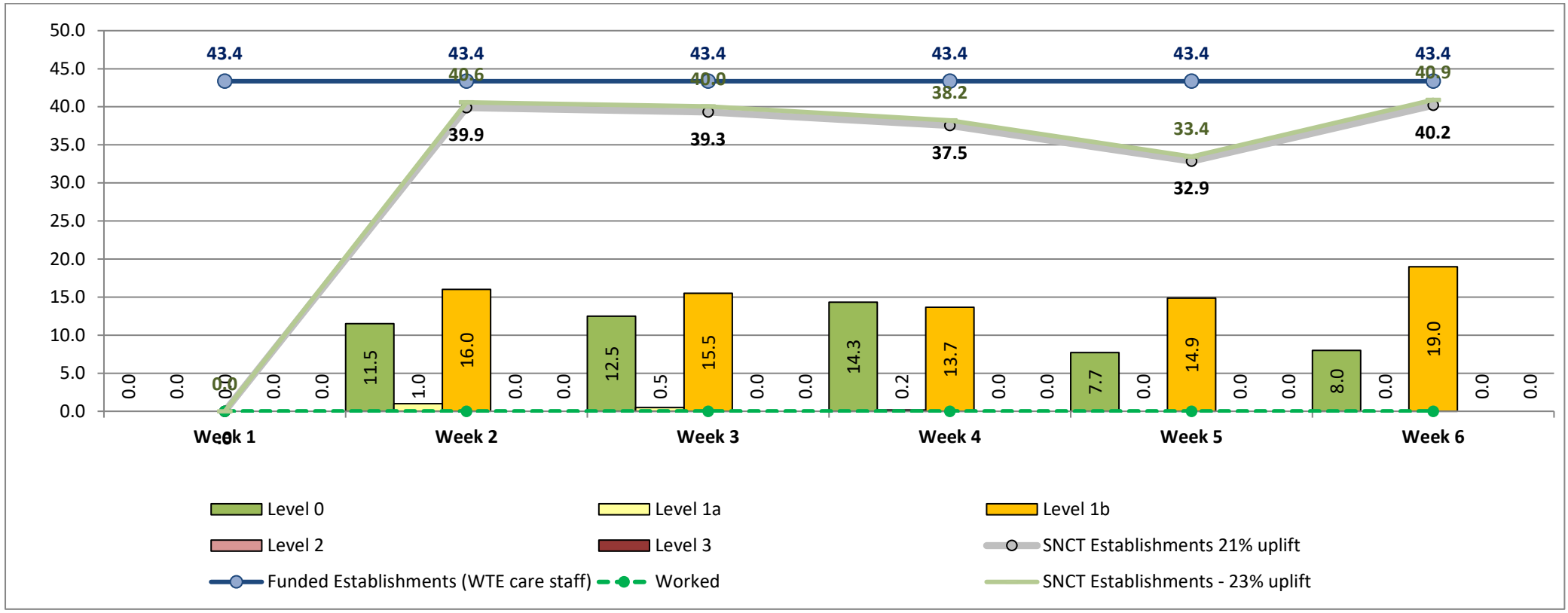
Number of Beds	Current Funded Establishment			Staffing Levels		
	Total	Qualified	Nursing Assistant	Early Q/NA	Late Q/NA	Night Q/NA
22	31.5	16.6	14	4/3	4/3	2/2
Comments: Ward currently working under establishment due to vacancy and sickness. According to Medway ward 14 has not been in escalation for full month of January and during this period there has been a slightly different patient case load due to covid.						



Quality Outcomes April 2021- November 2021 -monthly average in (brackets)			
Friends and Family Test - Recommend Rate	75%	Staffing Incidents	0
Your care your voice survey score (Oct 20)	-	Falls (Monthly Average)	54 (7)
Patient safety incident (excl. community acquired pressure damage)	95 (12)	Complaints	4
Validated Category 2 Pressure Damage (Monthly Average)	4	Medication errors	6

Ward 22 Care of the Elderly

Number of Beds	Current Funded Establishment			Staffing Levels		
	Total	Qualified	Nursing Assistant	Early Q/NA	Late Q/NA	Night Q/NA
29	43.4	22.1	19.45	5/4	4/4	2/3
Comments: Misconception lates are quieter than early shift, ward manager would prefer extra HCA or Q on late shift						

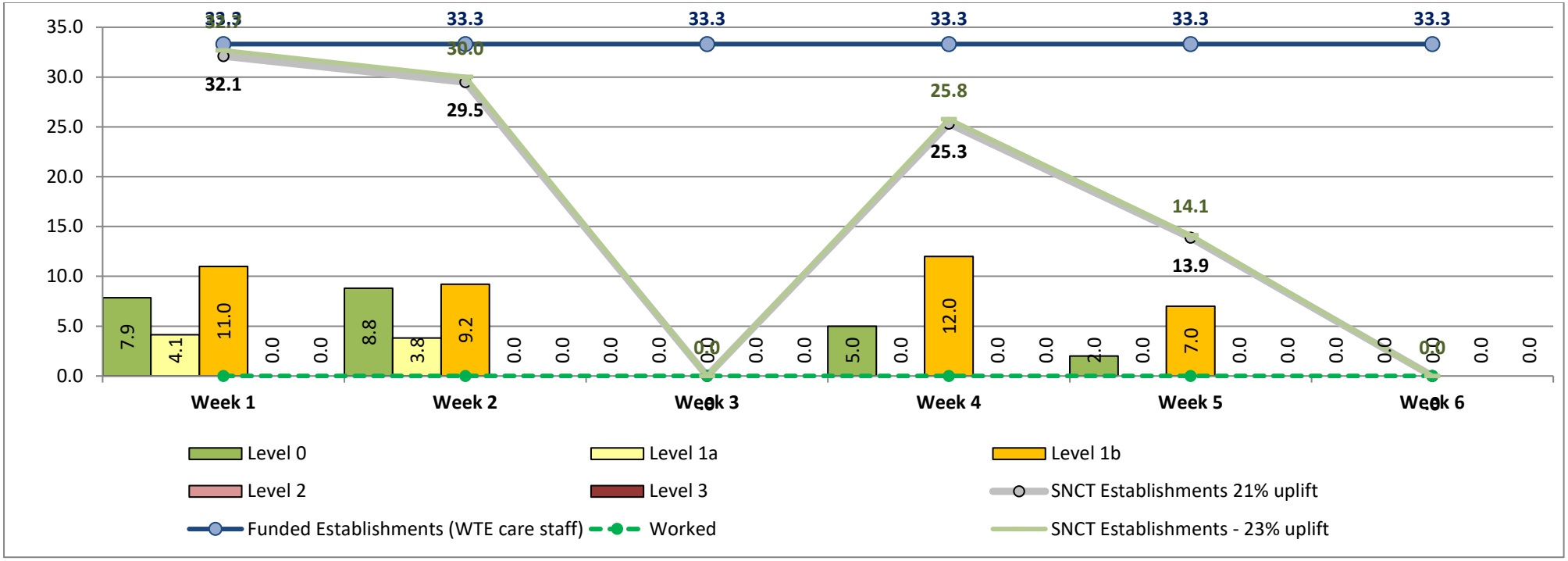


Quality Outcomes April 2021- November 2021 -monthly average in (brackets)			
Friends and Family Test - Recommend Rate	-	Staffing Incidents (insufficient nurses)	1
Your care your voice survey score (Oct 20)	94.7%	Falls (Monthly Average)	54 (7)
Patient safety incident (excl. community acquired pressure damage)	75 (9)	Complaints	3
Validated Category 2 Pressure Damage (Monthly Average)	0	Medication errors	4

Ward 23 Care of the Elderly

Number of Beds	Current Funded Establishment			Staffing Levels		
	Total	Qualified	Nursing Assistant	Early Q/NA	Late Q/NA	Night Q/NA
24	33.3	15.1	18.2	4/3	3/3	2/3

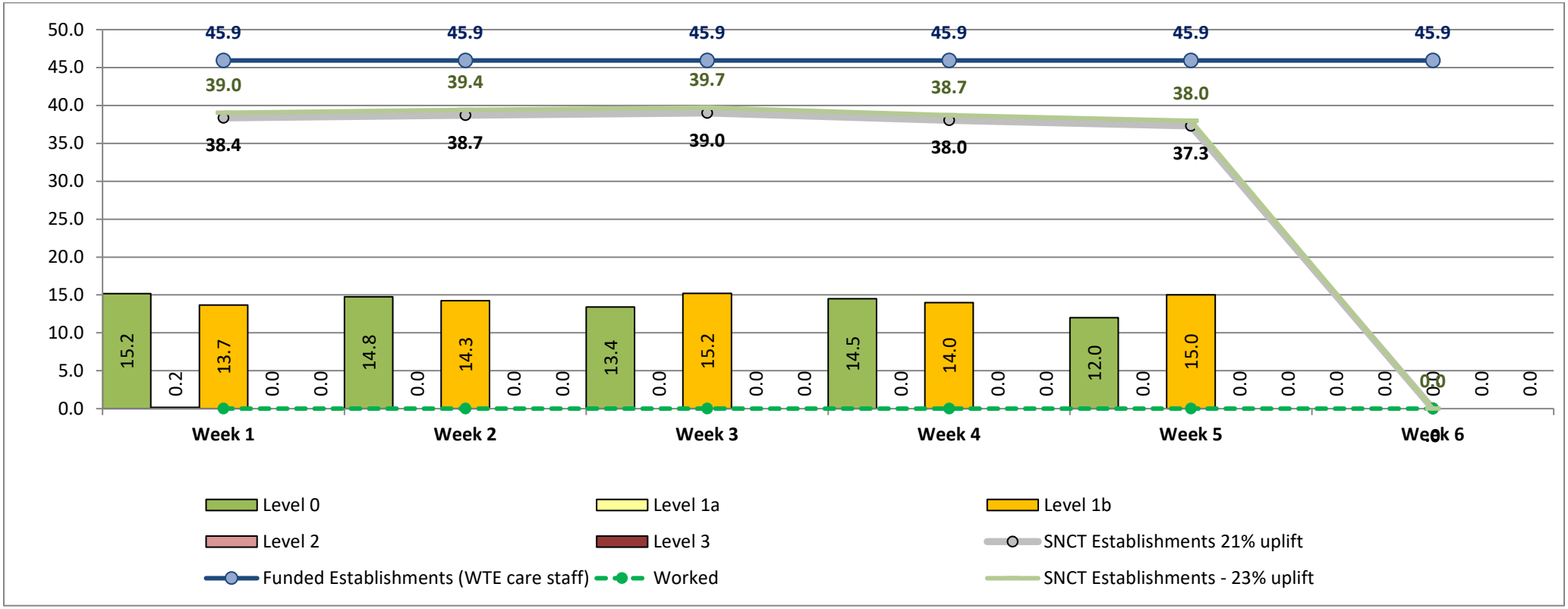
Comment: Normal patient group is made up of dementia patients, who require time. During the data collection period there were bed closures due to Covid. The patient group was not representative of the usual type of ward patients, and you would expect to have more 1B types. 1B patients require nursing interventions rather than HCA intervention. There has been a high usage of bank and agency, the ward has enhanced care requirements, frequent 1-1s, Violence and aggression type incidents requiring support and intervention to avoid escalation. Ward manager feels the ward would benefit from an extra Q/HCA on a late as delirium patients often require additional support in the afternoon/evening period (more 1C patients) and support complex discharges. The ward manager explained, often from a SNCT perspective Ward 23's patients can often vary considerably from other elderly care wards. For example, a 0 on the SNCT signifies someone who just requires one member of staff to meet their care needs from a physical perspective however for a patient who lacks capacity the intervention and reassurance they can require from that member of staff can be significantly different from someone with capacity. The evidence around Dementia care from people living with the disease and those caring for people with the disease all tells us that these people need time and often that is the one thing you feel you can't give your patient. The Friends and Family result below is based on only two responses.



Quality Outcomes April 2021- November 2021 -monthly average in (brackets)			
Friends and Family Test - Recommend Rate	50%	Staffing Incidents (insufficient staff)	1
Your care your voice survey score (Oct 20)	-	Falls (Monthly Average)	68 (9)
Patient safety incident (excl. community acquired pressure damage)	107 (13)	Complaints	3
Validated Category 2 Pressure Damage (Monthly Average)	1	Medication errors	5

Ward 24 Care of the Elderly

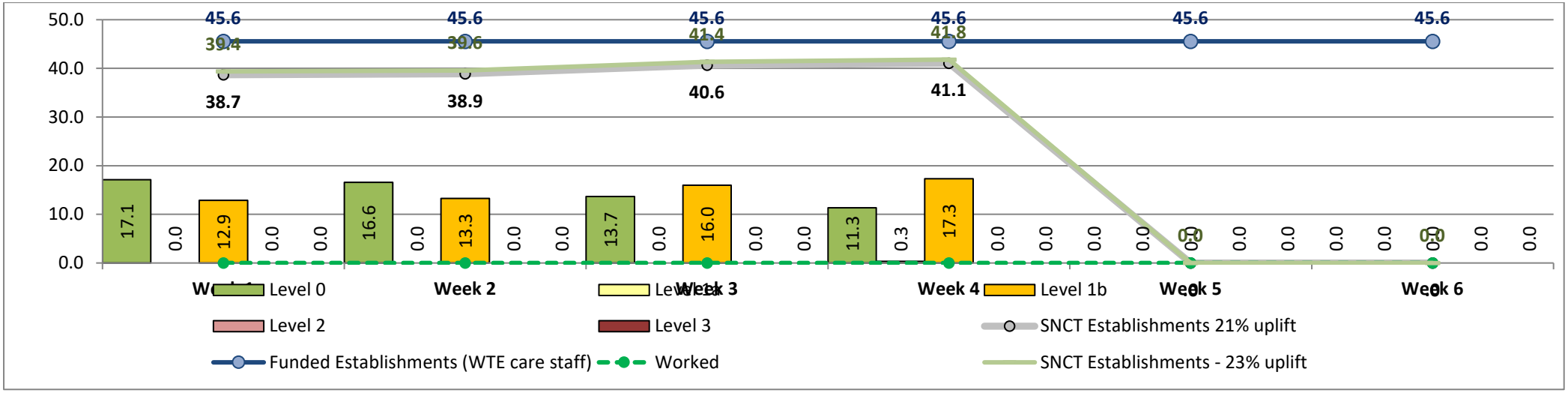
Number of Beds	Current Funded Establishment			Staffing Levels		
	Total	Qualified	Nursing Assistant	Early Q/NA	Late Q/NA	Night Q/NA
29	45	22.1	23.8	5/4	4/4	2/3
Comments: staffing levels ok if all staff are recruited to, review once fully established.						



Quality Outcomes April 2021- November 2021 -monthly average in (brackets)			
Friends and Family Test - Recommend Rate	85.7%	Staffing Incidents (insufficient staff)	1
Your care your voice survey score (Oct 20)	-	Falls (Monthly Average)	89 (11)
Patient safety incident (excl. community acquired pressure damage)	156 (20)	Complaints	3
Validated Category 2 Pressure Damage (Monthly Average)	9 (1)	Medication errors	15 (2)

Ward 25 Care of the Elderly

Number of Beds	Current Funded Establishment			Staffing Levels		
	Total	Qualified	Nursing Assistant	Early Q/NA	Late Q/NA	Night Q/NA
30	45.6	22.1	23.5	5/4	4/4	2/3
Comments: The dependency of patients is quite high, and the ward manager feels 5 HCA's on a LD would be beneficial to the ward						



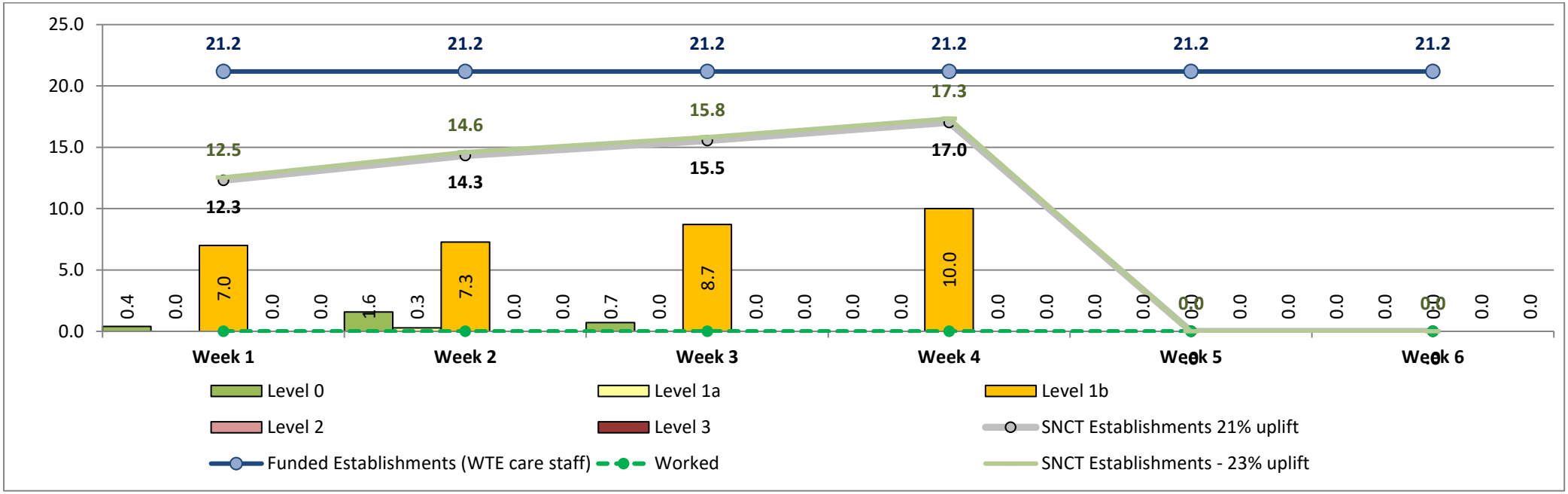
Quality Outcomes April 2021- November 2021 -monthly average in (brackets)			
Friends and Family Test - Recommend Rate	62.5%	Staffing Incidents	0
Your care your voice survey score (Oct 20)	97.6%	Falls (Monthly Average)	83 (10)
Patient safety incident (excl. community acquired pressure damage)	115 (14)	Complaints	3
Validated Category 2 Pressure Damage (Monthly Average)	2	Medication	13 (2)

COTE

The establishment of all COTE wards will reduce by 3.94 band 5 and 4.24 band April 2022 onwards with removal of nonrecurrent winter uplift. New staff are not staying if they had not chosen to work in COTE and were appointed as part of a generic recruitment drive. Going forward this will be addressed so encourage bespoke recruitment along with international recruitment opportunities. In general, across COTE ward managers feel the vacancy rate is contributing to sickness absence rates. An additional nurse in the mornings would allow the nurse in charge to attend ward round. Consensus was that wards 22,24,25 should be the same; slightly less for 23 to reflect fewer beds.

Ward St Bedes

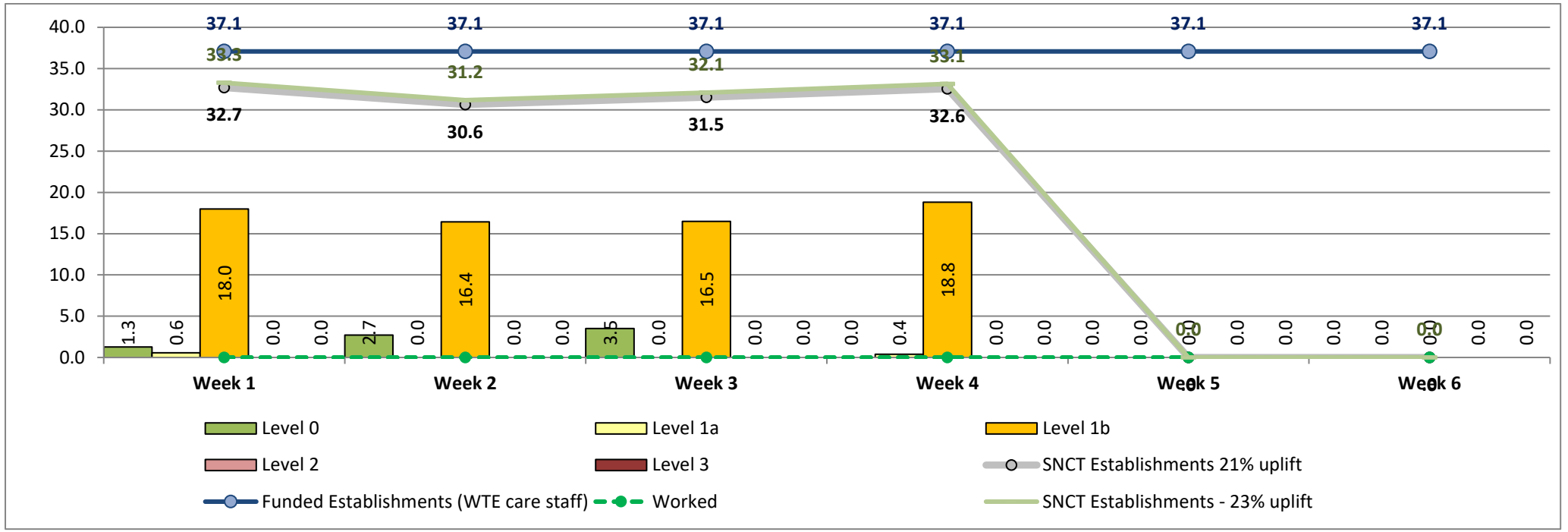
Number of Beds	Current Funded Establishment			Staffing Levels		
	Total	Qualified	Nursing Assistant	Early Q/NA	Late Q/NA	Night Q/NA
10	21.2	12.1	9.1	3/2	2/2	2/1
Comments:	The SNCT was mainly 1b's, summer data collection very similar. The unit is stand alone, lone environment, the patient care group is End of Life requiring high levels of support including syringe drivers for medication delivery along with an increased frequency of break through medication. St Bedes is usually quite stable for staffing, lately there has been increased movement however, currently no vacancies. If enhanced cares are required on nights support is requested from site.					



