MEETING OF THE BOARD OF DIRECTORS IN PUBLIC

Gateshead Health NHS Foundation Trust

Date: Wednesday 30th November 2022
Time: 9:30 am
Venue: Rooms 9&10, Education Centre/Teams

AGENDA

	TIME	ITEM	STATUS	PAPER
1.	9:30 am	**Welcome and Chair's Business**		
2.	9:33 am	**Declarations of Interest** To declare any pecuniary or non-pecuniary interests *Check – Attendees to declare any potential conflict of items listed on the agenda to the Company Secretary on receipt of agenda, prior to the meeting*	Declaration	Verbal
3.	9:35 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 27 September 2022** To be agreed as an accurate record	Agree	Enclosure 4
5.	9:42 am	**Matters Arising / Action Log**	Update	Enclosure 5
		ITEMS FOR DECISION		
6.	9:45 am	**Calendar of Board Meetings 2023/24** To approve the dates for 2023/24, presented by the Company Secretary	Approval	Enclosure 6
		ITEMS FOR ASSURANCE		
7.	09:50 am	**Assurance from Board Committees** i. Finance and Performance Committee – 25 October and 29 November 2022 (verbal) ii. Quality Governance Committee – 19 October 2022 iii. Digital Committee – 10 October 2022 iv. POD Committee – 8 November 2022	Assurance	Enclosure 7
8.	10:10 am	**Chief Executive's Update Report** To receive a briefing report from the Chief Executive	Assurance	Presentation
9.	10:20 am	**Industrial Action Update** To receive a briefing report from the Executive Director of People & Organisational Development	Assurance	Enclosure 9
10.	10:35 am	**Governance Reports** i. **Organisational Risk Register** ii. **Quality Accounts Priorities 6 monthly update** To receive the reports presented by the Chief Nurse	Assurance	Enclosure 10
11.	10:45 am	**Finance Update** To receive the report, presented by the Group Director of Finance and Digital	Assurance	Enclosure 11
12.	10:55 am	**SIRO and Digital Update** To receive the report, presented by the Group Director of Finance and Digital	Assurance	Enclosure 12
13.	11:05 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.	11:25 am	**Nurse Staffing Exception Report** To receive the report, presented by the Chief Nurse	Assurance	Enclosure 14
15.	11:35 am	**Maternity Update** i. **Report following Independent Investigation into East Kent Maternity and Neonatal Services** ii. **Maternity Integrated Oversight Report** To receive the report, presented by the Chief Nurse	Assurance	Enclosure 15
16.	11:50 pm	**Learning from Deaths 6 Monthly Report** To receive the report, presented by the Medical Director	Assurance	Enclosure 16
17.	12:00 pm	**Well-Led Review Closure Report:** To receive the report presented by the Company Secretary	Assurance	Enclosure 17
		ITEMS FOR INFORMATION		
18.	12:10 pm	**Patient & Staff Story** • Mr Lawson	Assurance	Presentation
19.	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 19
20.	12:45 pm	**Questions from Governors in Attendance** To receive any questions from governors in attendance		Verbal
21.	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 Wednesday 25th January 2023 at 9:30am		Verbal
22.	1:00 pm	**Chair Declares the Meeting Closed**		Verbal
23.	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

Gateshead Health NHS Foundation Trust

Trust Board

Minutes of a meeting of the Board of Directors
held at 9.30 am on Wednesday 27th September 2022, in
Room 3, Education Centre, Queen Elizabeth Hospital and via MS Teams

Present:	
Mrs A Marshall	Chair
Mrs J Baxter	Chief Operating Officer
Dr R Bonnington	Non-Executive Director
Dr G Findley	Chief Nurse
Mrs K Mackenzie	Group Director of Finance and Digital
Mr A Moffat	Non-Executive Director
Mrs Y Ormston	Chief Executive
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
Mrs A Stabler	Non-Executive Director
In Attendance:	
Mr N Halford	Deputy Medical Director
Ms J Richardson	Trust Volunteer (22/132)
Mrs K Roberton	Deputy Director of Corporate Services and Transformation
Ms D Waites	Corporate Services Assistant
Mrs A Venner	Deputy Director of People & OD
Governors and Members of the Public:	
Ms H Adams	Staff Governor
Mr L Brown	Public Governor - Western
Mr C Toon	Appointed Governor
Apologies:	
Mr A Beeby	Medical Director
Miss J Boyle	Company Secretary
Mrs L Crichton-Jones	Executive Director of People & OD
Cllr M Gannon	Non-Executive Director

Agenda Item	Discussion and Action Points	Action By
22/127	**CHAIR'S BUSINESS:** The meeting being quorate, Mrs A Marshall, Chair, declared the meeting open at 9.30 am and confirmed that the meeting had been convened in accordance with the Trust's Constitution and Standing Orders. She welcomed those present including the Trust's Governors. Mrs Marshall formally expressed her sadness on behalf of the Board following the recent death of Her Majesty the Queen and wished to confirm that there are no plans to rename the Trust as the Trust is named after Queen Elizabeth, the Queen Mother.	

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22/128	**DECLARATIONS OF INTEREST:** Mrs A Marshall requested that Board members present report any revisions to their declared interests or any additional declaration of interest in any of the items on the agenda.	
22/129	**APOLOGIES FOR ABSENCE:** Apologies for absence were received from Mr A Beeby, Miss J Boyle, Mrs L Crichton-Jones, and Cllr M Gannon.	
22/130	**MINUTES OF THE PREVIOUS MEETING:** The minutes of the meeting of the Board of Directors held on Wednesday 27th July 2022 were approved as a correct record.	
22/131	**MATTERS ARISING FROM THE MINUTES:** The Board action log was updated accordingly and there were no additional matters arising from the minutes.	
22/132	**VOLUNTEER STORY:** The Board welcomed Ms Julie Richardson who provided a brief account of her role as a Trust volunteer. She discussed some of her duties as a volunteer which includes face to face contact with patients enabling other staff to continue with their duties. She described how this supports both patients and staff and felt that it was an extremely rewarding part of the role and ensures volunteers feel part of the team. She highlighted some of her experiences volunteering at other organisations and felt that there were some opportunities to explore the role further and the Board agreed that this would be beneficial to expand the service further. Mrs Marshall thanked Ms Richardson for attending the Board and also expressed her thanks to all volunteers, highlighting the importance of the role within the Trust. Dr G Findley, Chief Nurse, explained that there are currently 102 volunteers across the Trust supporting roles within patient experience and the Trust's response team and welcomed the opportunity to develop the role further. Ms Richardson left the meeting.	

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22/133	**DECLARATIONS OF INTEREST:** Mrs K Roberton, Deputy Director of Corporate Services and Transformation, presented the declaration of interest for Mrs Kris Mackenzie, Group Director of Finance and Digital, for inclusion into the Board's register of interests. She informed the Board that Mrs Kris Mackenzie, Group Director of Finance and Digital, joined the Board of Directors on 1 September 2022, having previously held the position of Operational Director of Finance at the Trust and provided assurance that Mrs Mackenzie has completed both the declaration of interests and fit and proper person declaration. Mrs Roberton highlighted to the Board that a family connection to Mrs Y Ormston, Chief Executive, has been appropriately declared and provided assurance that safeguards have been put in place to ensure independence, and safeguards were also implemented throughout the recruitment process. Independent fit and proper person checks against public registers have also been conducted with no issues to highlight. After consideration, it was: **RESOLVED:** i) to approve the inclusion of Kris Mackenzie's declaration of interest return in the Board's register of interests. ii) be assured that the self-declaration in respect of fit and proper persons has been completed in accordance with the Trust's policy.	
22/134	**CONSTITUTION AMENDMENT:** Mrs K Roberton, Deputy Director of Corporate Services and Transformation, presented the proposed constitutional amendment to reclassify volunteers as public members with respect to Foundation Trust membership. She explained that a constitutional amendment was made in July 2019 to recategorise volunteers within the staff membership category. This meant that any volunteers who wished to stand for election as Governors would then need to stand as staff Governors, with both staff and volunteers being eligible to vote within staff Governor elections. However a number of implications of this constitutional amendment have become apparent recently, and consideration needs to be made as to whether a further amendment is required to reverse the original change. Most notably, the current approach would prevent public Governors becoming volunteers whilst maintaining their Governor positions. The paper outlines the options available and considers which approach would best protect and promote volunteering and maximise the opportunities for representation at the Council. Mrs Roberton	

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	highlighted that there would be an impact on existing Governors from both Option 1 and Option 2 and this options appraisal has been undertaken impartially based on an assessment of appropriate governance as requested by those Governors who may be affected. It is recommended that Option 2 is approved to enact a constitutional change to recognise volunteers as public members and this option is also supported by the Governor Governance and Development Committee. Mrs Marshall highlighted that this will also be presented to the Council of Governors meeting tomorrow (28 September 2022) and explained that herself and Miss Boyle, Company Secretary, have met with the affected Governors who agreed that it was important to take the most appropriate approach from a governance and representation perspective. Mr M Robson, Vice Chair, felt that this approach would provide the opportunity for volunteers to reinforce the Governor role within the organisation. Following a query from Mrs A Stabler, Non-Executive Director, on Governor attendance at meetings, Mrs Marshall explained that there is no current obligation for this however there is further work to be undertaken to review constituencies and Council composition. After consideration, it was: **RESOLVED:** i) to approve Option 2 to enact a constitutional change to recognise volunteers as public members ii) to note the recommendation of the Governor Governance and Development Committee that the Trust takes a wider look at the make-up of constituencies and Council composition next year to ensure that it remains fit for purpose and reflective of system-working requirements.	
22/135	**BOARD COMMITTEE TERMS OF REFERENCE:** Mrs K Roberton, Deputy Director of Corporate Services and Transformation, presented the revised terms of reference for the Board committees. She explained that following the approval of the Trust's new strategy and the corporate objectives for 2022/23, the Company Secretary has undertaken a review of the terms of reference of the committees which have responsibility for seeking assurance over the delivery of the strategy and objectives. Mrs Roberton drew attention to the summary of changes: **Quality Governance Committee**: • Reference to seeking assurance over health inequalities and Gateshead system contribution	

Agenda Item	Discussion and Action Points	Action By
	• Reference to strategies within the remit of the Committee. **Finance and Performance Committee**: • Reference to strategies within the remit of the Committee. • Transformation role description expanded to include seeking assurance over major schemes likely to impact upon operational and financial performance (e.g. New Operating Model). **Digital Committee:** • No changes proposed to align to the strategy and objectives. • Minor amendment made to align quoracy to other committees and reference the role of the Governor observers. **People and Organisational Development (POD) Committee** (a wider review of the terms of reference has been undertaken by the POD team, resulting in a number of these amendments): • No specific changes required to align to the strategy. • Attendees revised to include senior managers, including a senior manager from Finance to provide cross-representation. • Reference to the role of Governor observers included. • Quorum amended in line with other committees. Discussion took place in relation to the quoracy of the Board Committee in particular Executive and Non-Executive Director members and flexibility for attendance therefore this will be looked at and amended. Mr M Robson, Chair of the Finance and Performance Committee, felt that it would be beneficial to expand the membership to include those required to present the Integrated Oversight Report ie. People and OD representation and this will be amended. A discussion was held regarding the monitoring of the Quality Improvement Strategy and which Committee would be most appropriately placed to do this. Given the intrinsic links to transformation, on reflection it was agreed that this oversight function would continue to rest with the Finance and Performance Committee. After discussion, it was: **RESOLVED:** to ratify the revised terms of reference for the Board Committees subject to the suggested amendments.	KR
22/136	**WINTER PLAN 2022/23:** Mrs J Baxter, Chief Operating Officer, presented the draft Strategic Winter Plan for 2022-23 for assurance prior to submission to NHS England. Mrs Baxter reported that the winter of 2022/23 is expected to bring an increase in demand for services as the Trust continues to meet the challenges of managing Covid alongside other winter viruses, the	