Quality Outcomes April 2021- November 2021 -monthly average in (brackets)			
Friends and Family Test - Recommend Rate	100%	Staffing Incidents	0
Your care your voice survey score (Oct 20)	-	Falls (Monthly Average)	9 (1)
Patient safety incident (excl. community acquired pressure damage)	25 (3)	Complaints	0
Validated Category 2 Pressure Damage (Monthly Average)	3	Medication errors	2

JASRU

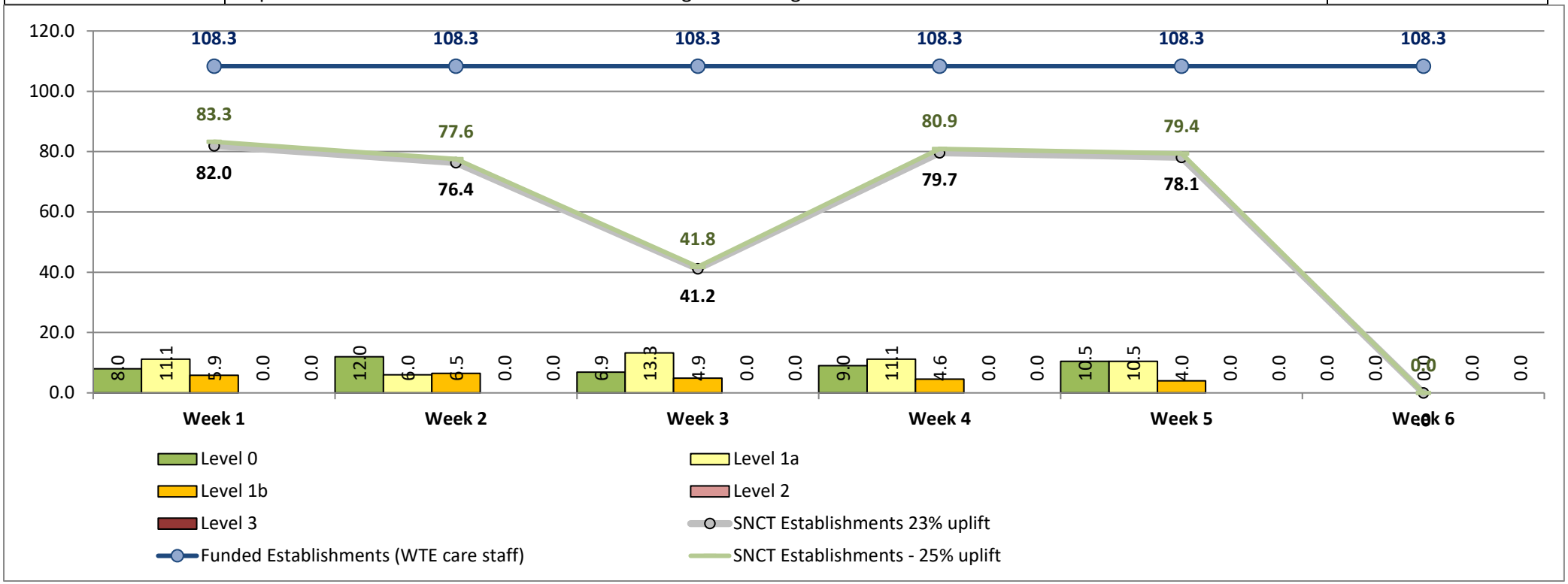
Number of Beds	Current Funded Establishment			Staffing Levels		
	Total	Qualified	Nursing Assistant	Early Q/NA	Late Q/NA	Night Q/NA
20	37.1	16.6	20.5	4/4	4/4	2/3
Comments: Ward manager feels the establishment is correct for the ward area, recent vacancy, maternity leave and long-term sickness has impacted on the ability to have 3 NA on nights, this is being addressed through recent recruitment.						



Quality Outcomes April 2021- November 2021 -monthly average in (brackets)			
Friends and Family Test - Recommend Rate	100%	Staffing Incidents	0
Your care your voice survey score (Oct 20)	-	Falls (Monthly Average)	13 (2)
Patient safety incident (excl. community acquired pressure damage)	24 (3)	Complaints	0
Validated Category 2 Pressure Damage (Monthly Average)	0	Medication errors	0

Ward EAU

Number of Beds	Current Funded Establishment			Staffing Levels		
	Total	Qualified	Nursing Assistant	Early Q/NA	Late Q/NA	Night Q/NA
48	108.3	75.5	32.8	14 +4	14+4	14+4
Comments:	SNCT for EAU used to collect data; ward managers state if planned matched actual, staffing levels feel safe. Slightly higher staffing ratio to reflect environment (all cubicles). EAU has 48 cubicles on the unit, and functions to allow early assessment and treatment to adult patients, who are referred from their G.P, SDEC or the Emergency Department (E.D). EAU is designed to accommodate unwell medical patients, whose illness requires a multidisciplinary approach and physiological observations to detect deterioration whilst their illness is being diagnosed or treated. caring for patients in the acute stages of their emergency admission. Patients are often unstable; have complex needs and require enhanced care at this stage of their admission. The ward manager has explained having a runner on top of a 1 to 6 patient ratio really improves patient flow and safety. Patient safety and staff wellbeing is a priority, and due to the complex case mix of patients it is essential all staff have access to regular training.					



Quality Outcomes April 2021- November 2021 -monthly average in (brackets)			
Friends and Family Test - Recommend Rate	86.7%	Staffing Incidents (insufficient nurses and staff)	25
Your care your voice survey score (Oct 20)	-	Falls (Monthly Average)	146 (18)
Patient safety incident (excl. community acquired pressure damage)	451 (56)	Complaints	9
Validated Category 2 Pressure Damage (Monthly Average)	0	Medication errors	93 (12)

Appendix 2: Surgery staffing establishment review summary March 22

Ward 14A

Old budget for trauma and orthopaedics – no longer active

		EARLY	5Q & 3HCA	5Q & 3HCA	6	2.00	146,030	130,060		-320	129,740
		LATE	4Q & 3HCA	4Q & 3HCA	5	15.70	654,670	509,720		-1,664	508,056
		NIGHT	2Q & 2HCA	2Q & 2HCA	2	14.12	421,350	480,655		-1,324	479,331
					BANK - Q		0	51,673			51,673
					BANK - UQ		0	83,449			83,449
					NON PAY		203,350	221,786			221,786

Bed modelling Summary 3- New budget for Trauma & Orthopaedics 28 beds on ward 21– highlighted in yellow……financial ledger now – professional opinion agrees with budget for case mix

28		WEEKDAY	WEEKEND	8A ACP	1.00	81,565
	EARLY	5Q & 4HCA	5Q & 4HCA	7	1.00	51,198
	LATE	4Q & 4HCA	4Q & 4HCA	6	2.00	97,069
	NIGHT	2Q & 3HCA	2Q & 3HCA	5	15.70	648,629
				2	19.45	607,933
				BANK - Q		-
				BANK - UQ		-
				NON PAY		244,876

Current contracted position

Band 7	1	
Band 6	2 + 1 seconded	+1 over
Band 5	10.84 + 1 x band 4 + RU seconded to band 6 = 12.84	-2.86- recruited 31/4/22
Band 2	13.59	-5.86- recruiting

Red flag and SNCT data for the staffing establishment review –

- SNCT Data collection for the winter is not entirely reliable because during the collection time frame for 10 days ward 14a was housing medical patients, and had a covid outbreak so the ward had reduced number of beds. The data shows that there are less 1B patients than would be present in the T&O population (2 transfer / and spinal #), therefore the WTE number has dropped –
- Pressure damage is an area for improvement (in line with BPT also)
- Staffing Datix is from April 21 and related to late sickness- no harm

- The Ward manager/ Matron / SLM are happy that the current planned staffing establishment each shift meets the requirements to deliver safe effective care currently for 24 beds and also for the planned 28 beds on ward 21 for T&O

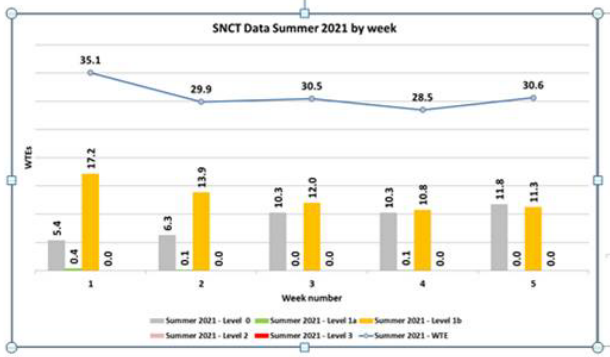
Ward 14a (Trauma or Orthopaedics)	Apr-21 to Nov-21	Monthly average*
Friends and Family Test - Number of Responses	15	
Friends and Family Test- Service experience rating % 'Very Good' or 'Good'	93.3%	
Your Care Your Voice Survey Score (Mar-21)	96.0%	
Pressure Damage - Validated Category 2 (and above)	12	2
Falls	12	2
Medication Errors	4	
Patient safety incidents (excluding community acquired pressure damage)	53	7
Staffing incidents	1	
Complaints	3	

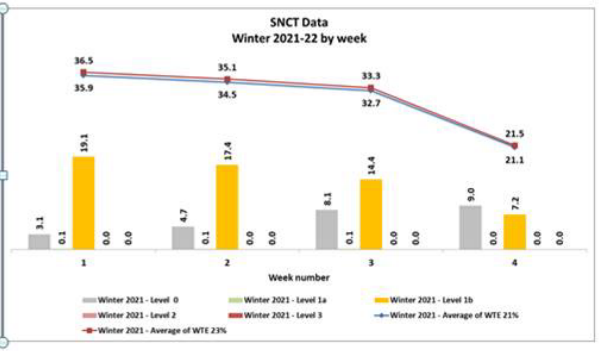
Staffing incidents	1
Insufficient nurses (due to sickness)	1

Top 5 Patient Safety Incidents by Type	Count	Monthly average*
Pressure damage	13	2
Patient falls	12	2
Infection prevention or control	5	
Delay / failure to treat / monitor	4	
Communication failure	4	
Medication	4	
Discharge or transfer issue	3	

Complaints Subjects	3
Clinical Treatment - Surgical Group	2
Communications	1

*Monthly average included where the average is greater or equal to 1. Rounded to the nearest whole number.





Ward 26

Agreed establishment

30 BEDS	7	1.00
	6	2.00
	5	15.70
	2	17.03

Level 1 (Ward 26)	EARLY	QUALIFIED	5
		HCA	4
	LATE	QUALIFIED	4
		HCA	4
	NIGHT	QUALIFIED	2
		HCA	2

Current contracted position

	Current budget	Contracted	Recruited and await start date	Comments	Vacancy Gap
B7	1.0	1.0			
B6	2.0	2.0			
B5/4	15.7	14.67		1.84 handed in notice 3.0 mat leave (B4 RTW 1/3/22) 0.6 LTS 1.0 secondment to stoma(RTW July 2022)	Recruited 30/4/22
B2/3	19.45	17.48		2.0 handed in notice 0.64 mat leave (RTW 1/4/22) 0.8 HK	3.37 WTE after notice period and HK removed

Red flag and SNCT data for the staffing establishment review –

- Although this data states ward 21 T&O- GO didn't move to Ward 26 until October 21 so the vast majority of the red flag data belongs to GO. There is a relatively low number incidents reported but this would be for 18 beds.
- Summer SNCT is not relevant to a 30 bedded surgical ward
- Winter SNCT supports that the funded establishment is adequate to meet the acuity of patients on the ward
- Possibly not reflected in the data is the challenge of managing multiple specialties in the last few months and also epidural patients at night
- The Ward manager/ Matron / SLM have suggested that a 3rd HCA would support the environmental factors on the ward especially for epidural patients. They are happy that the current planned qualified staffing establishment each shift meets the requirements to deliver safe effective care currently for 30 beds on ward 26- however following discussion with HR AD surgery we have identified that the extra 3.9wte qualified staff who are currently being recruited to in critical care to deliver a level 1 step down model may be part of the supportive plan for this – further discussion required

Ward 21 (Orthopaedic Elective)	Apr-21 to Nov-21	Monthly average*
Friends and Family Test - Number of Responses	73	
Friends and Family Test- Service experience rating % 'Very Good' or 'Good'	91.8%	
Your Care Your Voice Survey Score (Sep-20)	95.0%	
Pressure Damage - Validated Category 2 (and above)	0	
Falls	8	1
Medication Errors	5	
Patient safety Incidents (excluding community acquired pressure damage)	34	4
Staffing Incidents	1	
Complaints	2	

Staffing Incidents	1
Insufficient nurses (due to staff movements)	1

Top 5 Patient Safety Incidents by Type	Count	Monthly average*
Patient falls	8	1
Medication	5	
Discharge or transfer issue	4	
Delay / failure to treat / monitor	4	
Infection prevention or control	4	
Communication failure	2	
Pressure damage	2	
Operations / procedures	2	

*Monthly average included where the average is greater or equal to 1. Rounded to the nearest whole number.

Complaints Subjects	
Clinical Treatment - Surgical Group	2

GO were located on ward 21 in the summer – with only 18 beds

Summer 2021-22

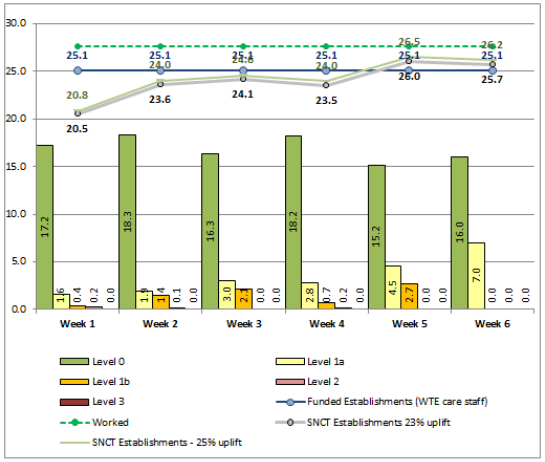
Select Ward --> Ward 21

Winter establishment currently used in the funded establishment

SNCT Dashboard - Ward 21

	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Average*
Funded Establishments (WTE care staff)	25.1	25.1	25.1	25.1	25.1	25.1	25.1
Qualified (WTE)	14.1	14.1	14.1	14.1	14.1	14.1	14.1
Unqualified (WTE)	10.9	10.9	10.9	10.9	10.9	10.9	10.9
23% Uplift							
SNCT Establishments 23% uplift	20.5	23.6	24.1	23.5	26.0	25.7	23.5
SNCT - Qualified	11.5	13.3	13.6	13.3	14.7	14.5	13.2
SNCT - Unqualified	8.9	10.3	10.5	10.3	11.4	11.2	10.2
25% Uplift							
SNCT Establishments - 25% uplift	20.8	24.0	24.6	24.0	26.5	26.2	23.9
SNCT - Qualified	11.7	13.5	13.8	13.5	14.9	14.7	13.5
SNCT - Unqualified	9.1	10.5	10.7	10.5	11.6	11.4	10.4
Worked (Care Staff) Monthly figure Jun 2021	27.6	27.6	27.6	27.6	27.6	27.6	27.6
Patient Acuity / Dependency Level							
Level 0	17.2	18.3	16.3	18.2	15.2	16.0	16.7
Level 1a	1.6	1.9	3.0	2.8	4.5	7.0	2.8
Level 1b	0.4	1.4	2.1	0.7	2.7	0.0	1.5
Level 2	0.2	0.1	0.0	0.2	0.0	0.0	0.1
Level 3	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Patient Acuity & Dependency Level Ward 21



SNCT Qualified / Unqualified based on funded establishment ratio 0.56 Qualified
0.44 Unqualified

*Averages based on full collection data not an average of weekly values

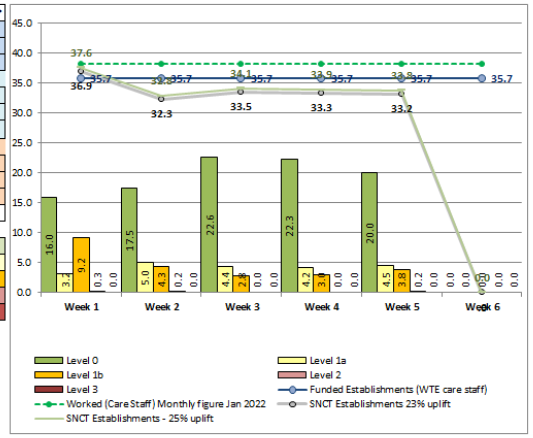
Winter 2021-22

Select Ward --> Ward 26

SNCT Dashboard - Ward 26

	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Average*
Funded Establishments (WTE care staff)	35.7	35.7	35.7	35.7	35.7	35.7	35.7
Qualified (WTE)	18.7	18.7	18.7	18.7	18.7	18.7	18.7
Unqualified (WTE)	17.0	17.0	17.0	17.0	17.0	17.0	17.0
23% Uplift							
SNCT Establishments 23% uplift	36.9	32.3	33.5	33.3	33.2	no data	33.8
SNCT - Qualified	19.3	16.9	17.5	17.4	17.4	no data	17.7
SNCT - Unqualified	17.6	15.4	16.0	15.9	15.8	no data	16.1
25% Uplift							
SNCT Establishments - 25% uplift	37.6	32.8	34.1	33.9	33.8	no data	34.4
SNCT - Qualified	19.7	17.2	17.9	17.7	17.7	no data	18.0
SNCT - Unqualified	17.9	15.6	16.3	16.1	16.1	no data	16.4
Worked (Care Staff) Monthly figure Jan 2022	38.2	38.2	38.2	38.2	38.2	38.2	38.2
Patient Acuity / Dependency Level							
Level 0	16.0	17.5	22.6	22.3	20.0	no data	19.6
Level 1a	3.2	5.0	4.4	4.2	4.5	no data	4.2
Level 1b	9.2	4.3	2.8	3.0	3.8	no data	4.7
Level 2	0.3	0.2	0.0	0.0	0.2	no data	0.1
Level 3	0.0	0.0	0.0	0.0	0.0	no data	0.0

Patient Acuity & Dependency Level Ward 26



SNCT Qualified / Unqualified based on funded establishment ratio 0.52 Qualified
0.48 Unqualified

*Averages based on full collection data not an average of weekly values

Ward 27

Agreed establishment

30 BEDS	7	1.00
	6	2.00
	5	15.70
	2	17.03

Level 2 (Ward 27)	EARLY	QUALIFIED HCA	5 4
	LATE	QUALIFIED HCA	4 4
	NIGHT	QUALIFIED HCA	2 2

Current contracted position

	Current budget	In post	Recruited and await start date	Comments	Gap
B7	1.0	1.0		Planning to retire July	
B6	2.0	2.0			
B5/4	15.7	12.64	1.0	1.0 Urology 1.0 secondment to SNP	2.06WTE Recruited 30/4/22
B2/3	17.03	14.33			2.73

Red flag and SNCT data for the staffing establishment review –

- Both the summer and winter SNCT data shows that the Funded establishment is less than the SNCT establishment with 23% uplift, average SNCT being 37.5 v Funded 35.7. this could be because of the CEV patients and or surgical patients are more acutely unwell
- There were 8 staffing Datix in the time period –
- 100 patient safety incidents demonstrate good reporting with falls and medication errors areas for improvement
- The Ward manager/ Matron / SLM are happy that the current planned staffing establishment each shift meets the requirements to deliver safe effective care currently for 30 beds on ward 27 (when CEV is delivered in the correct speciality and not GS)

T27 - Treatment Centre level 2	Apr-21 to Nov-21	Monthly average*
Friends and Family Test - Number of Responses	81	
Friends and Family Test - Service experience rating % 'Very Good' or 'Good'	93.8%	
Your Care Your Voice Survey Score		
Pressure Damage - Validated Category 2 (and above)	1	
Falls	37	5
Medication Errors	11	1
Patient safety Incidents (excluding community acquired pressure damage)	100	13
Staffing Incidents	8	1
Complaints	5	

Staffing Incidents	8
Insufficient nurses (due to staff shortages/unfilled shifts)	4
Staffing - insufficient nurses (other reason)	2
Insufficient nurses (due to sickness)	1
Staffing - insufficient staff (other)	1

Top 5 Patient Safety Incidents by Type	Count	Monthly average*
Patient falls	37	5
Delay / failure to treat / monitor	13	2
Medication	11	1
Infection prevention or control	9	1
Staffing / resource issue	8	1

Complaints Subjects	5
Clinical Treatment - Surgical Group	2
Privacy, Dignity & wellbeing (including patients' property & expenses)	1
Admissions, discharge & Transfers	1
Clinical Treatment - General Medical Group	1

*Monthly average included where the average is greater or equal to 1. Rounded to the nearest whole number.