Agenda Item	Discussion and Action Points	Action By
	ongoing costs and challenges of attaining greater winter capacity and a parallel need to recover activity significantly affected by the pandemic. She highlighted that some comments have already been received however explained that the focus of the plan continues to be on avoiding admissions, reducing length of stay and ensuring timely discharge although staffing shortages, in particular nurse staffing vacancies, continue to provide a challenging environment. Mrs A Stabler, Non-Executive Director, queried whether the impact of ambulance diverts and delayed discharges was being reviewed by the Integrated Care Board (ICB) and Mrs Y Ormston, Chief Executive, highlighted that discussions were taking place at the Local A&E Delivery Board and the ICB were involved with the Urgent and Emergency Care Programme. Mrs Baxter explained that escalation beds were not linked to winter planning due to the ongoing need and this therefore continues to drive overspend. Mr M Robson, Vice Chair, drew attention to Section 16 of the report which highlights the use of Better Care Fund funding for 14.5 full-time equivalent roles to support capacity within the PRIME service to increase discharges and queried how this would be monitored. Mrs Baxter explained that this will be monitored by the Gateshead System Board and the Trust is working in collaboration with the Local Authority. She further explained that demand and capacity analysis was taking place and a Management Graduate Trainee was supporting with this work. Mrs M Pavlou, Non-Executive Director, requested an update on the joint work with the Local Authority and Mrs Ormston advised that meetings continue to take place however felt that it would be beneficial to highlight concerns in relation to shared staffing risks within the report and how these were being mitigated and discussed by the People & OD Committee to address the gaps. Mrs Baxter will ensure that further details are included in relation to the risk around finance, staffing and recruitment. Following further discussion, it was: **RESOLVED:** to approve the draft Strategic Winter Plan 2022-23 prior to submission to NHS England subject to suggested amendments.	JMB
22/137	**ASSURANCE FROM BOARD COMMITTEES** **Finance and Performance Committee (F&P):** Mr M Robson, Chair of the F&P Committee, noted that the Board had been appraised verbally of the key points from the July meeting at the July 2022 Board of Directors' meeting. He also drew attention to the written assurance report relating to the August meeting with no items for escalation.	

Agenda Item	Discussion and Action Points	Action By
	Mr M Robson provided a verbal update on the meeting yesterday (26 September 2022) and reported that there were no items to escalate. The meeting focussed on the following areas where gaps in control and assurance have been identified: • Integrated Oversight Report – the Committee focussed on the response domain and noted that urgent and emergency care, and cancer performance remains under pressure therefore were not fully assured. The Committee identified a need to further develop workforce key performance indicators (KPI) metrics and outcome measures, which therefore presents potential gaps in control and assurance. • Financial revenue – despite a reported improvement in deficit due to Elective Recovery Fund (ERF) funding, the Committee remain unassured due to pay variances and as such requested further assurance to be brought to the next meeting on major drivers such as delayed discharges, variances due to staffing levels and the continued use of escalation beds. • Financial outturn – the Committee received the first analysis taking into account a range of variables which suggest a deficit and therefore were not assured. Some gaps in control were identified due to the lack of detail surrounding cost reduction plans however potential mitigating actions were discussed and will be looked into further at future meetings. • Supply Procurement – internal audit have now been commissioned to investigate further. • Corporate objectives – gap in assurance identified within the report and it was felt that further work was required in relation to the new format. • Organisational Risk Register - partial assurance as incomplete report and some elements were not up to date. Therefore further work required. • Board Assurance Framework – gaps in the report were reviewed and further work to be completed prior to the next meeting. **Quality Governance Committee (QGC):** Mrs A Stabler, Chair of QGC provided a brief verbal overview to accompany the narrative report and highlighted that there was one issue to escalate in relation to the Looked After Children Annual Report. She reported that the Clinical Commissioning Group (CCG) completed a review of the service and have not yet shared the outcome. The Committee therefore have requested escalation by the Board to the Integrated Care Board (ICB) noting the increased activity and the capacity of the service to continue to deliver the required outcomes for looked after children. Mrs G Findley, Chief Nurse, reported that this has been raised with the CCG and has been assured that the report has been completed however has still not been received. Mrs Findley confirmed that she will escalate this to the Integrated Care Board however Mrs Y Ormston,	GF

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	Chief Executive, explained that this can also be picked up at the Gateshead System Board. Mrs Stabler highlighted that another issue has been raised in relation to a discrepancy of CAS alerts being noted as open on the Integrated Oversight Report and the number noted as open on the Trust's internal system. Mrs Findley reported that this relates to a difference in external and internal reporting systems and has been picked up however is consistent with other Trusts. **Digital Committee** Mr A Moffat, Chair of the Digital Committee, provided a brief verbal overview to accompany the narrative report and reported that there were no items for escalation. He highlighted the following key points: • EPR System Strategy Outline Business Case has been socialised and reviewed by a third party. Following a query from Mrs Marshall as to whether this should come back to Board, Mr Moffat reported that further discussions will take place at the next Digital Committee and will report back to the Board. • Service Key Performance Indicators – good progress being made and reporting has much improved. The Committee were partially assured due to some outstanding targets however it was noted that these are now being shared with the Senior Management Team. • Internal Audit Reports – no items overdue however a number of outstanding actions have been extended. **People and Organisational Development (POD) Committee** Dr R Bonnington, Chair of the POD Committee, provided a brief verbal overview to accompany the narrative report and reported that there were no items for escalation. She highlighted the following key points: • Workforce supply – the Committee were partially assured due to the increase in the vacancy gap. It was noted that further modelling work was being undertaken to include forward look and benchmarking. • Equality Diversity and Inclusion report was presented and outstanding actions to be addressed. • GMC Survey – the Committee were partially assured due to the lack of progress on the Junior Doctor mess and hot food provision out of hours. This has been escalated to be addressed. Mrs Y Ormston, Chief Executive, explained that this is being looked at however alternative solutions may be required. The Board discussed the concerns around workforce supply and Dr Bonnington reported that the Committee were assured that work is being undertaken. Mrs Ormston felt that it was important to identify the current gap to ensure robust plans are in place and Mrs A Venner, Deputy Director of People & OD explained that controls were in place including a working group with nursing and operational colleagues to	