Summer 2021-22

Select Ward --> Ward 27

Winter establishment currently used in the funded establishment

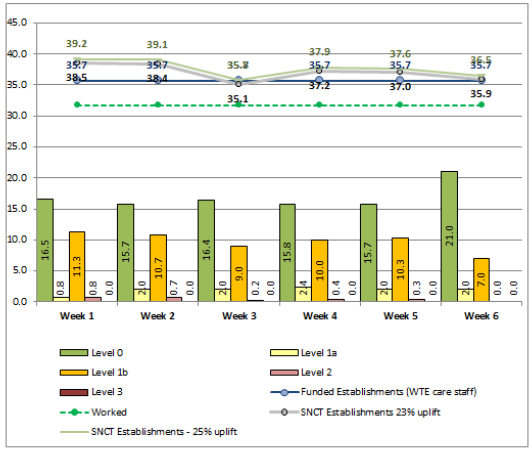
SNCT Dashboard - Ward 27

	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Average*
Funded Establishments (WTE care staff)	35.7	35.7	35.7	35.7	35.7	35.7	35.7
Qualified (WTE)	18.7	18.7	18.7	18.7	18.7	18.7	18.7
Unqualified (WTE)	17.0	17.0	17.0	17.0	17.0	17.0	17.0
23% Uplift							
SNCT Establishments 23% uplift	38.5	38.4	35.1	37.2	37.0	35.9	37.3
SNCT - Qualified	20.1	20.1	18.4	19.5	19.4	18.8	19.5
SNCT - Unqualified	18.3	18.3	16.7	17.7	17.6	17.1	17.8
25% Uplift							
SNCT Establishments - 25% uplift	39.2	39.1	35.8	37.9	37.6	36.5	37.9
SNCT - Qualified	20.5	20.5	18.7	19.8	19.7	19.1	19.8
SNCT - Unqualified	18.7	18.6	17.0	18.1	17.9	17.4	18.1
Worked (Care Staff) Monthly figure Jun 2021	31.7	31.7	31.7	31.7	31.7	31.7	31.7
Patient Acuity / Dependency Level							
Level 0	16.5	15.7	16.4	15.8	15.7	21.0	16.2
Level 1a	0.8	2.0	2.0	2.4	2.0	2.0	1.9
Level 1b	11.3	10.7	9.0	10.0	10.3	7.0	10.1
Level 2	0.8	0.7	0.2	0.4	0.3	0.0	0.5
Level 3	0.0	0.0	0.0	0.0	0.0	0.0	0.0

SNCT Qualified / Unqualified based on funded establishment ratio 0.52 Qualified
0.48 Unqualified

*Averages based on full collection data not an average of weekly values

Patient Acuity & Dependency Level Ward 27



Winter 2021-22

Select Ward -->	Ward 27

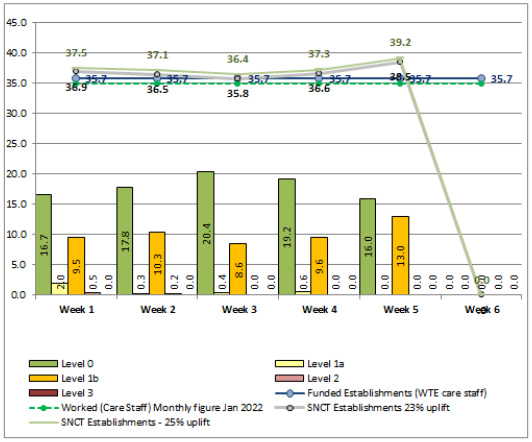
SNCT Dashboard - Ward 27

	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Average*
Funded Establishments (WTE care staff)	35.7	35.7	35.7	35.7	35.7	35.7	35.7
Qualified (WTE)	18.7	18.7	18.7	18.7	18.7	18.7	18.7
Unqualified (WTE)	17.0	17.0	17.0	17.0	17.0	17.0	17.0
23% Uplift							
SNCT Establishments 23% uplift	36.9	36.5	35.8	36.6	38.5	no data	36.6
SNCT - Qualified	19.3	19.1	18.7	19.2	20.1	no data	19.1
SNCT - Unqualified	17.6	17.4	17.1	17.5	18.3	no data	17.4
25% Uplift							
SNCT Establishments - 25% uplift	37.5	37.1	36.4	37.3	39.2	no data	37.2
SNCT - Qualified	19.6	19.4	19.1	19.5	20.5	no data	19.5
SNCT - Unqualified	17.9	17.7	17.4	17.8	18.7	no data	17.7
Worked (Care Staff) Monthly figure Jan 2022	34.9	34.9	34.9	34.9	34.9	34.9	34.9
Patient Acuity / Dependency Level							
Level 0	16.7	17.8	20.4	19.2	16.0	no data	18.3
Level 1a	2.0	0.3	0.4	0.6	0.0	no data	0.8
Level 1b	9.5	10.3	8.6	9.6	13.0	no data	9.7
Level 2	0.5	0.2	0.0	0.0	0.0	no data	0.2
Level 3	0.0	0.0	0.0	0.0	0.0	no data	0.0

SNCT Qualified / Unqualified based on funded establishment ratio 0.52 Qualified
0.48 Unqualified

*Averages based on full collection data not an average of weekly values

Patient Acuity & Dependency Level Ward 27



Ward 21/28

Below is the agreed nursing establishment for the 14 bedded unit- ward 28 (cost centre (20029)

	Grade	PROPOSED STAFFFING ESTABLISHMENT WTE	PROPOSED STAFFFING ESTABLISHMENT ANNUAL COST	Budget Journal
14 Bed	7	1.00	51,198	- 51,198
Elective Unit	6	2.00	97,069	- 97,069
	5	11.13	471,458	- 471,458
	2	10.94	347,186	- 347,186

NEW 14 Bed Elective	EARLY	QUALIFIED	3
		HCA	2
	LATE	QUALIFIED	3
		HCA	2

Orthopaedic Unit	NIGHT	QUALIFIED HCA	2 2

Current contracted position

Band 7	1	
Band 6	2	
Band 5	8.93 (including 1 x Nursing associate +qualified on ward 4)	-2.2
Band 2		

Red flag and SNCT data for the staffing establishment review –

In order to complete the annual staffing review we are required to have 2 sets of SNCT Data collection unfortunately both sets of data are not accurate- take with different case mix/ pending covid medicine/medical boarder and Trauma – with both 24/30/ and 14 beds
The red flag data above covers the last 12 months and unfortunately captures both T&O and Gynae Onc, it has been broken down below to represent T&O

Ward 21
There is one patient safety which is a staffing incident listed as Ward 21 T&O.

Ward 26
58 Patient safety incidents (50 T&O / 8 Gynae)
32 Falls (29 T&O / 3 Gynae)
8 Medication (6 T&O / 2 Gyna)
0 Staffing incidents
0 Complaints

- Falls is an area for improvement for T&O elective
- Ward manager/ SLM/ matron is happy that the current planned staffing establishment each shift meets the requirements to deliver safe effective care currently for 14 beds

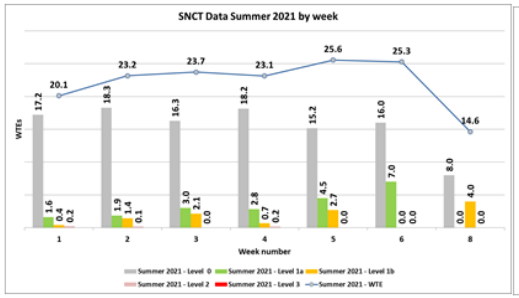
Ward 21 (Orthopaedic Elective)	Apr-21 to Nov-21	Monthly average*
Friends and Family Test - Number of Responses	73	
Friends and Family Test- Service experience rating % 'Very Good' or 'Good'	91.8%	
Your Care Your Voice Survey Score (Sep-20)	95.0%	
Pressure Damage - Validated Category 2 (and above)	0	
Falls	8	1
Medication Errors	5	
Patient safety Incidents (excluding community acquired pressure damage)	34	4
Staffing Incidents	1	
Complaints	2	

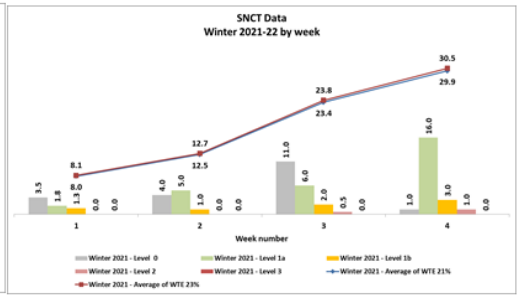
Staffing Incidents	1
Insufficient nurses (due to staff movements)	1

Top 5 Patient Safety Incidents by Type	Count	Monthly average*
Patient falls	8	1
Medication	5	
Discharge or transfer issue	4	
Delay / failure to treat / monitor	4	
Infection prevention or control	4	
Communication failure	2	
Pressure damage	2	
Operations / procedures	2	

Complaints Subjects	
Clinical Treatment - Surgical Group	2

*Monthly average included where the average is greater or equal to 1. Rounded to the nearest whole number.





NHS
Gateshead Health
NHS Foundation Trust

Report Cover Sheet

Agenda Item: 14ii

Report Title:	**Nursing Staffing Exception Report**			
Name of Meeting:	Trust Board			
Date of Meeting:	25 May 2022			
Author:	Laura Edgar, People Data and Information Lead Karen Roberts, Deputy Director of Nursing			
Executive Sponsor:	Gillian Findley, Chief Nurse and Professional Lead for Midwifery and AHP's			
Report presented by:	Karen Roberts, Deputy Director of Nursing			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☒
	This report is to provide assurance to the Board that staffing establishments are being monitored on a shift-to-shift basis.			
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*	This report provides information relating to ward staffing levels (funded against actual) and details of the actions taken to address any shortfalls. April continued with significant staffing challenges as we experienced a surge on COVID-19 activity within the organisation. This has impacted on staffing resource and the clinical operating model. Significant staffing challenges remain due to vacancies and we continue focused work around the recruitment and retention of staff. 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 assurance of this operating as expected is provided by the number of staffing incident reports raised within the Datix system.			

<table>
<tr><td></td><td colspan="5">Ongoing concentrated work continues within the safe staffing Task and Finish Group to review staffing establishments, recruitment, managing sickness absence, recording and escalation of staffing challenges. Regular updates are shared with the executive team as the group progresses.</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 17 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 colspan="2">Yes
☐</td><td colspan="2">No
☐</td><td>Not applicable
☒</td></tr>
</table>

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Gateshead Health NHS Foundation trust
Nursing and Midwifery Staffing Exception Report
April 2022

1. Introduction

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 2022

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 (%)
80.8%	113.9%	89.2%	119.7%

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 pandemic 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%.

A Safer Nursing Care Tool (SNCT) data collection was undertaken throughout the month of January and will be triangulated with key performance indicators and professional judgement templates in line with the National Staffing review from the National Quality Board. The outcome and recommendations from this review are to be presented at Trust Board.

Contextual information and actions taken

Cragside have been running on average 75 % bed capacity throughout April. They have also experienced high sickness absence rates at 20.9%.

Critical care department have shown low fill rates as they currently have 8.7 registered WTE vacancies, which are now recruited into. Sickness absence for the department throughout April was 9.1%.

Emergency Care Centre- EAU continue to support escalated areas within POD 1. There are currently 15 WTE qualified vacancies, of which 7 have now been recruited into. Sickness absence rates throughout April were 6.8%.

JASRU have 4.87 WTE registered staff vacancies. JASRU continue to support ward 12 medicine with one registered staff. They have higher sickness absence rates throughout April 22.6%. They are receiving support from the POD team for long-term sickness absence management.

Ward 8 demonstrates ongoing reduced registered fill rates as they support ward 12 with a registered staff member. They experienced sickness absence rates of 18.7% for registered staff throughout April.

Ward 9 currently have six WTE registered nurse vacancies. They continue to support Ward 10 who have experienced increased sickness absence rates of 10.6%.

Ward 11 experienced 13.1% sickness absence overall for the month of April. Ward 11 has been running with an increased bed capacity for the majority of the month.

Ward 21 elective orthopaedics operated with reduced bed capacity throughout April. Sickness absence rates for the area were 11.5%.

Ward 22 currently have 6.31 WTE registered staff vacancies. They have demonstrated 8.8% sickness absence throughout April.

The exceptions to report for April are as below:

April 2022	
Qualified Nurse Days	**%**
Cragside Court	68.1%
Critical Care Department	73.4%
Emergency Care Centre- EAU	74.7%
JASRU	60.9%
Ward 08	58.7%
Ward 09	66.2%
Ward 11	69.4%
Ward 21 Elective Ortho	69.2%
Ward 22	74.2%
Qualified Nurse Nights	**%**
Emergency Care Centre – EAU	71.0%
Ward 10	68.7%
Healthcare Assistant Days	**%**
JASRU	65.9%
Healthcare Assistant Nights	**%**
N/A	

In April 2022 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 7.9. This compares well when benchmarked with other peer reviewed hospitals.

4. Monitoring Nurse Staffing via Datix

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 whether triggers as to when a staffing related DATIX should be submitted could be added to this process 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 DATIX 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.

Further drill down into DATIX data has been able to show that of the 12 reported staffing incidents, one related to administrative staff and one to a shortage of medical staff, therefore 10 related to nursing, demonstrating the need for more granular information going forward. All staffing incidents were reported as no/low harm incidents. The table below shows the 12 staffing incidents in yellow, and in blue, patient safety incidents reported by these areas within the month. This table appears to show some potential correlation particularly in relation to ward 14 on the 9th of April 2022, however this will require some further exploration to confirm this.

Table of staffing and patient safety incidents reported for these areas

Business Unit	Service	Ward/Dept	Incident date	Day/ Night	Category	Sub category
Surgical Services	Critical Care	Critical Care Department	03/04/2022	Night	Staffing / res	Insufficient nurses (due to staff shortages/unfilled shifts
Nursing, Midwifer	Risk & Patient Safety	Patient Safety	12/04/2022	Night	Staffing / res	Staffing - insufficient nurses (other reason)
Surgical Services	Surgical Services - Di	Surgical Services - Divisional Manage	30/04/2022	Day	Staffing / res	Staffing - insufficient doctors
Surgical Services	General Surgery	T27 (General Surgery)	30/04/2022	Day	Patient falls	Fall from height - bed
Surgical Services	General Surgery	T27 (General Surgery)	09/04/2022	Day	Staffing / res	Staffing - insufficient nurses (other reason)
Medical Services	General Medicine	Ward 12 (Escalation)	04/04/2022	Night	Staffing / res	Insufficient nurses (due to staff movements)
Medical Services	General Medicine	Ward 12 (Escalation)	02/04/2022	Night	Safeguarding	Protection of vulnerable adults issue
Medical Services	General Medicine	Ward 12 (Escalation)	02/04/2022	Day	Staffing / res	Staffing - insufficient staff (other)
Medical Services	General Medicine	Ward 14 (General Medicine)	09/04/2022	Day	Violence, abu	Actual physical assault - on patient by staff
Medical Services	General Medicine	Ward 14 (General Medicine)	09/04/2022	Day	Staffing / res	Staffing - insufficient staff (other)
Medical Services	General Medicine	Ward 14 (General Medicine)	09/04/2022	Day	Delay / failur	Treatment / procedure - delay / failure
Medical Services	General Medicine	Ward 14 (General Medicine)	09/04/2022	Night	Delay / failur	Monitoring - Failure to complete observations
Medical Services	General Medicine	Ward 14 (General Medicine)	09/04/2022	Night	Infection pre	Infection - Respiratory
Surgical Services	Trauma & Orthopaed	Ward 14a (Trauma & Orthopaedics)	12/04/2022	Day	Staffing / res	Insufficient nurses (due to sickness)
Medical Services	Respiratory	Ward 9 (Respiratory)	05/04/2022	Day	Staffing / res	Insufficient nurses (due to staff movements)
Medical Services	Emergency Care	Emergency Care Admin	17/04/2022	Day	Staffing / res	Staffing - insufficient staff (other)
Chief Operating O	EPRR & Site Resilienc	Site Resilience	05/04/2022	Night	Staffing / res	Staffing - insufficient staff (other)
Medical Services	Emergency Care	Ward 2 - Emergency Admission Unit	05/04/2022	Day	Medication	Non-controlled drug incident
Medical Services	Ward 21 Escalation	Ward 21 Escalation	06/04/2022	Night	Staffing / res	Staffing - insufficient nurses (other reason)
Surgical Services	Trauma & Orthopaed	Ward 21 (Orthopaedic Elective)	06/04/2022	Night	Patient falls	Fall on same level - cause unknown

A task and finish group 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 measure 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 currently generated monthly and discussed at the Nursing and Midwifery Professional Forum. The report currently helps identify areas where nurse staffing may have fallen below planned levels and what actions were taken to manage the situation and the ongoing work of the task and finish, will enhance this understanding.

The numbers of staffing incidents are an effect of the Global COVID19 pandemic and subsequent government guidelines around self-isolation when staff have tested positive or had significant contact throughout the 4th wave of COVID 19.

5. Patient Safety Incidents

The below table outlines patient safety incidents reported via DATIX from ward areas in April 2022. They are categorised in no/low harm, moderate harm, and severe harm/death. The reporting culture within each area may impact on the data presented below. The information this month also includes staffing incidents reported for each area and whether the report was made during a day or night shift.

Ward	No harm	Low harm	Severe Harm/Death	Staffing incidents reported	Day shift/Night shift
Cragside Court	8	8	0		
Critical Care Dept	8	2	0	1	Night
Emergency Care Centre - EAU	34	11	0	1	
JASRU	4	2	0		
Maternity Unit	1	7	0		
Paediatrics	3	0	0		
Special Care Baby Unit	0	0	0		
St. Bedes	2	4	0	2	2 x nights
Sunniside Unit	9	4	0		
Ward 08 Cardiology	4	5	0		
Ward 09 Respiratory	5	12	0	1	Day
Ward 10	16	7	0		
Ward 11 Gen Medicine	13	9	0		
Ward 12	12	9	0	2	1 x day 1 x night
Ward 14 Medicine	15	23	0	1	1 x day
Ward 14A Trauma	5	0	0	1	1 x night
Ward 21 Elective Ortho	3	1	0		
Ward 21 Medicine	2	1	0	1	1 x night
Ward 22 Gen Medicine	13	2	0		1 x day 1 x night
Ward 23 Jubilee Wing	12	4	0		
Ward 24 Jubilee Wing	13	1	0		
Ward 25 Jubilee Wing	15	7	0		
Ward 26 Gynae	8	2	0		
Ward 27 Treat/Centre	8	3	0	2	

6. Governance

Actual staff on duty on a shift-to-shift basis compared to planned staffing is displayed on the ward boards alongside key quality and outcome metrics i.e. safety thermometer, infection measures.

7. Conclusion

This paper provides an exception report for nursing and midwifery staffing in April 2022, and also provides assurance of ongoing work to triangulate quality and safety metrics against staffing and care hours.

8. Recommendations

The Board is asked to receive this report for assurance.

Gill Findley

Appendix 1- Table 3: Ward by Ward staffing April 2022.

	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
Emergency Care Centre - EAU	74.7%	104.3%	71.0%	104.7%	1345	5.2	3.7	8.8
Ward 8	58.7%	88.1%	100.2%	106.7%	602	3.0	2.9	5.9
Ward 9	66.2%	102.1%	80.2%	120.1%	770	2.9	2.8	5.7
Ward 10	83.5%	144.3%	68.7%	146.4%	702	2.3	3.6	5.9
Ward 11	69.4%	108.1%	103.2%	140.6%	727	2.3	3.3	5.6
Ward 12	85.4%	252.0%	103.3%	141.7%	795	2.1	3.7	5.8
Ward 14 Medicine	78.2%	121.3%	105.2%	169.4%	713	2.5	3.6	6.2
Ward 14A	83.7%	136.4%	102.2%	119.4%	797	2.4	3.7	6.1
Ward 21 Elective Ortho	69.2%	94.3%	81.1%	85.4%	168	7.8	8.6	16.4
Ward 21 Medicine	81.8%	94.2%	91.7%	130.1%	364	4.2	3.9	8.1
Ward 22	74.2%	109.2%	109.6%	111.4%	844	2.3	3.5	5.8
Ward 23	80.0%	144.5%	102.3%	110.1%	703	2.4	4.3	6.6
Ward 24	79.8%	125.6%	107.8%	121.9%	895	2.2	3.8	6.0

	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 25	75.8%	96.3%	108.9%	132.6%	919	2.1	3.2	5.3
Ward 26	88.2%	124.0%	107.9%	119.6%	810	2.7	3.5	6.2
Ward 27	89.7%	89.3%	100.6%	105.5%	796	2.7	2.7	5.4
Cragside Court	68.1%	123.1%	108.5%	158.5%	355	4.5	7.2	11.7
Critical Care	73.4%	82.5%	75.7%	95.2%	186	33.2	5.8	39.0
JASRU	60.9%	65.9%	101.0%	102.8%	557	2.7	3.5	6.2
Maternity	115.8%	132.0%	89.3%	98.5%	527	12.8	5.1	17.9
Paediatrics	115.8%	124.7%	104.8%		42	53.4	16.3	69.7
SCBU	89.1%	121.0%	100.2%	89.9%	142	11.5	4.4	15.9
St Bedes	92.0%	116.2%	93.7%	163.3%	279	5.1	5.3	10.4
Sunniside	89.2%	134.2%	96.7%	123.6%	217	7.3	6.5	13.8
QUEEN ELIZABETH HOSPITAL - RR7EN	**80.8%**	**113.9%**	**89.2%**	**119.7%**	**14255**	**4.0**	**3.8**	**7.9**

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 15

Report Title:	Learning from Deaths Report			
Name of Meeting:	Trust Board			
Date of Meeting:	Wednesday 25th May 2022			
Author:	Andy Ward – Senior Information Analyst – Quality & Patient Safety Wendy McFadden – Strategic Lead Clinical Effectiveness			
Executive Sponsor:	Andy Beeby – Medical Director			
Report presented by:	Andy Beeby – Medical Director			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
	To provide an update on Mortality and Learning from deaths over the last six months.			
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*	Quality Governance Committee – 20th April 2022			
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 Trust's latest published SHMI (Summary Hospital-level Mortality Indicator) for November 2020 to October 2021 is 1.04 placing the Trust with the banding of deaths 'as expected'. The HSMR (Hospital Standardised Mortality Ratio) for Gateshead in the last 12 months (Feb-21 to Jan-22) is 115.9 placing the Trust with 'More Deaths than expected' as calculated by the model. This indicator continues to be monitored closely. The increase in congestive heart failure crude mortality observed by the HSMR and by the Medical Examiner is influencing the HSMR and therefore the Trust has undertaken additional reviews.			

<table>
<tr><td></td><td colspan="6">The Trust recognises the need to triangulate all the information from the Medical Examiner work, mortality reviews, mortality alerts, SI's

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.</td></tr>
<tr><td>Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper</td><td colspan="6">To receive the paper for assurance</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:</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>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>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 and Learning from Deaths Report

Executive Summary

The Trust's latest published SHMI (Summary Hospital-level Mortality Indicator) for November 2020 to October 2021 is 1.04 placing the Trust with the banding of deaths 'as expected'. Comparing to local Trusts the SHMI places the trust in the centre of the pack.

The HSMR (Hospital Standardised Mortality Ratio) for Gateshead in the last 12 months (Feb-21 to Jan-22) is 115.9 placing the Trust with 'More Deaths than expected' as calculated by the model. This indicator continues to be monitored closely. Please note that caution is required when interpreting the HSMR as this indicator uses case mixing against the previous 10 years of activity, in light of the pandemic this is likely be considerably different to recent activity.

The increase in congestive heart failure crude mortality observed by the HSMR and by the Medical Examiner is influencing the HSMR and therefore the Trust has undertaken additional reviews.

Trust staff recently attended a workshop from 'Better Tomorrow' a forum for those interested in Learning from Deaths, and in how that learning can influence future patient care. The initial workshop titled the(mis)understanding of Hospital Statistics and demonstrated the following

- There is no correlation between a high HSMR and avoidable deaths.
- The HSMR is a poor screening test for 'bad hospitals'.
- False alarms can have a significant negative impact.

The Trust recognises the need to consider how best to triangulate all the information from the Medical Examiner work, mortality reviews, mortality alerts, SI's

Trust has the sixth highest HSMR when compared to peer group performance of neighbouring Trusts. The HSMR is sensitive to palliative care coding. the Trust palliative care coding rate is line with the national average.

49.2% (582 of 1,188) of inpatient deaths have been reviewed for deaths occurring between March 2021 and February 2022.

61.1% (11 of 18) learning disability deaths have been reviewed, outstanding cases will be scheduled for future mortality council meetings

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 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)

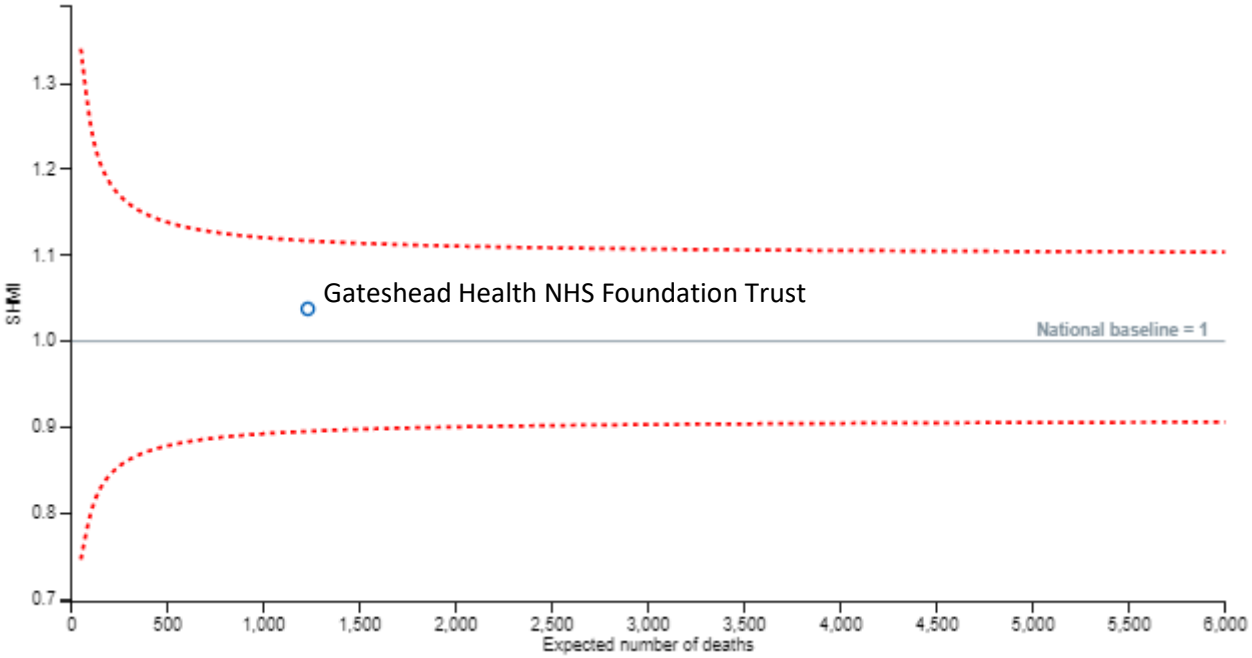
The SHMI is currently published monthly. Each publication includes discharges in a rolling twelve-month period.

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 has been 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.

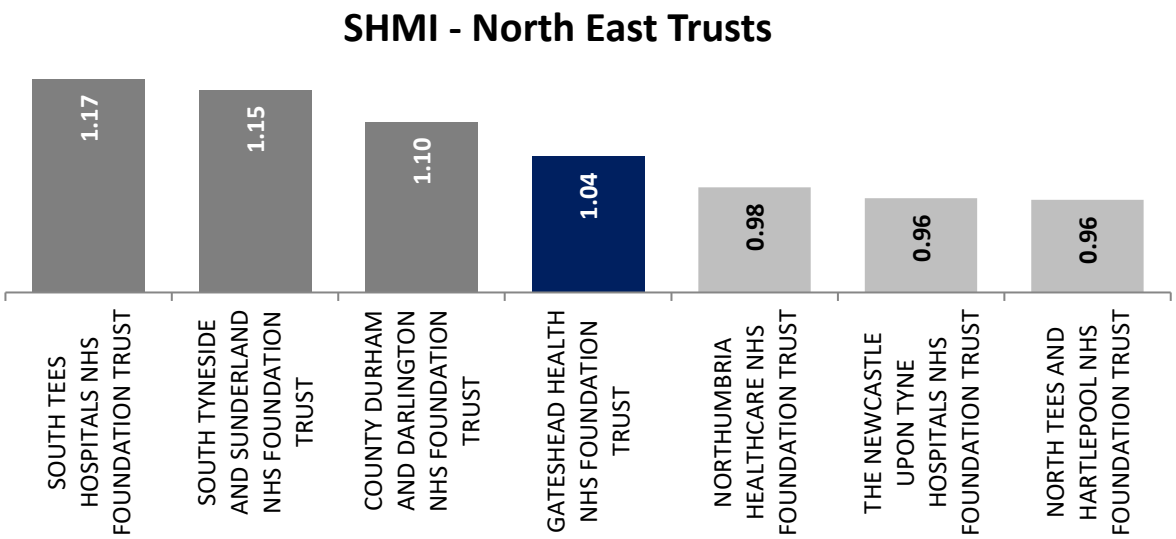
The latest SHMI published for Gateshead Trust on 10th March 2022 covering the period from November 2020 to October 2021 has a SHMI Banding of 'As Expected' with a score of 1.04, above the national baseline of 1.00



- 14 Trusts had a higher-than-expected number of deaths.
- 92 Trusts had a number of deaths within the expected range.

• 16 Trusts had a lower-than-expected number of deaths.

From comparison with local Trusts, Gateshead Health NHS Foundation Trust sits central within the pack. South Tees, South Tyneside and Sunderland, and County Durham have 'Higher Deaths than expected'. The remaining four Trusts have deaths 'As Expected'.



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.

Better Tomorrow – (mis) Understanding Mortality Statistics

Trust staff recently attended a workshop from 'Better Tomorrow', a forum for those interested in Learning from Deaths, and in how that learning can influence future patient care. The initial workshop titled the(mis)understanding of Hospital Statistics and demonstrated the following:

Misconceptions

- Excess Deaths (Observed – Expected) does not equal clinically avoidable deaths.
- Expected deaths does not equal clinically expected deaths.
- Unexpected deaths does not equal clinically avoidable deaths.

Findings

- The conception that a high HSMR or SHMI means more avoidable deaths and therefore poorer care is not true. There is no correlation between a high HSMR and avoidable deaths.
- The general notion that hospitals with a higher risk adjusted mortality have poorer quality of care is neither consistent nor reliable.
- The findings of the Mid-Staffordshire enquiry do not uphold the use of hospital standardised mortality ratios as a screening test for 'bad hospitals'.
- Crying wolf / False alarms. CQC Alert Papworth hospital.
  Spurious alert, hospital morale shaken, management and board members preoccupied for weeks, 50 person hours reviewing and formulating response.

The Trust recognises the need to consider how best to triangulate all the information from the Medical Examiner work, mortality reviews, mortality alerts, SI's and how best to incorporate the use of national indicators alongside internal indicators.

HSMR Trust Position February 2021 to January 2022

The HSMR covering the twelve-month period February 2021 to January 2022 is 115.9, identifying the Trust as having 'More Deaths as Expected' when compared to Trusts nationally, considering the Trust patient case mix.

#	Trust	Score
1	RVW | NORTH TEES & HARTLEPOOL	85
2	RXP | COUNTY DURHAM & DARLINGTON	91
3	RTD | THE NEWCASTLE UPON TYNE HOSPITALS	95
4	RTR | SOUTH TEES HOSPITALS	102
5	RTF | NORTHUMBRIA HEALTHCARE	108
6	RR7 | GATESHEAD HEALTH	116
7	ROB | SOUTH TYNESIDE AND SUNDERLAND	136

Colouring Key:

Green: Represents that the trust is below or between the 95% Control limits.

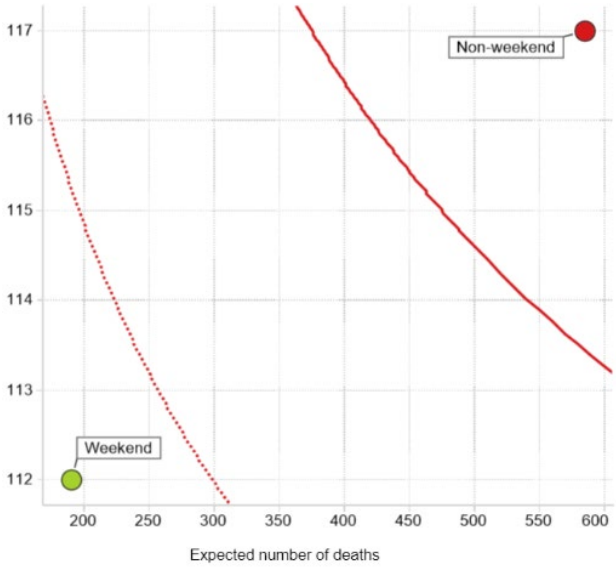
Amber: Represents that the trust is between the 95% and 99.8% Control limits.

Red: Represents that the trust is above the 99.8% Control limits.

Comparing to regional Trusts, Two Trusts have an HSMR with fewer deaths than expected (North Tees, County Durham and Darlington); Two Trusts have deaths as expected (Newcastle South Tees); and three Trusts have a more deaths than expected for this period (Northumbria, Gateshead, and South Tyneside & Sunderland).

Inpatient deaths HSMR by day of admission

Data from HED shows that the HSMR for weekday admissions is banded as higher than expected (HSMR = 117); The HSMR from weekend admissions is banded as expected (HSMR= 112)



	Lower CI	HSMR	Upper CI
Overall	108	116	123
	More Deaths than Expected (99.8% CL)		
Weekday admission	109	117	126
	More Deaths than Expected (99.8% CL)		
Weekend admission	97	112	128
	Deaths as Expected		

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.

Pneumonia

Pneumonia deaths continued to feature for the Trust since the last report in September, however Pneumonia is no longer triggering in the HSMR in the latest alert data but continues in the SHMI. Case note review continues to provide assurance that these cases were not preventable.

Congestive Heart Failure

The most striking alert has been for Congestive heart failure. The Trust has observed an increase in the crude mortality for this diagnosis group, and divergence between the observed value the statistical expected value hence the alert.

Following discussion at the Trusts Mortality and Morbidity Steering Group it was agreed that additional mortality council meetings would be arranged to solely consider heart failure cases. Cases are also being identified via the medical examiner for review.

Two Mortality Council meetings have taken place where 15 cases were reviewed.

- Two additional Mortality Council meetings have been scheduled to review heart failure deaths – 15 cases have been reviewed 12 x Hogan 1 and 3 x Hogan 2. 7 x NCEPOD 1, 4 x NCEPOD 3 and 4 x NCEPOD 4. Learning identified in terms of NCEPOD 3 and 4's was 1) delays in discharges as a result of delays in obtaining social care packages, 2) recognition of patient dying, 3) reduced access to obtaining ECHOs and telemetry and appropriateness of placing patients in wards where there is limited access to monitoring 4) ECGs not documented

within patient notes 5) Senior decision making and handover 6) Referrals to heart failure team 7)

Outcomes
12x Hogan 1 – Definitely not preventable
3 x Hogan 2 – Slight evidence of preventability

7 x NCEPOD 1 – Good Practice
4 x NCEPOD 3 – Room for Improvement organisational care
4 x NCEPOD 4 - Room for Improvement organisational and clinical care

Learning identified from the NCEPOD 3 and 4's cases is detailed on page 11.

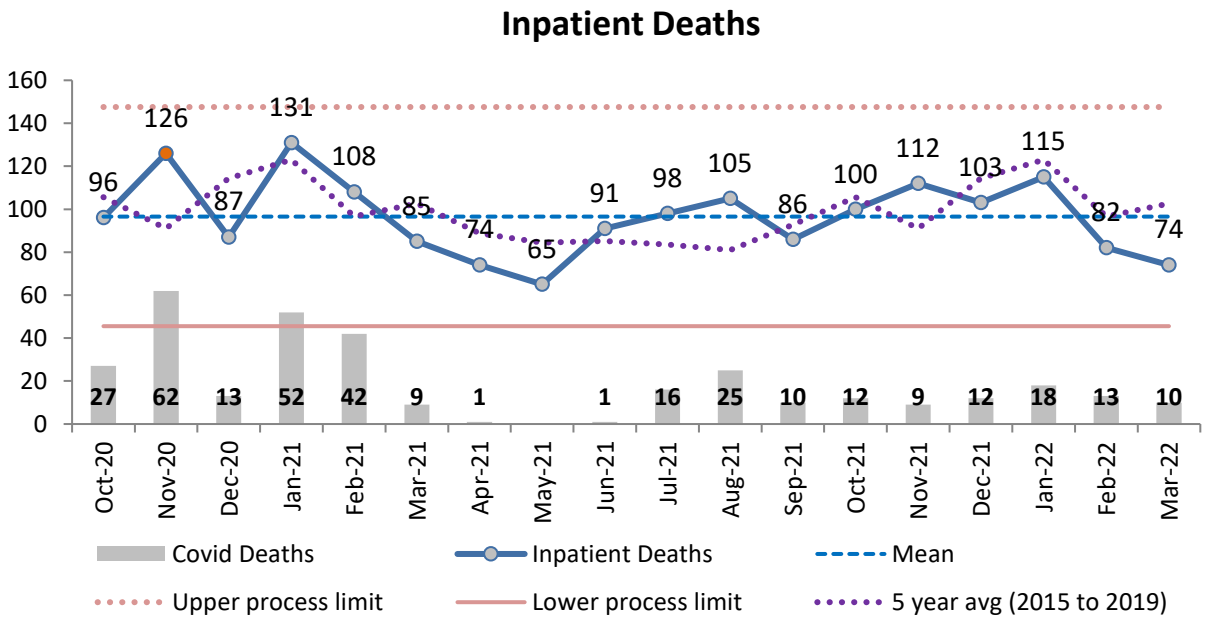
Alerts continue to be presented and discussed at each Mortality and Morbidity Steering Group. The latest figures from alerts investigated are provided below.

Alert	CCS Diagnostic Group	Period	Expected Deaths	Observed Deaths	Obs -Exp	HSMR / CUSUM Score	% Reviewed (where death within Trust)	% Definitely not preventable	% NCEPOD Good Practice
HSMR	Cancer of the Oesophagus	Jan-21 to Dec-21	4	11	7	266	54.5%	100%	83.3%
HSMR	Congestive heart failure; non hypertensive	Jan-21 to Dec-21	45	75	30	168	36.0%	96.3%	69.2%
SHMI	Congestive heart failure: non hypertensive	Dec-20 to Nov-21	50	81 (69 in Hospital)	31	162	39.1%	96.3%	76.9%
SHMI	Pneumonia	Dec-20 to Nov-21	140	174 (147 in Hospital)	35	125	48.3%	98.6%	88.7%
SHMI	Cystic Fibrosis – Other lower respiratory disease	Dec-20 to Nov-21	9	18 (11 in Hospital)	9	203	9.1%	100%	100%
HSMR CUSUM*	Congestive heart failure; non hypertensive	Nov-21	9	18	9	7.25	27.8%	100%	80.0%
HSMR CUSUM*	Peritonitis and intestinal abscess	Dec-21	2	4	2	7.71	100.0%	100%	100%
HSMR CUSUM*	Cancer of bronchus; lung	Dec-21	14	23	9	5.31	64.3%	100%	88.9%
HSMR CUSUM*	Respiratory failure; insufficiency; arrest	Nov-21	3	6	3	3.55	33.3%	50.0%	50.0%
HSMR CUSUM*	Liver disease: alcohol related	Nov-21	6	9	3	3.46	77.8%	100%	100%

* For CUSUM alerts, cases within the three months prior to the alert are considered in the figures

Inpatient mortality

The chart below provides the figures for inpatient deaths and Covid-19 deaths.



4. Trust Mortality Database and Learning from Deaths

The Trust is required to provide figures relating to mortality review and preventability, these figures are provided below.

Period: **01/03/2021** **to** **28/02/2022**

Deaths in Period	1188
Deaths Reviewed*	582
Learning Disability Deaths	18
Learning Disability Deaths Reviewed*	11
Severe Mental Illness Deaths	156
Severe Mental Illness Deaths Reviewed*	8
Potentially Avoidable Deaths	0

*Deaths reviewed at level 1 or Level 2 for all deaths, and reviewed at level 2 for Learning Disability and Severe Mental Illness

	Deaths in period	Deaths reviewed*	%
All Deaths	1188	585	49.2%
Learning Disability	18	11	61.1%
Severe Mental Illness	156	8	5.1%

	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
All Deaths	96.4%	3.2%	0.3%	0.0%	0.0%	0.0%	0%
Learning Disability	81.8%	18.2%	0.0%	0.0%	0.0%	0.0%	0%
Severe Mental Illness	87.5%	12.5%	0.0%	0.0%	0.0%	0.0%	0%

Mortality Review Compliance

49.2% (585 of 1,188) deaths have been reviewed between March 2021 and February 2022.