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	review a number of plans including recruitment and retention. Dr G Findley, Chief Nurse, highlighted that 16 new registered nurses were due to compete their training this month and good progress is being made in relation to the recruitment of 50 international nurses with additional funding being provided from NHS England & NHS Improvement. Mrs Ormston felt that it was important for the Board to be sighted on workforce figures and Dr Findley confirmed that the working group is focussed on this and highlighted that a new Workforce Analyst is now in post and will be reviewing reports to provide further assurance. Mrs Ormston suggested that reports are triangulated to highlight sickness absence, vacancies and any quality risks. Mrs J Baxter, Chief Operating Officer, highlighted that the Finance & Performance Committee have reviewed current workforce gaps against agency and bank spend and an options paper has been presented looking at staffing pressures within Theatres. **Audit Committee:** Mr A Moffat, Chair of Audit Committee, provided a brief verbal overview to accompany the narrative report and highlighted that there was an item to escalate in relation to the lack of implementation of overdue Internal Audit recommendations. Mrs K Mackenzie, Group Director of Finance and Digital, commented that a number of conversations have taken place with the Senior Management Team (SMT) and a report is presented at the weekly meeting. She highlighted that there is some educational work to be completed and this will be discussed at the forthcoming SMT away day. She will ensure a full update is provided on an ongoing basis to provide further assurance and Mr Moffat felt that it would be useful for Executive Leads to attend future Committee meetings to provide updates. Mrs Marshall thanked the Committee Chairs for their reports. After consideration, it was: **RESOLVED**: to receive the reports for assurance	
22/138	**CHIEF EXECUTIVE'S UPDATE REPORT** Mrs Y Ormston, Chief Executive, gave a verbal update to the Board on the current issues: **Operational Performance:** As highlighted in the Integrated Oversight Report (Agenda Item 15), pressures continue on a daily basis and are mainly related to delayed discharges. Mrs Ormston reported that performance is not quite back to standards however the Trust is performing well compared to other trusts within the region. Work continues to improve patient flow.	

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	Our People: Mrs Ormston reminded the Board of earlier discussions in relation to workforce supply and reiterated that the Trust's top priority remains recruitment. Progress is being made in relation to appraisal rates however work is ongoing. **Provider Collaborative/Integrated Care System/Integrated Care Board:** Governance arrangements continue to be developed and an ICB event recently took place to discuss improvement in System Resilience and preparation for winter. Other key updates included a visit from NHS England/NHS Improvement to learn best practice and the Trust has been identified as one of the best performers in some of the metrics in Urgent and Emergency care specifically ambulance handovers. The Care Quality Commission is due to conduct a medicines management inspection in the Trust and the visit is part of a pilot which focuses on this one specific area only. Dr R Bonnington, Non-Executive Director felt that it was important to acknowledge the hard work being undertaken around operational pressures and the Board acknowledged the continued staffing pressures. Mrs Marshall noted that following the death of Her Majesty the Queen, the Trust held a day of mourning and continued to deliver clinical services over the bank holiday in line with the Trust's internal Emergency Preparedness Resilience and Response Plan and thanked staff for their involvement. Following further discussion, it was: **RESOLVED:** to receive the update for assurance.	
22/139	**GOVERNANCE REPORTS** **Corporate Objective Delivery:** Mrs K Roberton, Deputy Director of Corporate Services and Transformation, presented the report which provides assurance over the plans to support the achievement of the corporate objectives for 2022/23. She reported that corporate objective delivery action plans have been developed by the Executive Director owners of each of the objectives and have been mapped to the Board Committees. The report summarises the progress made towards the delivery of the actions which in turn support the delivery of the corporate objectives and Mrs Roberton highlighted that there are currently no overdue sub-actions, although a number are considered at risk and 9 sub-actions have been completed.	

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	Following a query on the total number of actions and figures within the categories, Mrs Roberton advised that some of the actions are double counted as they fall into two categories however agreed that meetings with the Executive Leads will take place to review these in detail.	KR/JB
	RESOLVED: to receive the report for assurance.	
	Board Assurance Framework (BAF): Mrs Roberton provided the Board with the current BAF for 2021/22 for review and assurance and highlighted that a new format BAF has been designed for 2022/23 in response to feedback from the Board and Internal Audit. She reported that BAF extracts relating to the corporate objectives within each Committee's remit have been presented to Committee meetings for review and triangulation against the controls and assurances considered as part of the business of the Committee. The Board noted that the contents should also be triangulated against the assurance, risks and issues discussed during the meeting to determine any gaps in controls. There has been no movement in the overall BAF risk scores for each summary risk, although it is recognised that the new BAF has only been reviewed at 1 to 2 meetings of each committee. Mrs Roberton highlighted that the new BAF is still being embedded and a training session has been held with Non-Executive Director colleagues, with a further session to be scheduled for October 2022 and a narrative guide is also in development. Following a request, meetings will also take place with Executive Leads.	KR/JB
	RESOLVED: to receive the report for assurance.	
	Risk Management Maturity & Risk Appetite Dr G Findley, Chief Nurse, presented the report to gain formal agreement on the levels agreed for risk management maturity and risk appetite. She reminded the Board that an assessment of risk management maturity and review of risk appetite was undertaken at the Board Strategy Session in June 2022. The report acknowledges that improvements have been made and demonstrates stronger performance in some areas than others, as well as scope for improvement across all areas. Following a review of Risk Appetite, 4 of 5 areas remain the same however the appetite for risks that may affect quality has been increased to 'seek' reflecting the challenging decisions that may be required to deliver strategic objectives. Dr Findley highlighted that the Board are asked to approve the levels for risk management maturity and risk appetite and these will then be reflected in the risk management strategy and policy and updated on the intranet, as well as being communicated to managers across the group. Following a query from Mr A Moffat, Non-Executive Director, on	

Agenda Item	Discussion and Action Points	Action By
	the process, Dr Findley explained that the strategy is currently in development and will come back to the Board for approval at a future meeting. **RESOLVED:** to approve the risk management maturity levels and risk appetite statements and levels. **Organisational Risk Register (ORR)** Dr G Findley, Chief Nurse, presented the updated ORR to the Board, noting that it is now received at the weekly Executive Team Meeting and bi-monthly Executive Risk Management Group. This report covers the period 15 July 2022 to 1 September 2022. Dr Findley reported that 3 new risks have been added to the ORR including a strategic risk relating to Covid which has resulted in 2 existing risks related to Covid being removed. One risk has been reduced which relates to the risk of further waves of Covid following the introduction of the vaccination programme. Two risks have been closed and a further two risks removed. Dr Findley advised the Board that this reflects active management of risk and improvement to compliance due to scrutiny by the Executive Team and Executive Risk Management Group. Following a query around cost reduction risks, Dr Findley highlighted that this was a timing issue and will now show on the ORR at future meetings. Mrs H Parker, Non-Executive Director, also felt that the risk relating to delayed discharges should be higher and Dr Findley explained that this was reduced due to the increased domiciliary provision however will be increased again to reflect further pressures. **RESOLVED:** to receive the report for assurance.	GF
22/140	**FINANCE UPDATE:** Mrs K Mackenzie, Group Director of Finance & Digital, provided the Board with a summary of performance as at 31 August 2022 (Month 5) for the Group (inclusive of Trust and QE Facilities, excluding Charitable Funds). She highlighted that the Trust has reported an actual deficit of £1.545m after adjustments for donated assets and gain & losses of asset disposal which is an improvement of £2.833m from the deficit reported at the end of July mainly due to the inclusion of £2.594m elective recovery fund income (ERF). Mrs Mackenzie explained that there are system pressures in relation to staffing costs specifically around agency, bank and overtime costs. There has also been very little achievement in relation to cost reduction plans and the Senior Management Team workshop in October will focus on looking at plans. Detailed discussions have also taken place at the Finance and Performance Committee.	