Cases scoring preventability of Hogan 2 or above at the level 1 consultant / ward team review are subject to a review at Mortality Council, many 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, they review all deaths and escalate cases for additional investigations i.e., Mortality Council, patient safety investigation.

Work is underway to allow the medical examiners service to undertake the Level 1 review and score cases, this will relieve some burden on ward teams and allow them to focus on the cases where their may be greater learning.

Reporting will be improved to identify Level 1 reviews undertaken be the Medical Examiner, Reviews by Consultant / Ward teams, and Mortality Council reviews

- 96.4% of cases are identified as being definitely not preventable.
- 87.1% of cases reviewed were identified as good practice.
- 12.7% of cases identified room for improvement.
- 0 deaths identified as potentially avoidable (Hogan score >=4)

5. Learning from Mortality Council

For the period August 2021 to March 2022, 108 cases had a level 2 review undertaken by the Mortality Council. The cases were mix of COVID-19 and non-COVID-19 deaths. The scores of the review are detailed in the table below:

Hogan 1 – Definitely not preventable	78
Hogan 2 – Slight evidence of prevention	16
Hogan 3 – Possibly preventable, less than 50:50	2
Hogan 4 – Possibly preventable, more than 50:50	0

NCEPOD 1 – Good practice	48
NCEPOD 2 – Room for improvement clinical care	3
NCEPOD 3 – Room to improve organisation of care	34
NCEPOD 4 – Room to improve clinical and organisational	11
NCEPOD 6 – Insufficient data	0

12 cases were unable to be scored and will come to the committee on completion of the relevant investigations.

Good practice identified:

Communication
Evidence of advanced care planning documents, regular palliative care review, discussions with family, recognition of end of life and communication with the Palliative Care Team. Issues have been highlighted with the process for the use of Do Not Attempt Cardiopulmonary Resuscitation

(DNACPR)s is not being followed appropriately for patients with a learning disability as has the timeliness of carrying out Mental Capacity Acts and Deprivation of Liberty (DoLs) assessments. The role of the Lead Nurse for Learning Disabilities and the support that can be provided will be promoted. An audit of all learning disability deaths that occurred between June and December 2021 to determine level of compliance with DNACPR process will be carried out. Amendments have been made to the DNACPR policy

Learning identified/actions taken:

Patient pathways
Patients with known specialist conditions to be taken to the most appropriate Accident & Emergency for treatment where there are the specialist teams with the relevant training to provide the best treatment. This was share with the ambulance trust who are reviewing their current vascular surgery pathway to ensure that were a patient is already under the care of a service for AAA should be taken directly to that Trust to avoid delay of urgent treatment

Clinical Care
A number of reviews have demonstrated issues related to nutrition in patients who were kept nil by mouth due to medical issues and did not receive adequate nutrition. It was highlighted that patients determined to be obese still require appropriate nutrition and that these patients can be protein deficient. Individual cases are fed back to Nutrition and Dietetics team. The Nutrition and Dietetics team are now represented on the Mortality Council and are able to provide specialist input into the discussions at the meeting.

Communication
Visiting restrictions
There have been several cases where families were unable to see their loved ones due to Covid restrictions. There was evidence of poor communication with family members who should have been contacted on a regular basis by telephone calls or limited visits. Some areas have expressed concerns about poor Wi-Fi signal at times. Patient experience volunteers were introduced not only to support patients keep in touch with their loved ones via iPads, emails etc., but also to provide company and a listening ear for patients. Further initiatives to support patients and their families with Letters to a loved one, letters to a friend were introduced.

Discharge
Issues were highlighted in terms of discharge processes. Review planning and timing of discharges, to prevent inappropriate discharges late at night. Ensure that discharges to nursing homes are appropriate in terms of the nursing home having the appropriate set up to care for patients at end of life. Ensure good communication and handover to care homes and discharge of elderly patients, particularly around medication

Documentation
Issues highlighted around the quality of documentation. Ensure the sensitive recording of decision making by patient's when they do not wish to undergo treatment options offered. Ensure that when undertaking a review for another specialty, the time of the review is documented in the patient record
All conversations had with and about patients should be clearly documented in the patient records.

Heart Failure Deaths
In response to national data, a sample of heart failure deaths were reviewed; themes identified were use of telemetry, need to expand heart failure team and heart failure pathways. Actions will

include more widespread use of telemetry both in cardiology ward and other areas in medicine. A business case being formulated by the heart failure specialist clinical lead to expand their services. Availability of ECHO within 24 hours of admission. Early review by cardiologists or care of the elderly consultants with specialised interest in heart failure. Clear guidelines for juniors when some of these patients are approaching end of life and do not need aggressive fluid and diuretic management. Involvement of palliative teams in the care of this group of patients. Admit or transfer patients with heart failure to the cardiology wards whenever possible.

6. Update on the Medical Examiner Service

The Medical Examiner service continues to go from strength to strength, aiming to review all deaths in hospital by the next working day. This includes deaths in Accident & Emergency and all Coroner's referrals. This has required some short notice changes to ME cover due to covid infection.

The Lead ME is working with the hospital learning from deaths process to update the policy to integrate learning from the ME system.

The Lead ME and MEO have agreed a process, sharing of information and documentation for a pilot to review expected Community deaths with a provisional start date of Monday 9 May 2022. The pilot will initially involve 4 GP Practices and help test the process before rolling out to other practices.

Two extra ME sessions have been advertised, with applicants invited from both community and hospital.

7. Recommendation

The Board is asked to receive this paper for information and assurance.

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 16

Report Title:	**Digital Update & SIRO Report**			
Name of Meeting:	Trust Board			
Date of Meeting:	25th May 2022			
Author:	Nick Black, Chief Digital Information Officer			
Executive Sponsor:	Jackie Bilcliff, Group Director of Finance & Digital			
Report presented by:	Nick Black, Chief Digital Information Officer			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
	This paper gives the Trust Board an update on progress against the digital roadmap for the Trust and the clinical systems options outline business case; together with the SIRO Annual Report.			
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*	SIRO report reviewed at Digital Assurance Group Digital roadmap progress reviewed at Digital Transformation Group with assurance provided to Digital Committee			
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 paper details a few of the key achievements over the last 6 months – clinically and operationally; together with sharing some of the assurances that have been provided to the Digital Committee. The paper also includes the SIRO annual report that provides an update on how the Trust manages our data and resources – and our compliance requirements related.			
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	Accept the report and support the ongoing assurance through the Digital Committee			

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:					
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)	All digital risks				
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☐		

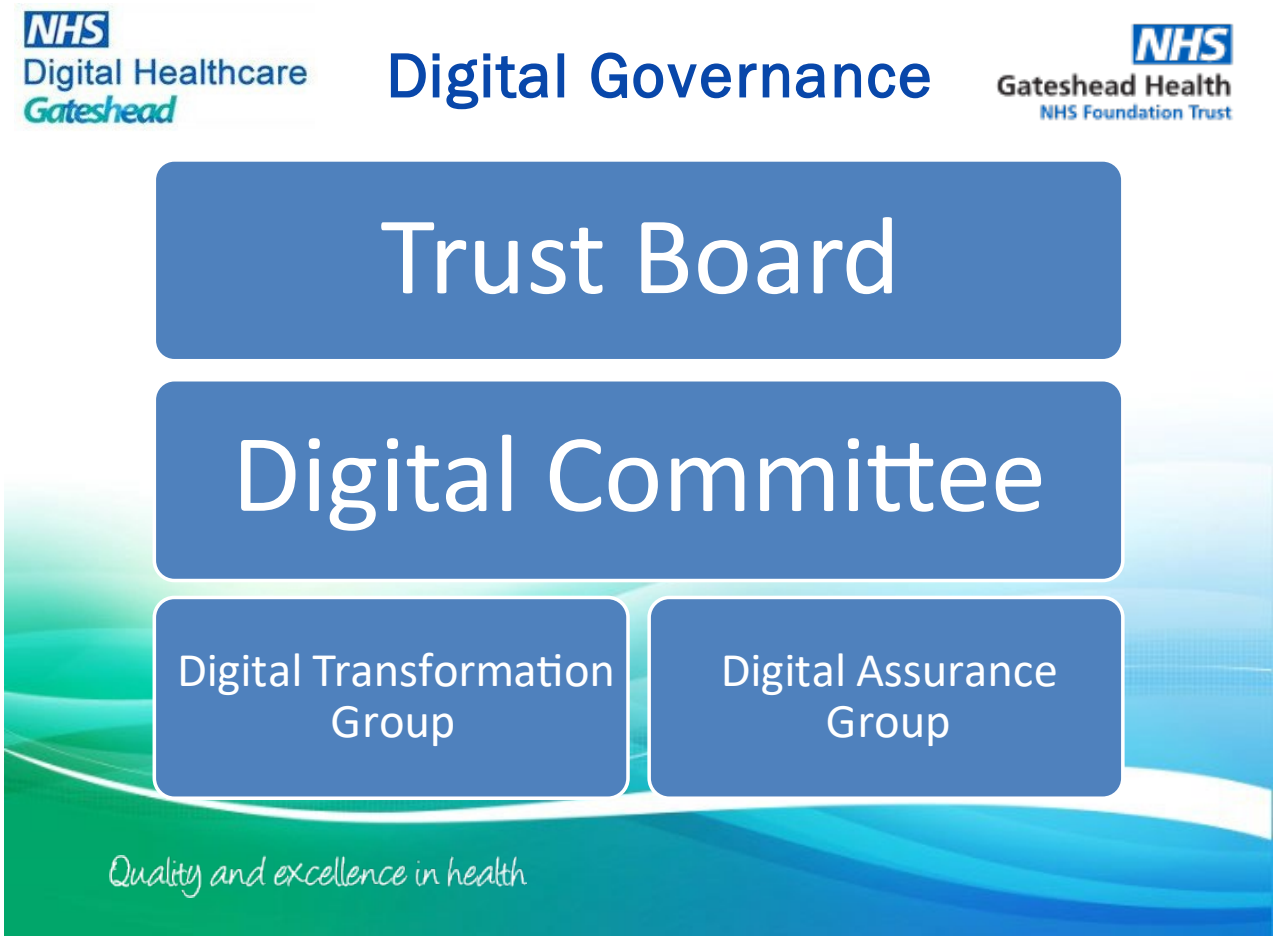
1. Digital Governance

The Digital Committee meets bi-monthly and has recently reviewed its Terms of Reference.

The refreshed responsibilities of the Committee are to:

- Seek assurance over the delivery of the strategic objectives mapped to the Committee
- Seek assurance over the responsiveness and effectiveness of the digital services
- Seek assurance over the management and quality of the Trust's Information Assets
- Seek assurance over compliance with the relevant Data Security and Protection toolkit standards
- Seek assurance that technology is secure and up-to-date and that IT systems are protected from cyber threats

The Digital Committee has two groups reporting in; the Digital Transformation Group with responsibility for digital strategy and managing all digitally enabled transformation/change; and the Digital Assurance Group with responsibility for managing existing systems, records, infrastructure and digital services.



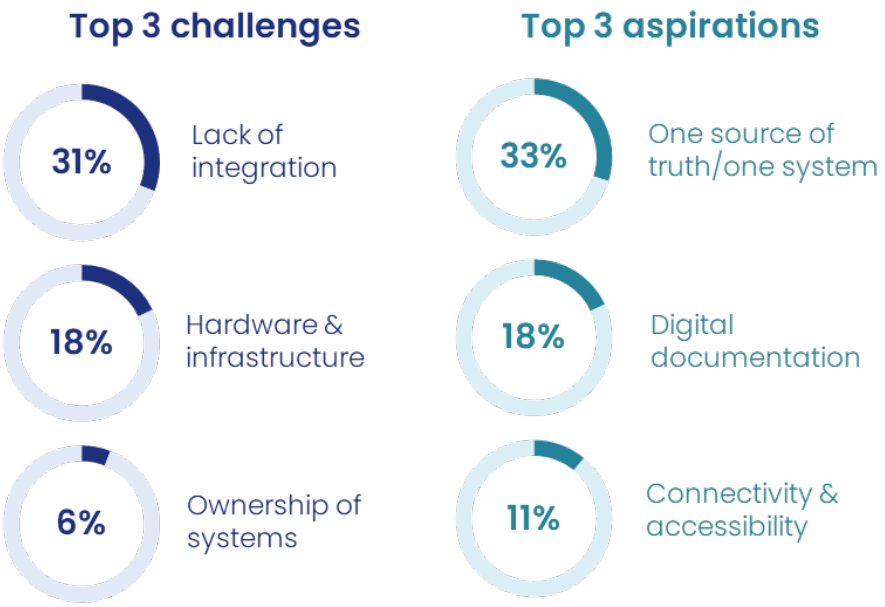
2. Digital Transformation Group (Strategy)

On the 28 March 2022, the Global Digital Exemplar Fast Follower programme celebration event was held. This significant milestone was held for NHSX to formally accredit the Trust as a 2022 digital leader after successfully fulfilling its commitments as part of the Global Digital Exemplar Programme.

This accreditation was recognition for the achievements that were delivered as part of the digital journey the Trust Board agreed to in January 2018.

In October 21, Channel 3 Consulting were commissioned to develop an Options Appraisal, and subsequently an Outline Business Case (OBC) to support further investment in Gateshead's Electronic Patient Record (EPR); focussing on the need for an integrated system, designed to improve the safety and quality of care. The OBC explores the preferred approach to achieving an integrated EPR in a supplier-agnostic manner with supplier selection expected through procurement and Full Business Case development.

During the options appraisal exercise prior to the OBC, Channel 3 engaged with 300+ stakeholders across Gateshead, through a combination of virtual, face-to-face interviews, drop-in sessions, and an online survey. The top 3 challenges and aspirations are outlined in the diagram below:



% of comments codified as 'challenges' and 'aspirations' from survey, interviews and drop-ins

The key message is that Gateshead staff recognise the digitisation achievements to date but have the appetite to further utilise technology and have expressed that the 'best of breed' approach, in its current form, is not optimal and is not preparing Gateshead for future ways of working.

Clinical staff have identified that the lack of integration poses a risk to patient safety, as patient record information is spread across clinical and paper systems and is not always documented consistently. Having a single source of the truth, with effective real-time integration across the different systems would address this risk.

The OBC is currently in final draft and will be shared at the Clinical Policy Group and Digital Transformation Group in June to ensure full clinical ownership and technical assurance of any decision. Clinical ownership is fundamental to effective adoption and uptake of any solution.

The OBC will feed into the refresh of the Digital Strategy which will be undertaken following the refresh of the Trust Strategy and Vision.

3. Digital Delivery and Assurance

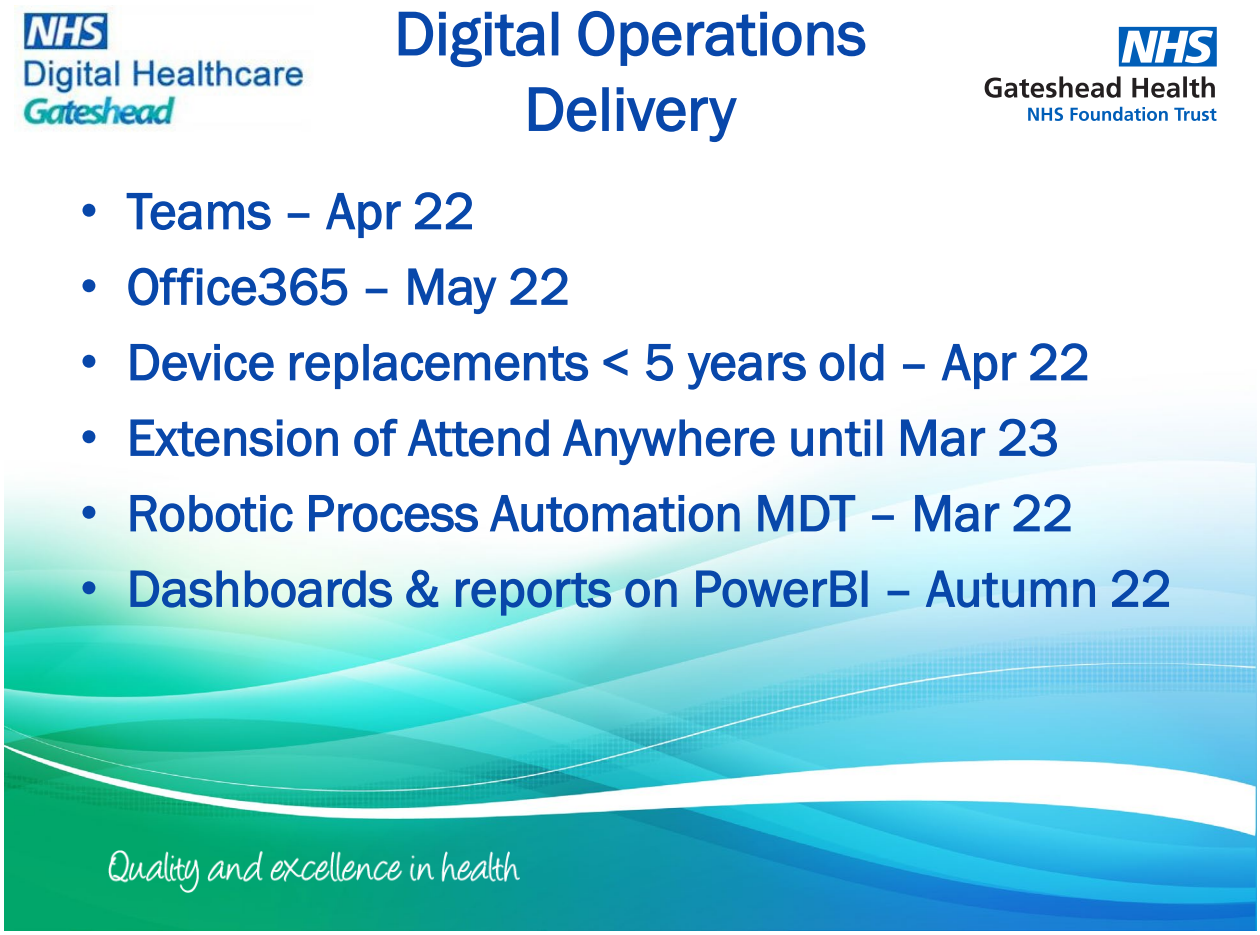
3.1 Digital Clinical Delivery

The slide below pulls out the highlights of the Digital Clinical Delivery over the last 6 months, together with a couple of key deliverables in the next few months.

- The use of Nervecentre continues to expand going live for observations in A&E, with Sepsis screening live in inpatients (in testing for A&E); Fluid balance is fully implemented with further nursing/AHP assessments continuing to being rolled out across the Trust.
- The development for SDEC digital whiteboards is complete, going live this week; with the Back of House digital whiteboards in clinical review – prior to roll out.
- The Digital CAS card has been developed to replace the paper processes in A&E; enabling attendance information to automatically flow back to the GP and other services.
- The imminent EMIS upgrade will provide the community and mental health teams with the capability to capture photographs directly into the patient record – supporting the tissue viability and community nursing teams.
- Gateshead have completed testing as an early implementer of the regional image sharing solutions and are waiting for the other Trust to catch up.
- The regional patient engagement portal development has had a few technical difficulties delaying go live into the summer, Gateshead have completed our testing and will be enabling letter sharing when the capability is released, providing a huge saving in postage costs.

3.2 Digital Operations Delivery

The slide below pulls out the highlights of the Digital Operations Delivery.



- Teams continues to be the place to have the bulk of Trust meetings, fundamentally changing how the Trust operates and enabling the new ways of working.
- The Office365 project is well underway with most personal folders and shared drives already migrated into the cloud – again enabling flexible working. Further support and guidance on how best to use the capability is being developed.
- Device replacements and upgrades have continued site wide to modernise and standardise the hardware in use – now to a maximum age of 5 years old.
- Attend Anywhere – the regional video consultation system contract has been extended until March 2023. There is work at ICS level to standardise solutions with Northumbria Trust going out to the market for solutions.
- Robotic Process Automation – a few automations are now live, support the booking team and MDTs. The system has huge capability to be developed further and we are actively seeking opportunities to eliminate manual processes.
- Updated live operational dashboards are now provided to the site management team to provide live views of pressures across the Trust, on top of core operational systems e.g. Nervecentre, Careflow. Further developments are in planning and are linked to the business case to move the reporting technology platform to Microsoft PowerBI from YellowFin.

3.3 Digital Service Assurance

The slide below pulls out the highlights of the Digital Service Assurance over the last 6 months.

- GDEFF Programme – full accreditation was achieved for GDE FF, both HIMSS 5 and on the NHSx Definition of Done by March 2022.
- The DSP toolkit requirements for 2020/21 were submitted and audited in June 2021 – meeting all requirements. The DSP toolkit 2021/22 is being audited in May 22, prior to final submission on 30 June 22.
- 100% of desktop devices are now on Windows10 and 100% of Windows servers are on Server 2012 or above. Regular patching continues with updated versions of Windows10 and Office365 begin patched; together with a managed replacement for Internet Explorer 11.
- Intrusion detection and prevention – this is fully operational with a review underway to provide assurance on its configuration.
- The new Rubrik immutable backup solution is fully operational with backups now being managed in line with industry best practice; stored for longer, in read only format and mirrored in the cloud.
- The 1st phase of network infrastructure refresh is heading to completion, with 4 edge switches remaining to be swapped over. This will be followed by a full replacement of the Wi-Fi access points once the stock arrive on site; then the Core Network by summer 2023.