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	Following a query from Mrs A Stabler, Non-Executive Director, relating to ERF funding and whether this was based on delivery, Mrs Mackenzie reported that no clarification has been received from the Integrated Care Board however discussions are taking place with Directors of Finance who are consistent in their financial assumptions. Following a further query from Mrs Stabler in relation to cost reduction plans, Mrs Mackenzie explained that cost reduction plans are being scrutinised by the Finance and Performance Committee however a focus on delivery for this financial year will be discussed in more detail at the October workshop. Mr A Moffat, Non-Executive Director, queried the expectations around plans and Mrs Mackenzie commented that some non-recurrent savings were expected due to vacancies however longer term recurrent plans are required to ensure consistent savings. Mrs Marshall highlighted that this links to recent discussions at the Transformation Board and plans have been requested to provide impact assessments. The Board acknowledged that robust plans were needed and Mr M Robson, Vice Chair, reported that Non-Executive Directors are welcome to attend future Finance and Performance Committee meetings to gain a better understanding of plans. After further discussion, it was: **RESOLVED:** to receive the report for assurance against corporate objectives and addressing financial risks.	
22/141	**INTEGRATED OVERSIGHT REPORT:** Mrs J Baxter, Chief Operating Officer, Dr G Findley, Chief Nurse, Mr N Halford, Deputy Medical Director, and Mrs A Venner, Deputy Director of People and Organisational Development, introduced the Integrated Oversight Report (IOR) for July and August 2022. The paper has been discussed and received in-depth scrutiny by the various Board Committees. **Safe:** Dr Findley highlighted that six serious incidents were reported in August and are under investigation, with one open patient safety alert not completed by the deadline however she reminded the Board that this was highlighted and discussed at the last meeting. There have been no harm incidents and no Never Events have been reported within the past 18 months. Mrs H Parker, Non-Executive Director, noted the increased number of medication errors and Dr Findley reported that this was a welcome finding due to a new post. Mr Halford explained that the errors had been reported early in the process and outlined a positive reporting safety culture. This would also result in increased levels of learning going forward however highlighted system issues rather than human error.	

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	Following a query from Mr A Moffat, Non-Executive Director, regarding a serious incident relating to discharge which resulted in death/ catastrophic consequences, Dr Findley explained that this had been reviewed by the Serious Incident Panel and has been referred to the coroner to undertake an investigation. A summary of this will be reported via the Quality Governance Committee. **Effective:** Mr Halford reported that there had been a deterioration in the average number of long stay patients and readmissions within 30 days remains high. He explained that this is due to changes in counting and recording in Same Day Emergency Care (SDEC) however a detailed clinical deep dive is also underway as additional assurance. **Responsive:** Mrs Baxter reported that Urgent and Emergency Care (UEC) performance remains a priority and a deep dive analysis is taking place. There has been an increase in emergency admissions and activity growth however there is evidence that SDEC processes are having an effect. Escalation beds continue to be required however the Trust is working with QE Facilities to improve flow and the transport team continue to support the North East Ambulance Service. Waiting lists continue to increase however diagnostic performance is doing well. Challenges remain within cancer performance in particular lung and lower GI due to an increase in referrals. Mrs Marshall highlighted that NHS England/NHS Improvement recently visited the Trust as we have been identified as one of the best performers in ambulance handovers and Mrs Baxter explained that she will be taking part in some recordings which will be included on their websites to share best practice. Mrs A Stabler, Non-Executive Director, queried the reason behind the cancer performance risk relating to haematology and Mrs Baxter agreed to look into this further and provide feedback. **Well-Led:** Mrs Venner reported that sickness absence is currently above the target rate and the POD team are working closely with managers around this and will be discussed at the Business Unit Quarterly Oversight Meetings. Core training data also continues to display special cause variation and is outside of expected levels with performance however face to face attendance has increased. Appraisal compliance has increased and the Appraisal Policy has recently been revised and implemented. Following a query from Mrs M Pavlou, Non-Executive Director, on the level of core training compliance within QE Facilities, Mr A Robson, Managing Director of QE Facilities, explained that some staff do not have access to electronic systems however there are plans to supply additional touch screen monitors which will help with this.	JMB

Agenda Item	Discussion and Action Points	Action By
	Mrs Y Ormston, Chief Executive, raised an issue with the restriction of inputting appraisals onto the ESR system and Mrs Venner will request the POD team to look into this further. Mr A Moffat, Non-Executive Director, raised a query in relation to sickness absence variations and Mrs Venner reported that each Business Unit has an allocated POD lead and measures are in place to ensure this is addressed. Mrs H Parker, Non-Executive Director, felt that it was important to ensure that in-depth discussions take place as it is expected that this will be a focus for the Care Quality Commission. The Board acknowledged the work being undertaken to address the pressures impacting on the Trust's performance and after consideration, it was: **RESOLVED:** to receive the report for assurance.	AV
22/142	**OCKENDEN NEXT STEPS & ASSURANCE VISIT:** Dr G Findley, Chief Nurse, provided an update to the Board following the visit to the Trust from the Regional Maternity Team on 16 June 2022. Dr Findley reported that this had been a positive visit and the recommendations will be incorporated into the Ockenden action plan and cycle of audit to include the continuous audit of complex pregnancies and risk assessments. As requested by NHS England, a copy of the report will also be shared with the Regional Chief Nurse, the Local Maternity System, Maternity Voices Partnership, and the Integrated Care Board, along with key findings and learning points from the Region to facilitate shared learning and collaborative working. Mrs A Stabler, Non-Executive Director, attended the maternity session where the regional feedback was shared and agreed to forward the presentation slides to Dr Findley. Mrs J Baxter, Chief Operating Officer, highlighted that the inspection report for human embryos has also been received which includes excellent feedback and the license renewal has been approved. The report will be presented to the next Quality Governance Committee. Following consideration, it was: **RESOLVED:** to receive the report for assurance.	AS
22/143	**NURSE STAFFING EXCEPTION REPORT:** Dr G Findley, Chief Nurse, presented the report for nursing and midwifery staffing in August 2022, and also provided assurance of ongoing work to triangulate workforce metrics against staffing and care hours.	

Agenda Item	Discussion and Action Points	Action By
	The report demonstrates some improvement in staffing fill compared to last month however there are still ongoing staffing challenges within the organisation. Focussed work continues around recruitment and retention of staff as well as managing staff attendance. Following a query from Mr A Moffat, Non-Executive Director, in relation to workforce initiatives, Dr Findley explained that workforce plans/fill rates are in place which also includes agency staff. After discussion, it was: **RESOLVED:** to receive the report for assurance and note that staffing establishments are being monitored on a shift-to-shift basis.	
22/144	**EPRR CORE STANDARDS SELF-ASSESSMENT REPORT:** Mrs J Baxter, Chief Operating Officer, presented the Emergency Preparedness, Resilience and Response (EPRR) core standards self-assessment to the Board prior to submission to NHS England. She highlighted that a review of the EPRR core standards and the associated plan has been undertaken and the overall level of compliance within the Trust has currently been assessed as Partial Compliance. It is acknowledged that although many positive steps have recently been undertaken, some standards will continue to require further review and enhancement. An internal audit has also been undertaken which has received positive feedback with a findings report to follow at a later date. Following further discussion, it was: **RESOLVED:** to receive the report for assurance and endorse the EPRR core standards prior to submission to NHSE.	
22/145	**GREEN PLAN 6 MONTHLY UPDATE:** Mr A Robson, Managing Director for QE Facilities, provided an update on the Green Plan for 2022-2025 which sets out the significant progress in reducing emissions from activities around the organisation. He explained that the plan has been shared with the North East and North Cumbria Integrated Care System and provides assurance over progress towards achieving the objectives and measurable targets outlined in the plan. The report highlights some of the key areas of focus including the re-application of car parking permits and Mr A Robson advised that this exercise is nearly complete and charging will commence next month. Solar panels and air source heat pumps have recently been installed which will help with the decarbonisation of onsite	

Agenda Item	Discussion and Action Points	Action By
	energy and work is also underway to remove piped nitrous oxide from Theatres. Mrs Marshall reminded the Board that the Carbon Literacy training was completed at the last Board Strategy Session and prompted the Board to complete the participant evidence forms to enable the certifications to be released. Following consideration, it was: **RESOLVED:** to receive the update for assurance.	
22/146	**REGISTER OF OFFICIAL SEAL:** Mrs K Roberton, Deputy Director of Corporate Services and Transformation, presented the details of the use of the official seal between September 2021 and September 2022. The Board noted the use of the official seal during this period and after consideration, it was: **RESOLVED:** to receive the report for assurance.	
22/147	**CYCLE OF BUSINESS:** Mrs K Roberton, Deputy Director of Corporate Services and Transformation, 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. Therefore the Board were encouraged to review the cycle of business ahead of the next meeting in November 2022 and it was: **RESOLVED:** to receive the cycle of business for information.	
22/148	**QUESTIONS FROM GOVERNORS IN ATTENDANCE:** There were no questions received from Governors.	
22/149	**DATE AND TIME OF THE NEXT MEETING:** The next meeting of the Board of Directors will be held at 9:30am on Wednesday 30th November 2022.	

Agenda Item	Discussion and Action Points	Action By
22/150	**CLOSURE OF THE MEETING:** Mrs Marshall declared the meeting closed	
22/151	**EXCLUSION OF THE PRESS AND PUBLIC:** **RESOLVED:** to exclude the press and public from the remainder of the meeting due to the confidential nature of the business to be discussed	

PUBLIC BOARD ACTION TRACKER

Gateshead Health NHS Foundation Trust

Item Number	Date	Action	Deadline	Executive Lead	Progress
22/60	25/05/2022	SIRO/Digital report – to arrange a digital session via Board Strategy Session	27/09/2022	JBoy	Digital Strategy and SIRO report to be featured on November Board agenda
22/63	25/05/2022	Well Led Action Plan – to be monitored via SMT with a closure report to September Board	27/09/2022	JBoy	Closure report deferred to November 2022
22/97	27/07/2022	BAF – to provide further instructions on completion and reporting back to Committees	27/09/2022	JBoy	Training session held with Non-Executive Directors in September, with a further session planned for those unable to attend (action also included within September minutes)
22/135	27/09/2022	Board Committee TOR – to review quoracy and include POD representative for F&P Committee. Amendment also required re. transformation section	30/11/2022	KR/JBoy	Amendment made re. quoracy and inclusion of POD representation. Completed
22/136	27/09/2022	Winter Plan – to ensure further details included in relation to risk around finance, staffing and recruitment	30/11/2022	JMB	Completed.
22/137	27/09/2022	Quality Governance Committee – to escalate the need to obtain a copy of the CCG review of the Looked After Children's Health Team to the ICB and Gateshead System Board.	30/11/2022	GF	Completed – ICB has responded to say they have asked the Designated Nurse for the ICB to review the findings of the report.
22/139	27/09/2022	Corporate Objective Delivery – meetings to take place with Executive Leads to review actions/figures	30/11/2022	KR/JBoy	Completed – format adjusted.
22/139	27/09/2022	Risk Management Strategy – to come back to Board for approval at future meeting	31/12/2022	GF	?January Board
22/141	27/09/2022	IOR – to provide feedback on haematology cancer performance risk	30/11/2022	JMB	Very small numbers of patients on the pathways. Common themes are: • 2 week waits: All Choice / cancellations breaches • Treatment breaches relate to complex pathways, multiple tests and changes in tumour groups/pathways following positive diagnostics

					• Process issues related to Admin/secretarial support in BU now resolved (re-booking after cancellations etc./ supporting clinical decisions after tests etc. /dictation)
22/141	27/09/2022	IOR – to review issue relating to restrictions for inputting appraisals onto ESR	30/11/2022	LCJ/AV	Scoped via POD matrix teams re required support- assistance provided with inputting appraisals. New form and Microsoft form for ease of inputting to be communicated w/c 21st November

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 6

Report Title:	**Calendar of Board Meetings 2023/24**			
Name of Meeting:	Board of Directors – Part 1			
Date of Meeting:	30 November 2022			
Author:	Diane Waites, Corporate Services Assistant			
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 inform the Board of the planned Board meeting dates for 2023/24.			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☒ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	-			
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*				
Recommended actions for this meeting:	The Board is asked to approve and receive the dates of the Board of Directors' meetings to be held in 2023/24.			