4. Summary

This paper gives the Trust Board an update on progress against the digital roadmap for the Trust and the clinical systems options outline business case.

The paper also details a few of the key achievements over the last 6 months – clinically and operationally; together with sharing some of the assurances that have been provided to the Digital Committee.

Recommendations

Trust Board is requested to:

- Accept the report and support the ongoing assurance through the Digital Committee

Nick Black, Chief Digital Information Officer

REPORT – FOR APPROVAL and ASSURANCE

SIRO Report 2021-22

Prepared for the Digital Assurance Group (DAG) to approve and the Board to accept

Purpose of Document:	This report summarises the Trust's key activities in relation to data protection and compliance with data protection law.
Actions required:	The DAG is required to receive and acknowledge the report, to note the key areas of work for the coming year.
Author:	Dianne Ridsdale, Information Governance and Security Manager / DPO Nick Black, SIRO and Chief Digital Information Officer
Date of DAG Meeting	17/05/2022

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5. Summary

In exercising its functions, Gateshead NHS Foundation Trust processes the personal data of members of the public, staff, third party contractors such as businesses that provide services under contract or sharing agreements.

It pertains to the period from 1 April 2021 – 30 March 2022.

Gateshead NHS Foundation Trust is registered as a data controller with the Information Commissioner's Office. Its ICO registration number is Z501467.

The purpose of this report is to demonstrate how the Trust:

- Protects our data and infrastructure from theft, damage, and destruction.
- Complies with data privacy and cybersecurity regulations and responsibilities by allowing data subjects to exercise their rights.
- Ensures our product designs and vendor decisions comply with privacy and cybersecurity regulations and protect our company's image.
- Ensures appropriate privacy audits.

6. Activities and Approach

This SIRO report is the first to review a full year of COVID-19 impacts.

IG operations were delivered remotely, due to the legal restrictions placed on movement and contact in response to the Covid-19 pandemic, and at a time when the transition period for the UK's exit from the European Union came to an end.

The organisation's data protection-related activities included, amongst other things:

- Providing training and support remotely
- Establishing and reviewing the provisions in contracts with third parties
- Establishing and reviewing the governance structure within IT to provide training and support with regards to Information Security management practices.
- Establishing reporting governance to the Digital Assurance Group and the Digital Committee
- Introducing data sensitivity, retention and N365 acceptable use Policy to align with the implementation of Office 365 throughout the Trust.
- Responding to legal developments such as Schrems II and the end of the EU exit transition period.
- Digital restructure to separate cyber assurance from operational delivery.

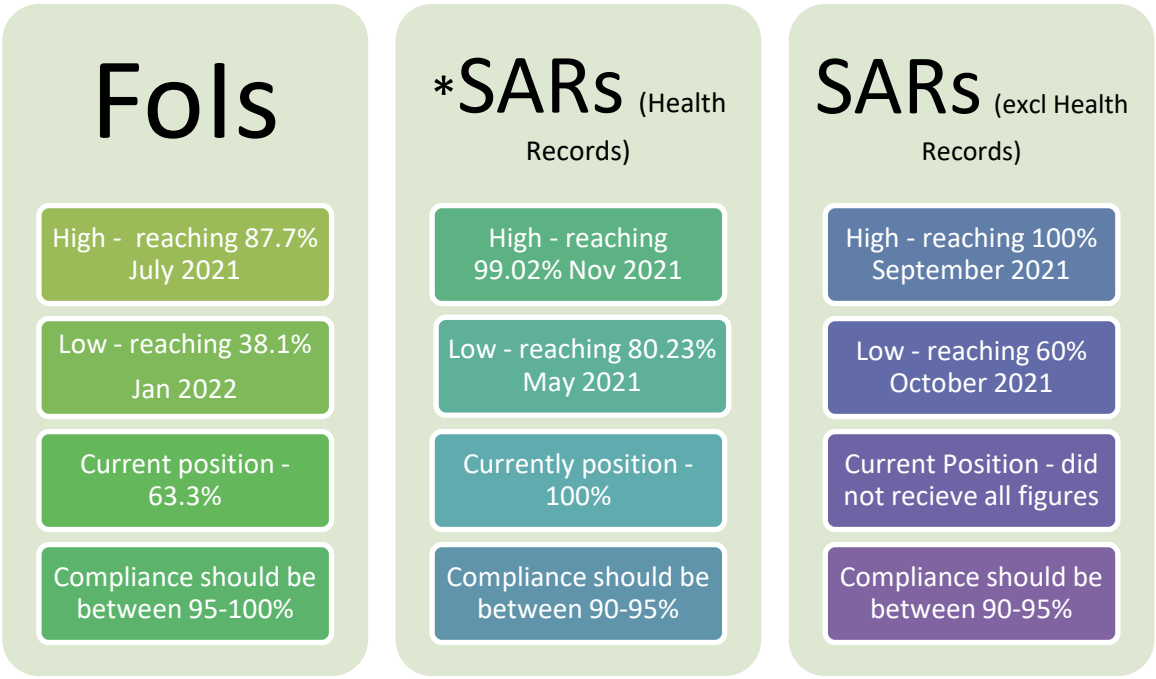
7. Portrait of the data we protect.

- Electronic and physical data ranging from address only to full health, staff records containing special category data.
- This data is kept within a range of environments from physical storage in offices and libraries; to electronic storage within systems and departmental networks including SharePoint/Teams areas.

It is essential that the Trust has a complete and up to date Information Asset Register and data flow map within all departments to fully understand the data it's responsible for. At the time of this report the Information Asset Owners are updating these documents for June submission of the Data Security and Protection Toolkit and full alignment to the Office 365 implementation.

8. Individual Data Rights

The following is for the period of 01/04/2021 – 01/03/2022



Across each of the statutory data rights, compliance rates have been below those required of a public body. The sole driver for this inability to meet the rates has been the impact that Covid-19 has had on these requests; internally within the Digital team, but more crucially as staff resource across the Trust has been at an all-time low, pressures on operational services have been unprecedented and priorities shifted to frontline which is reflected in these figures.

To improve the situation as Covid-19 pressures change, action plans have been implemented and improvements are already evident within those areas. Health Records have already reported improvements via the progress report provided to the Digital Assurance Group.

Reporting will begin with regards to other information requests such as right to have specific processing stopped, right for rectification, right to have data transferred etc. within this financial year.

9. Data incidents

85 data incidents were reported to, and investigated by, the Trust which had IG elements.

The types of incidents have involved, for example, emails being sent to the wrong email address, and documents containing details for the wrong person being attached to emails or sealed and posted; or other technical failures such as no process or process not followed by staff.

No incidents have been deemed to meet the threshold of risk which would require them to be reported to the ICO.

10. Data Protection Impact Assessments (DPIAs)

Data Protection Impact Assessment (DPIA) must be completed for any new system, changes in a system or process which uses personal information. The need for a DPIA must be considered at the earliest opportunity before the tender process commences, the change is implemented, sharing occurs etc.

A DPIA makes sure any proposal will be compliant with any privacy and Information Governance requirements and that these are built into the planning stage, money is not wasted on purchasing new systems or services that are not compliant with the Trusts' legal obligations that later must be changed or added to, often at an additional cost and that sharing practices are justified and clearly set out.

For this reporting period the IG team have:

- Issued 15 DPIAs which have not been returned for review
- Returned 10 DPIAs to leads with comments from a review
- Approved 17 as assured if risks identified are sufficiently mitigated
- Deemed 8 as not applicable due to no personal or special category data is to be processed.

11. Areas of risk

Top 3 risks

Datix ref	Risk	Inherent Risk Rating	Current Risk
1636	Malware such as Ransomware Compromising Unpatched Endpoints, Servers, and Equipment	25	10
2171	System or Technology Change	25	10
1490	Failure to manage Information Assets	20	9

The IG Team has recently appointed an Information Security Specialist to assist the IT department and the SIRO in identifying, gaps in processes, monitoring and management, gaps in security and risk reporting and to be a point of contact for advice, guidance and to monitor progress and action plans.

Assurance on digital risks is provided through Digital Assurance Group, with escalation to Digital Committee where required.

12. Training

Employees and board members have been asked to annually complete a Data Security and Protection e-learning module within ESR.

- The annual requirement was achieved in July 2021, with just over 95% of employees completing their training in the previous twelve months
- Current position has dropped down to 80%

13. Looking to the future

- Information Asset Owners (IAOs) must continue to embed local data protection and security management structures throughout their areas of responsibility while also providing greater

assurances in areas such as asset management, information flows, audit reporting to DAG and the Digital Committee.

- It is essential the Board, executives, leads and managers champion awareness of staff IG responsibilities, accountabilities, and training requirements to address and reduce incidents and risks.
- The restart of the Information Risk Management Programme will assist Information Asset Owners to fully incorporate all elements within their audit programmes to safeguard data and security of the Trust infrastructure. This applies to all areas of the Trust and will assist the Trust in moving to a proactive strategy.
- IT to work with the Information Security Specialist to implement processes to assist them in the management, monitoring and reporting of their operational areas to move to a proactive, department.
- The IG team will implement specific awareness programmes as part of the Information Risk Programme with targeted webinars, infographics, and communications to support staff in following the correct procedures, auditing practices and due diligence that their accountable for.
- The IG team will work with L&D and the Communications team with the continuation of communications within QE Weekly, and social media highlighting the importance of completing IG core skills training and the training dashboard to assist managers with staff awareness and compliance while also providing bitesize awareness to staff on specific topics highlighted by incident trends and queries.
- The IG team will review all their policies and procedures to ensure they're fit for purpose and any gaps are filled.
- The IG team will continue to report to the Digital Assurance Group to drive the data protection and confidentiality programme for the Board and the SIRO to make their strategic decisions in this area.

14. Final thoughts

The IG function is here to assist with ensuring our product designs and vendor decisions comply with privacy and cybersecurity regulations and protect our company's data and image.

The Framework of policies and procedures provided by the IG Team are integral in ensuring the right due diligence is undertaken before any agreement/contract is signed where information is to be processed and/or network/system configurations are required and where any department wishes to share data.

The IG team continues to focus on protecting and upholding the rights and freedoms of the people whose personal data the Trust holds and continues to support and emphasize the institutional and individual accountability and responsibility, to ensure a healthy and positive approach to the ownership and management of personal data. This culture still has some way to becoming embedded in the Trust as it evolves and continues to restructure itself however with the Board and SIRO driving the agenda from the "top down" I am seeing a shift for the better.

Following a busy and challenging year, there is more to do to address the identified risks, and some have persisted once identified. However, the Board should be encouraged by the overall approach the organisation has taken to data protection during this period, and the culture that is developing to overcome challenges.

The Trust is only as strong as its weakest link and the recent challenges of the pandemic have seen a period of innovation in the UK tech sector and an unlocking of data. This is the perfect opportunity for the data protection and confidentiality agenda to strengthen links across the Trust with the sponsorship of the Board, Executives, Departments and Service Leads.

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 17

Report Title:	**Ockenden Final Report – Maternity service gap analysis and current position**			
Name of Meeting:	Board of Directors meeting			
Date of Meeting:	**Wednesday 25th May 2022**			
Author:	Lesley Heelbeck			
Executive Sponsor:	Gillian Findley/Helen Routh			
Report presented by:	Gillian Findley			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☒	**Assurance:** ☒	**Information:** ☒
	The Final Ockenden report was published in March 2022. The maternity service has performed a gap analysis and highlighted the immediate issues for action within the service.			
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*	Ockenden compliance reviewed against initial 7 immediate and essential actions. Reported as an exception within the March IOR			
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 second and final Ockenden report builds upon the first report in that all the (immediate and essential actions) IEAs within that report remain important and must be progressed however within the second report there are a further 15 IEA/recommendations which are further subdivided into actions for the system. Providers must ensure robust planning and operational change aligned to the report's four key pillars: • **Safe staffing levels** • **A well-trained workforce** • **Learning from incidents** • **Listening to families** A Full nursing and midwifery service staffing review underway is underway including review of the Midwifery Continuity of Carer (MCOC) strategy. The roll out of further continuity of carer teams has been paused. The HOM will provide a summarised report to Chief Nurse by the end of May 2022.			

<table>
<tr><td></td><td colspan="6">The Maternity Voice Partnership leads have a copy of the report, and we will involve our service users in the planning and implementation of the recommendations.
The Maternity safety and quality strategy will be aligned to the report's four key pillars.
There are also significant pressures on the obstetric medical staff rota.
Time needs to be built in to job plans for fetal monitoring training and MDT training. This is currently on our risk register as due to vacancies, covid absence and long-term sickness we are unable to release large numbers of clinical staff for training.

Work and support will be required within the Trust corporate teams to ensure that all Board reporting requirements are met.</td></tr>
<tr><td>Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper</td><td colspan="6">A full gap analysis of Maternity services' assessment against each of the 15 IEAs has been performed and enclosed for review and information.
Within this report the IEAs with the most immediate actions required for our maternity service have been highlighted and for the board to be cited upon.</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:</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>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>Responsive
☒</td><td>Well-led
☒</td><td>Effective
☒</td><td colspan="2">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">2687 – Face to face Skills drills training</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>

1. Executive summary

The National focus is upon the improvement of safety within Maternity services. The Ockenden report was published in December 2020. The final report of the Independent Maternity Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust was published at the end of March 2022. The size and scale of this review is unprecedented in NHS history. There are now at least two other independent maternity service reviews in progress at this time which has caused concerns that this may be indicative of some wider systemic issues.

The report investigation highlights an NHS Provider Trust and maternity service that failed in several ways:

- To investigate
- To learn
- To improve
- To safeguard mothers and their babies at one of the most important times in their lives

In the first Ockenden report there were outlined the Local Actions for Learning, (LAfL) and Immediate and Essential Actions, (IEAs) to be implemented at the Trust and across the wider maternity system in England. The second report builds upon the first report in that all the LAfL and IEAs within that report remain important and must be progressed however within the second report there are a further 15 IEA/recommendations which will be further subdivided into actions for the system and an equal number of Local Actions for the Trust under investigation.

All providers must ensure robust planning and operational change aligned to the report's four key pillars:

- **Safe staffing levels**
- **A well-trained workforce**
- **Learning from incidents**
- **Listening to families**

A full gap analysis is enclosed within the paper.

2. Introduction

The first Ockenden report is one year on, and all Maternity units have undergone a process of review and self-assessment. Our self- declaration with the progress so far and actions needed to achieve compliance with the IEAs now has been confirmed by external review and scrutiny by the Regional Perinatal Oversight Group/NENC LMNS. The team provided verbal feedback where evidence could be made more specific to be more robust and advised upon further actions required to give more assurance than reassurance.

The National Maternity transformation team have designated accountability for monitoring and oversight of the recommendations to the Regional Perinatal Oversight Group/NENC LMS and to follow up with assurance and support visits. The purpose of the visits is for the Trusts to provide assurance to the LMNS and the Region's against the 7 immediate and essential actions implementation from the first published part of the Ockenden report. These visits are intended to be supportive for LMNSs and Trusts, using an appreciative enquiry and learning approach which will foster partnership working. Gateshead Health Maternity unit has the assurance and support visit planned for the 16th of June 2022. There is a set number of 'KLOE's that the Trust and maternity service have been asked to supply before the visit.

The Maternity service has made significant improvements to work towards full compliance with the 7 IEAs. There is a working action plan and completed assessment and assurance document which is monitored via

local and regional reporting. The IEAs from the second Ockenden report will be incorporated into this working document as many of the themes overlap and are linked with the Maternity Incentive Scheme safety actions.

3. Context

The second report by the independent maternity review team have identified new themes which have been shared across all maternity services in England as a matter of urgency to bring about positive and essential change.

The key themes are:

- **Patterns of repeated poor care**

The quality of care and investigation procedures carried out by the Trust were poor and did not identify where opportunities for learning and improving quality of care have been missed.

- **Failure in governance and leadership**

Failure to work collaboratively across disciplines

- **Missed opportunities**

The review team believes that the Trust Board and the CCGs were 'reassured' rather than 'assured' with regards to governance and safety within the maternity service.

- **Poor complaints handling/poor reporting, grading and investigation of incidents**

Lessons were not learned or shared with teams and families

Complaint responses were not empathetic, open, and honest

Throughout the various stages of care the review team has identified:

- Failing to follow national clinical guidelines and resuscitation guidelines
- Delays in escalation

4. Recommendations

A full gap analysis of our assessment against each of the 15 IEAs has been performed and enclosed. However, for this report the IEAs with the most immediate actions required for our maternity service have been highlighted below:

The main risk around safe staffing is the effect of Covid absence and isolation combined with WTE vacancies and inability to recruit. Daily escalation is in process with safe staffing levels maintained by increase bank use. The MCOC teams are supporting with which impacts upon an effective delivery of this model of care. NHS England and NHS Improvement are working with the Department of Health and Social Care to implement the 15 Immediate & Essential Actions (IEAs) and every Trust, ICS and LMS/LMNS Board must consider and then act on the report's findings.

'All trusts must review and suspend, if necessary, the existing provision and further roll out of Midwifery Continuity of Carer (MCoC) unless they can demonstrate staffing meets safe minimum requirements on all shifts.' (IEA 2, Safe Staffing page 164).

- Review of MDT training
- Review preceptorship programmes and support of newly qualified midwives.
- To further develop and consolidate the links to the Regional Maternal medicine network to enhance the care and safety of complex pregnancies
- Financing a safe workforce

The maternity service is assessing the staffing position and will make one of the following decisions for their maternity service by the end of May 2022:

- Trusts that can demonstrate staffing meets safe minimum requirements can continue existing MCoC provision and continue to roll out, subject to ongoing minimum staffing requirements being met for any expansion of MCoC provision.
- Trusts that cannot meet safe minimum staffing requirements for further roll out of MCoC but can meet the safe minimum staffing requirements for existing MCoC provision, should cease further roll out and continue to support at the current level of provision or only provide services to existing women on MCoC pathways and suspend new women being booked into MCoC provision.
- Trusts that cannot meet safe minimum staffing requirements for further roll out of MCoC and for existing MCoC provision, should immediately suspend existing MCoC provision and ensure women are safely transferred to alternative maternity pathways of care, taking into consideration their individual needs; and any midwives in MCoC teams should be safely supported into other areas of maternity provision. All Trusts are required to submit CoC Action Plans for submission by June 15th to region. This will require approval within the Trust boards. Meetings with the MCOC team's haves been arranged alongside listening events for all staff who have been impacted by the recommendations and have concerns.

There are also significant pressures on the obstetric medical staff rota. Time needs to be built in to Job plans for fetal monitoring training and MDT training. This is currently on our risk register as due to vacancies, covid absence and long-term sickness we are unable to release large numbers of clinical staff for training. Face to Face skills drills and prompt training has been re-commenced and prioritised. Year 3 MIS premium rebate has been ring fenced for safety training and will be used for further Prompt equipment and training. The Obstetric theatre scrub case has been agreed by the SBU operational Board, however 5.6 WTE midwives are required to perform this role until a scrub team can be recruited to.

Summary

A Full nursing and midwifery service staffing review underway is underway including review of the MCOC strategy. The HOM will provide a summarised report to Chief Nurse by the end of May 2022.

The Maternity service senior leadership team have a current working action plan which is based around implementation and achievement of compliance with the 7 IEAs and 12 actions contained within the first Ockenden report. This has been reported via the IOR to the Trust board in March 2022. The plan will be externally reviewed by the NENC LMS. All staff have been sent a copy of the report and listening events to support staff are being planned. The Maternity Voice Partnership leads have a copy of the report, and we will involve our service users in the planning and implementation of the recommendations. The Maternity safety and quality strategy will be aligned to the report's four key pillars.

Work and support will be required within the Trust corporate teams to ensure that all Board reporting requirements are met.

Lesley Heelbeck

Head of Midwifery/SCBU

Gateshead Health NHS Foundation Trust

Ockenden Report- Final (May 2022)

Appendix

Gap analysis against the 15 recommendations and Essential Actions

Strategic overview of which organisation is responsible for responding to each of the 15 essential actions

Essential Action	National	LMNS	Provider Trust	Neonatal Network	Commissioners
1. Workforce Planning	✓	✓	✓		
2. Safe Staffing		✓	✓		
3. Escalation & Accountability			✓		
4. Clinical Governance Leadership			✓		
5. Clinical Governance Incident Investigation & Complaints			✓		
6. Learning From Maternal Deaths	✓	✓	✓		
7. Multi-Disciplinary Training		✓	✓		
8. Complex Antenatal Care		✓	✓		
9. Pre-Term Births			✓	✓	
10. Labour And Birth			✓		
11. Obstetric Anaesthesia	✓		✓		
12. Postnatal Care			✓		
13. Bereavement Care			✓		
14. Neonatal Care		✓	✓	✓	✓
15. Support Families			✓		

Summary of the 15 essential actions including the action required by each of the organisations and current position of Gateshead Maternity service.