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)					

Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒

Gateshead Health NHS Foundation Trust

Board of Directors' Meetings 2023/24

During 2023/24 the Board of Directors will hold 9 public meetings including the Annual General Meeting.

Date	Time	Venue
25 January 2023	9.30am	Rooms 9&10, Education Centre
29 March 2023	9.30am	Rooms 9&10, Education Centre
24 May 2023	9.30am	Rooms 9&10, Education Centre
26 July 2023	9.30am	Rooms 9&10, Education Centre
20 September 2023 Annual General Meeting	9.30am	Rooms 9&10, Education Centre
27 September 2023	9.30am	Rooms 9&10, Education Centre
29 November 2023	9.30am	Rooms 9&10, Education Centre
31 January 2024	9.30am	Rooms 9&10, Education Centre
27 March 2024	9.30am	Rooms 9&10, Education Centre

Gateshead Health NHS Foundation Trust

Assurance Report Agenda Item: 7i

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☒
Committee Reporting Assurance:	Finance & Performance Committee October 2022			
Name of Meeting:	Finance & Performance Committee			
Date of Meeting:	October 2022			
Author:	Mr M Robson, Non-Executive Director			
Executive Lead:	Mrs K Mackenzie, Group Director of Finance & Digital Mrs J M Baxter, Chief Operating Officer			
Report presented by:	Mr M Robson, Non-Executive Director			
Matters to be escalated to the Board:	No escalation required			
Executive Summary:	**Items received for assurance:** **Integrated Oversight Report** The Committee received a report which covers the reporting period for May and June 2022. The Committee noted the key areas of pressures within the report and received partial assurance as there are still some outstanding issues. The author's recommendation was not assured due to significant assurance gaps. **Financial Revenue Report** The report was presented for the period April to September 2022 the Trust has reported an actual deficit of £2.224m after adjustments for donated assets and gain & losses of asset disposal. This is a deterioration of £0.679m from the adjusted deficit reported at the end of August mainly due to the impact of the 2022-23 final pay award settlement and the additional bank holiday. The author's recommendation was partial assurance. **Cost Reduction Programme** The report was presented which outlined the Trust has a CRP target this year of £10.939m against which it is expecting to transact £5.968m, leaving a gap of £4.972m to be delivered with a financial plan that delivers a surplus of £1.610m (adjusted financial performance against which the Trust is monitored). Expenditure predicted in plan exceeds the level of income that the Trust anticipated receiving, therefore, the Trust has a cost reduction target (CRP) to ensure it can deliver a £1.610m surplus.			

	The author's recommendation was partial assurance. **Pay Award Paper** The report was presented which informed the committee that there is a risk of an unfunded gap. Following the announcement of the final pay award NHSE announced a further increase to contract settlements equivalent to a 1.66% increase with the expectation this increase along with the original 2% would fund the total cost of the 2022-2023 pay award. The author's recommendation was partial assurance. **Supply Procurement Minutes** The Committee received a verbal update on the internal investigation and advised that the outcome will be presented at the December Audit Committee. **Capital Plan** The report was presented which showed the expenditure for the six months to the end of September was £2.616m, this is £1.977m less than the expected phased plan and results from delays in the development of the New Operating Model project. This underspend is offset by accelerated spending on the new maternity theatre which was completed ahead of expected phasing and over budget, and decarbonisation works being brought forward to the early part of the year. This represents a current £1.385m forecast over commitment on CDEL. This commitment was made at a point in time when considering the likelihood of slippage on schemes and additional capital funding being made available at short notice as the year progressed. The Executive Team, supported by the Capital Steering Group, are closely monitoring the capital programme as it progresses throughout the year. Regular forecast revisions are undertaken, and schemes are being reviewed for deliverability, with potential slippage identified to ensure that capital expenditure will be managed in line with funding identified The author's recommendation was partial assurance. **Change Control Agreement:** A report was presented asking the F&P Committee to approve the waiving standing orders for the CT & MRI Service. The Supply and Procurement Committee (SPC) considered the papers on the above and the recommendation was to approve the waiving of standing orders, but due to the value the item was escalated to Senior Management Team (SMT). The paper was also considered at SMT, and despite having delegated authority to ratify the decision, SMT would like to request further ratification from Finance and Performance Committee.

	The paper requests waiving of standing orders with respect to the temporary provision of two additional mobile diagnostic units in advance of the CDH being mobilised. The total cost for seven months is £1.6m including VAT, with non-recurrent external funding available to support up to the end of March 2023. The author's recommendation was partial assurance.	
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 2868 – Risk to delivery of NOM 3127 - Finance forecast outturn position 3128 – Capital Cost	
People and OD Implications:		