1. Workforce Planning

Essential Action- financing a safe maternity workforce
The recommendations from the Health and Social Care Committee Report: The safety of maternity services in England must be implemented.

National

- To fund maternity and neonatal services appropriately requires a multiyear settlement to ensure the workforce is enabled to delivery consistently safe maternity and neonatal care across England.
- Minimum staffing levels should be those agreed nationally
- Feasibility and accuracy of the Birth-rate Plus tool and associated methodology must be reviewed nationally by all bodies, and as a minimum, NHSE, RCOG, RCM, RCPCH

LMNS

- Where there are no agreed national levels, staffing levels should be agreed with the LMNS. This must encompass the increased acuity and complexity of women vulnerable families and additional mandatory training to ensure trusts are able to safely meet organisational CNST and CQC requirements

Gateshead Trust are required to ensure:	**Current trust position**
• Minimum staffing levels must include a locally calculated uplift, representative of the three previous years' data, for all absences including sickness, mandatory training, annual leave, and maternity leave	Current 22% uplift for midwifery and support staff. This will need to be reviewed against current required training needs for all staff. Review required of medical staffing non-clinical hours to assess if appropriate number of hours are provided

Essential Action – Training
Health and Social Care Select Committee view that a proportion of maternity budgets must be ring-fenced for training in ever maternity unit should be implemented

National

• Deliver a fully funded and nationally recognised labour ward co-ordinator education module, which supports advanced decision-making, learning through training in human factors, situational awareness, and psychological safety, to tackle behaviours in the workforce. • The review team acknowledges the progress around the creation of Maternal Medicine Networks nationally, which will enhance the care and safety of complex pregnancies. To address the shortfall of maternal medicine physicians, a sustainable training programme across the country must be established, to ensure the appropriate workforce long term.	
Trusts • Implement a robust preceptorship programme for newly qualified midwives (NQM), which supports supernumerary status during their orientation period and protected learning time for professional development as per the RCM (2017) position statement.	**Current position** • Preceptorship programme in development with Trust practice development team. 12-week supernumery period in place.
• All NQMs must remain within the hospital setting for a minimum period of one year post qualification. This timeframe will ensure there is an opportunity to develop essential and competencies on which to advance their clinical practice, enhance professional confidence and resilience and provide a structured period of transition from student to accountable midwife.	• Currently band 5 midwives rotate into the community and continuity of care teams. This has been very well evaluated but will have to be reviewed and will put pressure on the band 6 midwives to support community services
• Ensure all midwives responsible for co-ordinating labour ward attend a fully funded and nationally recognised labour ward co-ordinator education module, which supports advanced decision-making, learning through training in human factors, situational awareness, and psychological safety, to tackle behaviours in the workforce. • Ensure newly appointed labour ward co-ordinators receive an orientation package which reflects their individual needs. This must encompass opportunities to be released from clinical practice to focus on their personal and professional development.	• Module not yet available but will work with current resources to develop • Delivery suite co-ordinator JD to be reviewed and aligned to specialist role with requisites for specialist skills • Progression package to band 7 for band 6 midwives to be developed by Matron and HOM with support from LMNS
• Develop a core team of senior midwives who are trained in the provision of high dependency maternity care. The core team should be large enough to ensure there is at least one HDU trained midwife on each shift, 24/7	• Small DGH and workforce which would mean training all senior midwives in HDU a difficult option and to maintain competencies. Mothers who need high dependency care are transferred to main site HDU and supported by midwives.
• Trusts must develop a strategy to support a succession-planning programme for the maternity workforce to develop potential future leaders and senior managers. This must include a gap analysis of all leadership and management roles to include those held by specialist midwives and obstetric consultants. This includes supportive organisational process and relevant practical work experience.	• Workforce plan in development which will include focus on leadership. Also link to the Nursing, AHP and Midwifery strategy • Gap analysis/succession planning discussions required for medical leadership positions
2. Safe Staffing	
Essential Action **All Trusts must maintain a clear escalation and mitigation policy where maternity staffing falls below the minimum staffing levels for all health professionals**	
Trusts • When agreed staffing levels across maternity services are not achieved on a day-to-day basis that should be escalated to the services' senior management team, obstetric leads, the chief nurse, medical director, and patient safety champion and LMNS	**Current position** Acuity tool used to report 4 hourly within the acute unit • Review escalation policy to NENC LMNS guidance and include safety champions, chief nurse, medical director
• Where there are no separate consultant rotas for obstetrics and gynaecology there must be a risk assessment and escalation protocol for periods of competing workload. This must be agreed a board level.	• Requires discussion at Business unit level
• Ensure the labour ward co-ordinator role is recognised as a specialist job role with an accompanying job description and person specification.	• JD to be developed not specialist now
• Review and suspend, if necessary, the existing provision and further roll out of Midwifery Continuity of Carer (MCoC) unless they can demonstrate staffing meets safe minimum requirements on all shifts. This will preserve the safety of all pregnant women and families, which is currently compromised by the unprecedented pressures that MCoC models place on maternity services already under significant strain. • Reinstatement of MCoC should be withheld until robust evidence is available to support its reintroduction.	• MCOC further roll out paused and staffing model under review to support safe staffing across acute and community services. Staffing levels are under review across acute and community services including MCOC teams. MCOC x 2 teams but 3rd team paused until review completed.
• The required additional time for maternity training for consultants and locally employed doctors must be provided in job plans. The protected time required will be in additional to that required for generic trust mandatory training and reviewed as training requirements change.	• Consultant training job plans
• Ensure there are visible, supernumerary clinical skills facilitators to support midwives in clinical practice across all settings. • Newly appointed Ban7/8 midwives must be allocated in a named and experienced mentor to support their transition into leadership and management roles.	• Recruitment & retention midwife in post – review workload with practice development midwife to support clinically • Mentorship programme to be developed for band 7 & 8 midwives/nurses

• Must develop strategies to maintain bi-directional robust pathways between midwifery staff in the community setting and those based in the hospital setting, to ensure high quality care and communication.	• Pathways in place between acute & community services but needs to be strengthened. MCOC model facilitates this.
• Should follow the latest RCOG guidance on managements of locums. The RCOG encourages the use of internal locums and has developed practical guidance with NHS England on the management of locums. This includes support for locums and ensuring they comply with recommended processes such as pre-employment checks and appropriate induction.	• External medical locums are very rarely used in the department at this current time
LMNS Receive notifications from Trusts when agreed staffing levels are not achieved on a day-to-day basis.	

3. Escalation And Accountability

Essential Action
Staff must be able to escalate concerns if necessary
There must be clear processes for ensuring that obstetric units are staffed by appropriately trained staff at all times
If not resident there must be clear guidelines for when a consultant obstetrician should attend

Trusts • Must develop and maintain a conflict of clinical opinion policy to support staff members in being able to escalate their concerns regarding a woman's care in case of disagreement between healthcare professionals. • When a middle grade or trainee obstetrician (non-consultant) is managing the maternity service without direct consultant presence trusts must have an assurance mechanism to ensure the middle grade or trainee is competent for this role. • Should aim to increase resident consultant obstetrician presence where this is achievable. • There must be clear local guidelines for when consultant obstetrician's attendance is mandatory within the unit. • There must be clear local guidelines detailing when the consultant obstetrician and the midwifery manager on-call should be informed of activity within the unit.	Conflict of opinion policy SOP to be developed RCOG mandatory Consultant attendance being implemented. Audit & evidence of trainee competency in development Review escalation policy to ensure clear re contacting midwifery manager on call/Consultant – do we need a midwifery manager on call formal rota?

4. Clinical Governance Leadership

Essential Action
Trust boards must have oversight of the quality and performance of their maternity services.
In all maternity services the Director of Midwifery and Clinical Director for obstetrics must be jointly operationally responsible and accountable for the maternity governance systems.

Trusts • Trust Boards must work together with maternity departments to develop regular progress and exception reports, assurance reviews and regularly review the progress of any maternity improvement and transformation plans. • Maternity service senior leadership teams must use appreciative inquiry to complete the National Maternity Self-Assessment Tool if not previously done. A comprehensive report of their self-assessment including governance structures and any remedial plans must be shared with their trust board. • Every trust must ensure they have a patient safety specialist, specifically dedicated to maternity services. • All clinicians with responsibility for maternity governance must be given sufficient time in their job plans to be able to engage effectively with their management responsibilities. • Ensure that those individuals leading maternity governance teams are trained in human factors, causal analysis and family engagement. • All maternity services must ensure there are midwifery and obstetric co-leads for developing guidelines. The midwife co-lead must be of a senior level, such as a consultant midwife, who can drive the guideline agenda and have links with audit and research. • All maternity services must ensure they have midwifery and obstetric co-leads for audits.	Governance and reporting structure in place. Self-assessment tool to be completed and reported to Safety Champions at next meeting in June 2022. Lead Midwife for Quality, Risk and Safety in post. Job plans require review to accommodate additional requirements. Training requirements will be reviewed. FLO trained midwifes and Professional Midwifery Advocates in post. Time and review of job plans required to facilitate additional requirements around audit and guidelines. Obstetric lead in post. No designated midwifery leads.

5. Clinical Governance – Incident Investigation and Complaints

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

Trusts • Maternity governance teams must ensure the language used in investigation reports is easy to understand for families, for example any medical terms are explained in lay terms • Lessons from clinical incidents must inform delivery of the local multidisciplinary training plan • Actions arising from a serious incident investigation which involve a change in practice must be audited to ensure a change in practice has occurred • Change in practice arising from an SI investigation must be seen within 6 months after the incident occurred. • Complaints which meet SI threshold must be investigated as such • Must involve service users (ideally via their MVP) in developing complaints response processes that are caring and transparent.	Glossary and terms of abbreviations on all shared reports Lessons learned and HSIB recommendations shared on mandatory training and form clinical skills drills if appropriate Action log maintained All SI reported Service users involved in PMRT and complaints Themes and trends monitored at all levels of business unit and trust governance meetings

• Complaints themes and trends must be monitored by the maternity governance team.	

6. Learning From Maternity Deaths

Essential Action
Nationally all maternal post-mortem examinations must be conducted by a pathologist who is an expert in maternal physiology and pregnancy related pathologies.
In the case of a maternal death a joint review panel/investigation of all services involved in the care must include representation from all applicable hospitals/clinical settings.

National
- NHS England and Improvement must work together with the Royal Colleges and the Chief Coroner for England and Wales to ensure that this is provided in any case of a maternal death
- This joint review panel/investigation must have an independent chair, must be aligned with local and regional staff and seek external clinical expert opinion where required.

LMNS
- The learning from the maternal death must also be shared across the LMNS

Trusts • Learning from this maternal death review must be introduced into clinical practice within 6 months of the completion of the panel.	All maternal deaths reported as SI. HSIB will be involved as external review and to involve families. MBRRACE reportable.

7. Multi-Disciplinary Training

Essential Action
Staff who work together must train together
Staff should attend regular mandatory training and rotas. Job planning needs to ensure all staff can attend.
Clinicians must not work on labour ward without appropriate regular CTG training
and emergency skills training

LMNS
- Must agree the content of Trust human factor training.

Trusts • All members of the multidisciplinary team working within maternity should attend regular joint training, governance and audit events. Staff should have allocated time in job plans to ensure attendance, which must be monitored. • Multidisciplinary training must integrate the local handover tools (such as SBAR) into the teaching programme at all trusts. • All trusts must mandate annual human factor training for all staff working in a maternity setting; this should include the principles of psychological safety and upholding civility in the workplace, ensuring staff are enabled to escalate clinical concerns. The content of human factor training must be agreed with the LMS. • There must be regular multidisciplinary skills drills and on-site training for the management of common obstetric emergencies including haemorrhage, hypertension and cardiac arrest and the deteriorating patient. • There must be mechanisms in place to support the emotional and psychological needs of staff, at both an individual and team level, recognising that well supported staff teams are better able to consistently deliver kind and compassionate care. • Systems must be in place in all trusts to ensure that all staff are trained and up to date in CTG and emergency skills. Clinicians must not work on labour wards or provide intrapartum care in any location without appropriate regular CTG training and emergency skills training. This must be mandatory	As per MIS Year 4 compliance

8. Complex Antenatal Care

Essential Action
Local Maternity Systems, Maternal Medicine Networks and trusts must ensure that women have access to pre-conception care.
Trusts must provide services for women with multiple pregnancy in line with national guidance
Trusts must follow national guidance for managing women with diabetes and hypertension in pregnancy

LMNS
- Women with pre-existing medical disorders, including cardiac disease, epilepsy, diabetes and chronic hypertension, must have access to preconception care with a specialist familiar in managing that disorder and who understands the impact that pregnancy may have.

Trusts • Must have in place specialist antenatal clinics dedicated to accommodate women with multifetal pregnancies. They must have a dedicated consultant and have dedicated specialist midwifery staffing. These recommendations are supported by the NICE Guideline Twin and Triplet Pregnancies 2019. • NICE Diabetes and Pregnancy Guidance 2020 should be followed when managing all pregnant women with pre-existing diabetes and gestational diabetes. • When considering and planning delivery for women with diabetes, clinicians should present women with evidence-based advice as well as relevant national recommendations. Documentation of these joint discussions must be made in the woman's maternity records. Must develop antenatal services for the care of women with chronic hypertension. Women who are identified with chronic hypertension must be seen in a specialist consultant clinic to evaluate and discuss risks and benefits to treatment. Women must be commenced on Aspirin 75-150mg daily, from 12 weeks gestation in accordance with the NICE Hypertension and Pregnancy Guideline (2019).	• No current twin clinics, due to small numbers at Gateshead • Multiple pregnancy guideline up to date in line with NICE • Diabetes in pregnancy guideline up to date in line with NICE • Aspirin risk assessment on Badger in line with NICE, & hypertension guideline Lead Consultant for maternity medicine – links to regional MDT meetings

9. Preterm Birth

Essential Action
The LMNS, commissioners and trusts must work collaboratively to ensure systems are in place for the management of women at high risk of preterm birth.
Trusts must implement NHS Saving Babies Lives Version 2 (2019)

Trusts • Senior clinicians must be involved in counselling women at high risk of very preterm birth, especially when pregnancies are at the thresholds of viability. • Women and their partners must receive expert advice about the most appropriate fetal monitoring that should be undertaken dependent on the gestation of their pregnancies and what mode of delivery should be considered.	Pre-term birth clinic in place led by Consultant Obstetrician and specialist midwife. • Specialist preterm midwife, named Consultant & HCA in post. Dedicated pathway & clinic.

	• Extreme preterm guideline in place – (regional) • On-going audit of extreme birth optimisation, pathways & outcomes (shared regionally)
Neonatal Network • Discussions must involve the local and tertiary neonatal teams so parents understand the chances of neonatal survival and are aware of the risks of possible associated disability. • There must be a continuous audit process to review all in utero transfers and cases where a decision is made not to transfer to a Level 3 neonatal unit and when delivery subsequently occurs in the local unit.	
10. Labour And Birth	
Essential Action **Women who choose birth outside a hospital setting must receive accurate advice with regards to transfer times to an obstetric unit should this be necessary.** **Centralised CTG monitoring systems should be mandatory in obstetric units**	
Trusts • All women must undergo a full clinical assessment when presenting in early or established labour. This must include a review of any risk factors and consideration of whether any complicating factors have arisen which might change recommendations about place of birth. These must be shared with women to enable an informed decision re place of birth to be made.	Aligned to IEA 5 in first Ockenden report. Audit of risk assessment included in audit cycle. Place of birth audit required.
• Midwifery-led units must complete yearly operational risk assessments. • Midwifery-led units must undertake regular multidisciplinary team skill drills to correspond with the training needs analysis plan. • It is mandatory that all women who choose birth outside a hospital setting are provided accurate and up to date written information about the transfer times to the consultant obstetric unit. Maternity services must prepare this information working together and in agreement with the local ambulance trust. • Maternity units must have pathways for induction of labour, (IOL). Trusts need a mechanism to clearly describe safe pathways for IOL if delays occur due to high activity or short staffing. • Centralised CTG monitoring systems must be made mandatory in obstetric units across England to ensure regular multi-professional review of CTGs.	No MLUs at Gateshead Operational policy in place and supported by consultant obstetrician and professional midwifery advocates. Home birth policy in place. Require meeting with NEAS to update and review. Work with MVP Clear pathway and guideline in place for IOL. Delays are reported via acuity tool and monitored through triangulation of complaints and patient experience feedback. Need to update IOL guidance to reflect. Audit being developed to capture data. Centralised CTG monitoring in place.
11.Obstetric Anaesthesia	
Essential Action **In addition to routine inpatient obstetric anaesthesia follow-up, a pathway for outpatient postnatal anaesthetic follow-up must be available in every trust to address incidences of physical and psychological harm.** **Documentation of patient assessments and interactions by obstetric anaesthetists must improve. The determination of core datasets that must be recorded during every obstetric anaesthetic intervention would result in record-keeping that more accurately reflects events.** **Staffing shortages in obstetric anaesthesia must be highlighted and updated guidance for the planning and provision of safe obstetric anaesthesia services throughout England must be developed.**	
National Resources must be made available for anaesthetic professional bodies to determine a consensus regarding contents of core datasets and what constitutes a satisfactory anaesthetic record in order to maximise national engagement and compliance.	

Trusts
• Conditions that merit further follow-up include, but are not limited to, postdural puncture headache, accidental awareness during general anaesthesia, intraoperative pain and the need for conversion to general anaesthesia during obstetric interventions, neurological injury relating to anaesthetic interventions, and significant failure of labour analgesia.
• Anaesthetists must be proactive in recognising situations where an explanation of events and an opportunity for questions may improve a woman's overall experience and reduce the risk of long-term psychological consequences.
• All anaesthetic departments must review the adequacy of their documentation in maternity patient records and take steps to improve this where necessary as recommended in Good Medical Practice by the GMC
• Obstetric anaesthesia staffing guidance to include:
  ○ The role of consultants, SAS doctors and doctors-in-training in service provision, as well as the need for prospective cover, to ensure maintenance of safe services whilst allowing for staff leave.
  ○ The full range of obstetric anaesthesia workload including, elective caesarean lists, clinic work, labour ward cover, as well as teaching, attendance at multidisciplinary training, and governance activity.
  ○ The competency required for consultant staff who cover obstetric services out of hours, but who have no regular obstetric commitments.
  ○ Participation by anaesthetists in the maternity multidisciplinary ward rounds as recommended in the first report.
	Compliant for PDP headache and accidental awareness during GA. Need to amend Badger to include a prompt to follow up the other conditions in clinic.
	
	Consultant Anaesthetist ward rounds each day. Involved with Debrief service when required.
	
	Audit required to understand baseline. Electronic records utilised on Badger.

12.Postnatal Care	
Essential Action **Trusts must ensure that women readmitted to a postnatal ward and all unwell postnatal women have timely consultant review.** **Postnatal wards must be adequately staffed at all times**	

Trusts • All trusts must develop a system to ensure consultant review of all postnatal readmissions, and unwell postnatal women, including those requiring care on a non-maternity ward. • Unwell postnatal women must have timely consultant involvement in their care and be seen daily as a minimum. • Postnatal readmissions must be seen within 14 hours of readmission or urgently if necessary. • Staffing levels must be appropriate for both the activity and acuity of care required on the postnatal ward both day and night, for both mothers and babies.	Postnatal re-admission reported on Maternity dashboard. • Postnatal readmissions reported via Datix & reviewed by MDT team • Postnatal ward acuity reporting MEOWS & care of women out with maternity setting guidelines updated & shared throughout Trust Audit required. Postnatal acuity tool used to monitor 4 hourly and reported weekly and within staffing reports.
13.Bereavement Care	
Essential Action **Trusts must ensure that women who have suffered pregnancy loss have appropriate bereavement care services.**	
Trusts • Must provide bereavement care services for women and families who suffer pregnancy loss. This must be available daily, not just Monday to Friday. • Must ensure adequate numbers of staff are trained to take post-mortem consent, so that families can be counselled about post-mortem within 48 hours of birth. They should have been trained in dealing with bereavement and in the purpose and procedures of post-mortem examinations. • Must develop a system to ensure that all families are offered follow-up appointments after perinatal loss or poor serious neonatal outcome. • Compassionate, individualised, high quality bereavement care must be delivered for all families who have experienced a perinatal loss, with reference to guidance such as the National Bereavement Care Pathway	• Bereavement care provided 24/7. No specialised midwife in post due to size of service but midwife with specialist interest utilised. • Medical staff take consent for PM • All parents and families have follow up and supported by trained FLO if required. • National Bereavement Care Pathway guidance followed but not fully implemented Bereavement pathway in place – not NBCP – needs updating • Time for bereavement lead midwife • All perinatal losses reported to MMBRRACE – PMRT letters sent with named contact & follow up meetings
14.Neonatal Care	
Essential Action **There must be clear pathways of care for provision of neonatal care.** **This review endorses the recommendations from the Neonatal Critical Care Review (December 2019) to expand neonatal critical care, increase neonatal cot numbers, develop the workforce and enhance the experience of families. This work must now progress at pace.**	
LMNS • Care that is outside this agreed pathway must be monitored by exception reporting (at least quarterly) and reviewed by providers and the network. The activity and results of the reviews must be reported to commissioners and the Local Maternity Neonatal Systems (LMS/LMNS) quarterly.	
Trusts • Neonatal and maternity care providers, commissioners and networks must agree on pathways of care including the designation of each unit and on the level of neonatal care that is provided. • Care that is outside this agreed pathway must be monitored by exception reporting (at least quarterly) and reviewed by providers and the network. The activity and results of the reviews must be reported to commissioners and the Local Maternity Neonatal Systems (LMS/LMNS) quarterly. • Maternity and neonatal services must continue to work towards a position of at least 85% of births at less than 27 weeks gestation taking place at a maternity unit with an onsite NICU. • Neonatal Operational Delivery Networks must ensure that staff within provider units have the opportunity to share best practice and education to ensure units do not operate in isolation from their local clinical support network. For example senior medical, ANNP and nursing staff must have the opportunity for secondment to attend other appropriate network units on an occasional basis to maintain clinical expertise and avoid working in isolation. • Neonatal providers must ensure that processes are defined which enable telephone advice and instructions to be given, where appropriate, during the course of neonatal resuscitations. When it is anticipated that the consultant is not immediately available (for example out of hours), there must be a mechanism that allows a real-time dialogue to take place directly between the consultant and the resuscitating team if required. • Neonatal practitioners must ensure that once an airway is established and other reversible causes have been excluded, appropriate early consideration is given to increasing inflation pressures to achieve adequate chest rise. Pressures above 30cmH2O in term babies, or above 25cmH2O in preterm babies may be required. The Resuscitation Council UK New-born Life Support (NLS) Course must consider highlighting this treatment point more clearly in the NLS algorithm. • Neonatal providers must ensure sufficient numbers of appropriately trained consultants, tier 2 staff (middle grade doctors or ANNPs) and nurses are available in every type of neonatal unit (NICU, LNU and SCBU) to deliver safe care 24/7 in line with national service specifications.	Specialised commissioners and Neonatal Network guidance followed. Reported via LMNS Clinical lead for SCBU and HOM attend Neonatal network Board. Need to develop secondment opportunity for current ANNP team within tertiary units. This will require an increase in the current ANNP team or service level agreement to swap staff between units. Compliant Compliant Compliant for Tier 2 and Tier 3, Tier 1 may need review (and Tier 3 with MIS changes)
Neonatal • Neonatal and maternity care providers, commissioners and networks must agree on pathways of care including the designation of each unit and on the level of neonatal care that is provided. • Care that is outside this agreed pathway must be monitored by exception reporting (at least quarterly) and reviewed by providers and the network. The activity and results of the reviews must be reported to commissioners and the Local Maternity Neonatal Systems (LMS/LMNS) quarterly. • Neonatal Operational Delivery Networks must ensure that staff within provider units have the opportunity to share best practice and education to ensure units do not operate in isolation from their local clinical support network. For example senior medical, ANNP and nursing staff must have the opportunity for secondment to attend other appropriate network units on an occasional basis to maintain clinical expertise and avoid working in isolation.	

• Each network must report to commissioners annually what measures are in place to prevent units from working in isolation.	
Commissioners • Neonatal and maternity care providers, commissioners and networks must agree on pathways of care including the designation of each unit and on the level of neonatal care that is provided. • Each network must report to commissioners annually what measures are in place to prevent units from working in isolation.	
15. Support Families	
Essential Action **Care and consideration of the mental health and wellbeing of mothers, their partners and the family as a whole must be integral to all aspects of maternity service provision** **Maternity care providers must actively engage with the local community and those with lived experience, to deliver services that are informed by what women and their families say they need from their care**	
Trusts • There must be robust mechanisms for the identification of psychological distress, and clear pathways for women and their families to access emotional support and specialist psychological support as appropriate. • Access to timely emotional and psychological support should be without the need for formal mental health diagnosis, as psychological distress can be a normal reaction to adverse experiences. • Psychological support for the most complex levels of need should be delivered by psychological practitioners who have specialist expertise and experience in the area of maternity care.	Non-commissioned Debrief service in place Specialist perinatal nurse attends specialist clinic weekly Referral pathways are in place Referral to specialist trauma counsellor utilised. • Birth reflections • Out to recruitment for public health midwife • Perinatal mental health team & named Consultant clinic

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 19

Report Title:	**Well-led action plan update**			
Name of Meeting:	Board of Directors – Part 1			
Date of Meeting:	25 May 2022			
Author:	Jennifer Boyle, Company Secretary			
Executive Sponsor:	Yvonne Ormston 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 provide the Board of Directors with an update on progress against the well-led action 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*	Board of Directors – January 2022			
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*	• In summary there are an increased number of completed actions (81% now completed), and a reduction in the red-rated (off-track) actions. • Assurance can be provided that there remains a commitment to complete all actions on the action plan, acknowledging that there have been some delays against original timescales due to operational pressures and capacity constraints.			
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	The Board of Directors is requested to review the latest action plan, noting the significant increase in completed actions and also the reduction in off-track actions. Assurance is provided that there will be a continued focus on addressing off-track and in progress actions and the plan will be monitored by the Senior Management Team with escalation of issues to the Board committees and Board where appropriate.			

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:	Well-led supports the ability to deliver against the corporate objectives through improved governance and accountability, rather than linking to specific corporate 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)	NMQ 2779 - The Trust fails to meet the CQC Fundamental Standards. (12) COO 2868 - Further waves of Covid may impact on the ability to deliver key performance targets and recovery plans (16)				
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒		

Well-Led Action Plan Update – May 2022

1. Executive Summary

1.1. The Board of Directors is presented with the latest version of the Well-Led action plan for review and assurance.

1.2. The Company Secretary has updated the plan as far as possible.

1.3. There has been a significant increase in the number of complete actions, which now account for 81% of the total actions, compared to 65% when the plan was last presented to the Board.

1.4. The off-track category now accounts for 9% of the total. A number of these actions are substantial pieces of work / projects which have been impacted upon by operational pressures and capacity constraints, although there remains a commitment to complete this work.

1.5. Actions which remain open as of May '22 will be closely monitored by the Senior Management Team with escalation of any emerging issues to the Board / Board committees as required.

2. Introduction

2.1. The Well-Led action plan was last formally reviewed at the Board of Directors in January 2022.

2.2. The action plan has been updated as far as possible and is presented to the Board for scrutiny and assurance.

2.3. Actions which were marked as complete on the last report to Board have been removed from the detailed plan appended to this report to assist the Board in identifying those actions which remain ongoing.

3. Key issues / findings

3.1. Following its latest update, the current status of the action plan, including how it compares to the January 2022 and September 2021 positions, can be summarised as follows:

Key	Description	May 22	May 22 as a % of total actions	Jan 22	Sept 21
	Not yet started	0	0%	3	6
	Started and on track no risks to delivery	3	7%	3	18
	Plan in place with some risks to delivery	1	3%	2	7
	Off track, risks to delivery and or no plan/timescales and or objective not achievable	4	9%	7	-
	Complete	35	81%	28	12
	TOTAL ACTIONS	**43**	**100%**	**43**	**43**

3.2. There are now no actions not yet started and the number of actions started with no risks to delivery has remained static at 3, which is a combination of actions moving to complete and other actions moving from ‘plan in place with some risks’ to on track to deliver.

3.3. Assurance can be taken from the improvement in the proportion of completed actions, which now account for 81% of the total number of actions.

3.4. Off-track actions have reduced from 7 to 4, accounting for 9% of total actions. There remains a clear commitment to complete these actions, which have been impacted by operational pressures and other capacity constraints.

4. Solutions / recommendations

4.1. The Board of Directors is requested to review the latest action plan, noting the significant increase in completed actions and also the reduction in off-track actions. Assurance is provided that there will be a continued focus on addressing off-track and in progress actions and the plan will be monitored by the Senior Management Team with escalation of issues to the Board committees and Board where appropriate.

REC REF	RECOMMENDATION	ACTIONS	LEAD	DELEGATED SENIOR MANAGER	DUE DATE	PROGRESS UPDATE	RAG SEPT 21	RAG JAN 22	PROPOSED RAG MAY 22
R1	*(Advisory)*	Develop a Board bespoke training / Coaching programme	Jennifer Boyle	N/a	Sept 2021 Proposed new timescale – October 2021	An internal Board development plan is in development with a number of suggested sessions. Proposal to extend the timescale to enable further discussion with the Board regarding future Board development, particularly taking into account any learnings and development areas from the first sessions from NHS Providers. Jan 22 – deadline missed. A draft plan is being worked up for discussion with the Chair, Chief Executive and wider Board. May 22 – Board development plan in place, which informed the schedule for the recent Board strategy day (although recognise there are pressures on time available)			
		Annual Board Effectiveness Review to be incorporated into the cycle of business	Kirsty Roberton	Jennifer Boyle	May 22	This action is not yet due as this work will reflect on the financial year 2021/22. May 22 – completed as part of the Board strategy day in February 2022			
		Annual Self-Assessment to be carried out within the cycle of business	Kirsty Roberton	Jennifer Boyle	May 22	This action is not yet due as this work will reflect on the financial year 2021/22. May 22 – as above – for Board this was carried out in February 2022. Board committee reviews of effectiveness not coterminous with the year-end this year			

REC REF	RECOMMENDATION	ACTIONS	LEAD	DELEGATED SENIOR MANAGER	DUE DATE	PROGRESS UPDATE	RAG SEPT 21	RAG JAN 22	PROPOSED RAG MAY 22
						given recent changes to committee terms of reference. Council of Governors review of effectiveness survey issued – to be reissued in Autumn to seek a higher response rate. Propose to close this action given work completed and inclusion of future reviews on cycles of business.			
	Succession Planning *(Advisory)*	Develop a Leadership Development Programme	Lisa Crichton-Jones	N/a	Oct 21	Work is ongoing and will be reported via the People and Organisational Development (POD) Portfolio Board. A programme has been drafted and will be shared for comment shortly. Jan 22 – Progress has been made in shaping the Leading and Managing Well programmes, as well as agreeing leadership development work for Senior Management Team. Red rating reflects that leadership and organisational development work has been paused in Q4 to focus on mandatory vaccination and staff volunteering. This approach is supported by the POD Committee. May 22 – Leading Well programme now launched. Joint Senior Management Team and Executive Team away days also held to develop the leadership team and ways of working. Propose to close this action from the plan and move to business as usual.			
R2	Identify Performance	Develop and	Joanne Baxter	N/a	Ongoing	Report now in existence and is under			

REC REF	RECOMMENDATION	ACTIONS	LEAD	DELEGATED SENIOR MANAGER	DUE DATE	PROGRESS UPDATE	RAG SEPT 21	RAG JAN 22	PROPOSED RAG MAY 22
	and Quality reports for the Trust	present Integrated Oversight reporting at board and committees				continuing development in terms of its format, content and presentation. Support is needed from the BI team to automate where possible. Reporting timescales need to be aligned to enable better triangulation. May 22 – report under continuous development and now includes maternity and community metrics. Further work planned to include health inequalities. Recommend this moves to business as usual as this will be under continuous review and development.			
R3	Draft Corporate Strategy	Develop a draft corporate strategy to present to the board	Kirsty Roberton/ Amanda Maskery	N/a	Sept 2021 Proposed new timescale – March 2022	Revised timescales have been agreed for the strategy work and a procurement exercise to identify external support is about to commence. The strategy will be developed in line with the 2021/22 year end. Jan 22 – external company appointed and project plan in place. Given current operational pressures the strategy won't be finalised by March, but this will occur in Q1 22/23. May 22 – the strategy is on the May 22 Board agenda for formal approval.			
R4	Feedback from ICS /ICP	Develop a communication plan for sharing	Kirsty Roberton / Helen Fox	N/a	Oct 21	Terms of reference for the Senior Leadership Forum (SLF) have been agreed. The SLF will have a focus on partnership			

REC REF	RECOMMENDATION	ACTIONS	LEAD	DELEGATED SENIOR MANAGER	DUE DATE	PROGRESS UPDATE	RAG SEPT 21	RAG JAN 22	PROPOSED RAG MAY 22
		feedback from ICS/ICP across senior management – 2 way process				working and collaboration, sharing learnings and key messages from external meetings. The first meeting of SLF is being arranged for October. Jan 22 – Executive Team discussions taking place in respect of SLF and its role (initial October meeting stood down). Once this is determined, the communications plan can be developed. May 22 – development work with the Senior Management Team (SMT) and Executive Team in April / May included consideration on how to ensure that this information would be shared. As the new format SMT is still evolving (first meeting on 19 May) this action is retained as ongoing to be prudent.			
R5	Capacity concerns raised by some Operational Business Units (OBU) management	Carry out a deep dive into capacity within OBUs and identify an action plan that includes capacity and staff wellbeing	Joanne Baxter	N/a	Dec 21	New structures now in place and all gaps to management structures filled. New roles of assistant service line managers in place and triumvirates starting to take shape. A deep dive reflection will take place in line with the agreed timescale. May 22 – due to operational pressures and capacity constraints the deep dive has not yet been undertaken			

REC REF	RECOMMENDATION	ACTIONS	LEAD	DELEGATED SENIOR MANAGER	DUE DATE	PROGRESS UPDATE	RAG SEPT 21	RAG JAN 22	PROPOSED RAG MAY 22
R6	Visibility	Develop programme of activity to include: Corporate – develop a back to floor and 15 steps programme for Execs, Non-executives and Council of Governors (COG) COG – visibility of non-executive directors with COG General – visibility of business units / staff with board	Helen Fox / Amanda Maskery	N/a	Sept 21 / ongoing	COVID restrictions have impacted the ability to fully relaunch the programme of visibility, although this has commenced on an informal basis. As the visibility programme restarts fully there will be a need to develop guidance on delivering feedback to ensure feedback loops are effectively closed. The Council of Governors' agenda has been reshaped for the September 2021 meeting to place an enhanced focus on the role of the Non-Executive Directors. Training is being held with the Council on 15 September to support them in their role of holding Non-Executive Directors to account. Jan 22 – the formal visibility programme restarted with Executive and Non-Executive Directors, but this was paused due to Omicron. Executive Directors have continued to meet with staff in operational Areas. This will be kept under review in light of restrictions. May 22 – Non-Exec and Exec walkrounds have recommenced. At present the walkrounds with Governors are still paused, but as we move back to face-to-face meetings the future format for these			

REC REF	RECOMMENDATION	ACTIONS	LEAD	DELEGATED SENIOR MANAGER	DUE DATE	PROGRESS UPDATE	RAG SEPT 21	RAG JAN 22	PROPOSED RAG MAY 22
						and a plan to restart them safely will be considered. Retain as ongoing but with some element of risk.			
R10		Develop cycle of business and reports (Audit Co)	Jennifer Boyle / Jackie Bilcliff	N/a	Oct 21 Proposed new date – Dec 21	Jan 22 – cycle of business developed and shared for comment in Dec 21. To be formally approved by the Committee in March 22. May 22 – cycle of business approved at March Audit Committee.			
	Finance & Performance *(Advisory)*	Develop cycle of attendance from BUs leadership teams	Jennifer Boyle / Kris Mackenzie	N/a	Oct 21	This requires further discussion to balance operational capacity with the ability to attend Board committees to represent operational business units where required. Jan 22 – further discussions are required once operational pressures ease. May 22 – no further action taken at present, although as the new SMT embeds this will be revisited.			
R12	Scheme of delegation	Ensure the scheme of delegation and Standing Financial Instructions (SFIs) reflect the decision-making authority of the	Kris Mackenzie / Kirsty Roberton	N/a	Sept 21	Discussions underway but this action is currently at risk due to capacity and timescales. Jan 22 – note that the review of the Constitution, SFIs, Scheme of Delegation and Standing Orders has been rescheduled to March 22 Board.			

REC REF	RECOMMENDATION	ACTIONS	LEAD	DELEGATED SENIOR MANAGER	DUE DATE	PROGRESS UPDATE	RAG SEPT 21	RAG JAN 22	PROPOSED RAG MAY 22
		Executive Team and SMT meetings. Ensure that expectations are clear in respect of the responsibility of SMT members for cascading and communicating key information from SMT to their teams.				May 22 – note that due to capacity constraints this action has been further delayed until after the year end processes have been completed.			
R13	Operational BU formal meetings	Undertake a review of effectiveness of the formal meetings in place across the Operational Business Units (OBUs) in six months' time. This should include comparing and contrasting the meeting structures. This	Jennifer Boyle / Kirsty Roberton	N/a	Jan 22	This action is due for completion in January 22 and has not yet been started, but no risks to delivery are identified at this stage. Jan 22 – planning meeting held between Company Secretary, Deputy Director of Corporate Services and Transformation and the Head of Quality and Patient Experience in Nov 21. Information requested from OBUs to commence review, but given operational pressures and reprioritisation of resource, this has been postponed. May 22 – due to capacity constraints this			

REC REF	RECOMMENDATION	ACTIONS	LEAD	DELEGATED SENIOR MANAGER	DUE DATE	PROGRESS UPDATE	RAG SEPT 21	RAG JAN 22	PROPOSED RAG MAY 22
		will enable a more accurate assessment of Business Unit governance to be made.				action has not been able to be progressed and is retained as off track.			
R16	Finance Reports	Where appropriate include a greater focus on forecast reporting within the Part 1 finance report to aid transparency regarding the likely year-end outturn. Include a brief overview of QE Facilities (QEF) performance in Part 2 of the finance report.	Kris Mackenzie	N/a	Sept 21 Proposed new date – Dec 21	The forecasting element of this action can only be fully completed once H2 planning requirements are published. As such, it is proposed the revised the target date for this action to December 21 to reflect the revised national timescales. May 22 – forecasting to be included for 2022/23 against the new financial plan for the year. Retain as ongoing to be prudent.			
R18	Data Quality	Identify ways in which the accountability and responsibility	Nick Black	N/a	Sept 21 Proposed new date – March 22	A relaunch of the work around Information Asset Owners' (IAO) roles and responsibilities is underway. This will reinforce the responsibility across the Trust for the information assets and the			

REC REF	RECOMMENDATION	ACTIONS	LEAD	DELEGATED SENIOR MANAGER	DUE DATE	PROGRESS UPDATE	RAG SEPT 21	RAG JAN 22	PROPOSED RAG MAY 22
		for data entry can be re-emphasised to staff, including education on the implications of entering inaccurate data.				data they are responsible for. A presentation was given to SMT, and an Information Asset Management plan is in place to support the relaunch, with an end date of March 22 (after which it becomes an annual cycle of review). May 22 – Information Asset Risk Management Plan has a revised completion date of 31 May 2022. Retain as ongoing to be prudent at this stage.			

Meeting:	Trust Board
Chair:	Alison Marshall
Financial year:	2021/22 and 2022/23

	Lead	Type of item	Public/Private	Sep-21	October 21 (extra Board)	Nov-21	Jan-22	Mar-22	April 22 (ext)	May-22	June 22 (year end)	Jul-22	Sep-22	Nov-22	Jan-23	Mar-23
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					√								√
Trust Strategic Aims & Objectives	Chief Executive	Item for Decision	Part 1					√		√						√
Board Assurance Framework - approval of closing and opening position	Company Secretary	Item for Decision	Part 1					√			√					√
Standing Financial Instructions & Delegation of Powers ***(deferred - to be rescheduled)***	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	√									√			
Constitution and Standing Orders - annual review ***(deferred - to be rescheduled)***	Company Secretary	Item for Decision	Part 1				√									
Board Committee Terms of Reference - Ratification	Company Secretary	Item for Decision	Part 1			√	√									
Board Committee Annual Reviews of Effectiveness and Terms of Reference Update	Company Secretary	Item for Decision	Part 1											√		
Items for Assurance			Part 1 & Part 2													
Board Committee Assurance Reports	Committee Chairs	Item for Assurance	Part 1	√		√	√	√		√		√	√	√	√	√
Corporate Objective Delivery	Company Secretary	Item for Assurance	Part 1	√			√	√		√			√		√	
Board Assurance Framework	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 & Part 2	√		√	√	√		√		√	√	√	√	√
Integrated Oversight Report	Chief Operating Officer	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 / Ockenden Update	Medical Director	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				√					√			√	
Improving People Practices Update	Exec Director of People & OD	Item for Assurance	Part 1				√					√			√	
WRES and WDES Report (6 monthly report)	Exec Director of People & OD	Item for Assurance	Part 1	√				√				√	√			√
Quality Accounts Priorities 6 monthly update	Chief Nurse	Item for Assurance	Part 1			√								√		
People's Plan Briefing (dependent upon national publication)	Exec Director of People & OD	Item for Assurance	Part 1													
Items for Information			Part 1 & Part 2													
Ad Hoc Items (i.e. items emerging during the year)			Part 1 & Part 2													
Trust Green Plan 2022-2025 annual updates	QEF Managing Director	Item for Assurance	Part 1					√								√