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: 7ii

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☒
Committee Reporting Assurance:	Quality Governance Committee October 2022			
Name of Meeting:	Trust Board			
Date of Meeting:	October 2022			
Author:	Mrs A Stabler, Non-Executive Director			
Executive Lead:	Dr G Findley, Chief Nurse			
Report presented by:	Mrs A Stabler, Non-Executive Director			
Matters to be escalated to the Board:	No escalation required			
Executive Summary:	**Items received for assurance:** **Integrated Oversight Report** The report was presented, 6 CDI cases noted in July were noted not to be related and covered different areas, however the committee were advised some areas were currently escalated to 6 beds rather than 4, it was expected they would reduce back once building work was completed. Duty of Candour compliance was again noted to still demonstrating concern for the period of June to August and assurance was given that it had been escalated to the Senior Management Team to support improvement. The committee reviewed the Health Inequalities data in the IOR and sought further clarification on how the 17% of our most vulnerable population were being supported to attend. The HSMR continues to show more deaths than expected. However, Mr Beeby explained that the most recent figures show an improved position. There was a deterioration in the average number of long stay patients and the front of house performance continues to demonstrate system and site pressures including the increase in 52 week waits. The Committee did however acknowledge the Trust continues to benchmark well against peers. **Maternity Oversight Report** The report was presented by informing the maternity service and reported that continued to ensure compliance with ten safety actions within the maternity incentive scheme year			

	four; However, work is being undertaken to demonstrate this via the action plan. Work continues to amend and update the Maternity dashboard to meet Ockenden requirements and support the Maternity IOR focusing on measures which can be SPC reported. The Committee acknowledged that two maternity serious incidents were reported during quarter one, we have no live HSIB investigations. It was noted that the estates programme is well underway with the service having two operational theatres and work on developing the pool room having commenced. The Committee noted that the Trust have submitted the application for Stage 1 UNICEFF accreditation and noted that the Chief Nurse was the Executive sponsor. **Mortality Six Monthly Update** The report was presented informing that the SHMI places the Trust within the banding of deaths as expected and that the HMSR continues to show more deaths than expected. The Trust's Medical Examiner Office has reviewed all deaths with 98.3% being identified as not preventable. The revised learning from deaths policy and the new process incorporating the Medical Examiner's review are now noted to be live in the Trust. Specifically, the revised process for identifying and reviewing deaths where a patient has a diagnosis of severe mental illness has cleared the backlog of 20 cases with the majority of cases demonstrating good collaborative working. The committee noted further work that had been agreed at the Mortality meeting that morning to look at how we report our reviews and learning from both Mental health and learning disability service users. **Safeguarding Annual Report** The annual report was presented and noted the amount of work that the team have undertaken in the past year. Risks highlighted within the report included: • The fragmented records, the team continue to explore ways of integrating record systems. • As previously escalated to the board the staffing issues in relation to the support of looked after children and the lack of sharing of the review report, it was noted by the Chief Nurse but no feedback has been received from escalations raised.

Serious Incident Report
The report was presented informing that engagement with the BU remains challenging due to ongoing operational pressures, and without this there is a risk that this year's serious incident performance may regress.. It was noted despite the pressure's compliance for reporting within 48 hours remains at 100%.

The Committee acknowledged ten overdue investigation reports and 17 action plans which were more than 60 days overdue in which the overdue actions are mapped to a panel in the next 10 weeks. However the national Patient Safety Team have confirmed that organisations do not have to meet the 60-day timeframe for investigations

Safe Staffing Report
The report was presented informing the committee that September has demonstrated increased staffing challenges due to the impact of the increased COVID-19 rates in the organisation. The report highlighted wards that fell below 75% fill rate and the mitigating actions taken by the senior nurses.

Areas of significant pressure continues are medicine and the care of the elderly. It was noted that there is work ongoing to address the sickness absence within the team and the SNCT is currently being analysed.

Medicine Quarterly Report
The report was presented informing that the pharmacist independent prescribers prescribed on average 12.9% of all adult in-patient medicine's items.

The impact of OPEL 3 on the delivery of and the medicines reconciliation function was also highlighted.

Prescription turnaround times in dispensary are running well with an average of 83 minutes in September and exemplar practice around VTE risk assessment and allergy status.

Quarterly Learning Report
The report was presented informing the core themes identified from the incidents were:

- clinical treatment / pathways
- communication
- admissions, discharge and transfers.

A task and finish group has been established on how the summary of incidents and learning are shared within the Trust.

<table>
<tr><td></td><td colspan="2">Patient Experience Complaints Action Plan
The Committee asked at the last meeting for assurance on the complaints procedure and a report was received outlining that 40 complaints were reopened in 2021/22. Noting that there was an average of four and a half months wait from the point of the complaint being submitted to a response being received with a range of 2 days to 11 months.

The Committee acknowledged that the Trust currently has 90 open formal complaints with 65 complaints overdue as of 11th October 2022 and a deep dive into the triangulating the distribution and allocation of incidents and complaints to Service Line Managers and Matrons has commenced.

Further assurance was sought for the next meeting re the complaints process and the number of overdue complaints in the Trust.

Gateshead Fertility Unit Renewal Inspection Report
The report was presented informing the HFEA inspected the fertility unit in July 2022 and the final report was received in September 2022 which noted some of the areas of non-compliance but none were identified as critical. A detailed action plan outlines individual actions required and progress.

Items received by the Committee for information:

• Mental Health Act Compliance Minutes – July 2022</td></tr>
<tr><td>Recommended actions for Board</td><td colspan="2">Board are asked to note the work of the Committee and the assurances received and note the areas of risk identified but note the actions in place to resolve.</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to: (Including reference to any specific risk)</td><td>Aim 1
☒</td><td>We will continuously improve the quality and safety of our services for our patients</td></tr>
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☐</td><td>We will be a great organisation with a highly engaged workforce</td></tr>
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<tr><td>Aim 5
☒</td><td>We will develop and expand our services within and beyond Gateshead</td></tr>
<tr><td>Financial Implications:</td><td colspan="2">None to Note</td></tr>
<tr><td>Links to Risks (identify significant risks and DATIX reference)</td><td colspan="2">ORR Risks, 2879 – Maternity, 2779 CQC Compliance/ Improvement, 2868 – Further wave of Covid, 2880</td></tr>
<tr><td>People and OD Implications:</td><td colspan="2">Gaps in workforce in nursing, midwifery and mental health.</td></tr>
</table>

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: 7iii

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☐
Committee Reporting Assurance:	Digital Committee Assurance Report from meeting held on 10 October 2022			
Name of Meeting:	Board of Directors			
Date of Meeting:	30 November 2022			
Author:	Mr A Moffat, Chair of the Digital Committee			
Executive Lead:	Mrs K Mackenzie, 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:	The need to progress the Clinical Systems Outline Business Case following the revision of the paper.			
Executive Summary: ***(outline assurances and gaps including mitigating actions)***	**Organisational Strategic Objectives** The report showed progress to plan against the agreed digital strategic aims and objectives for 22/23 with the recognition of some risk in relation to the capacity of the digital team. As such this was rated as partially assured. **Digital Strategy** A draft of the refreshed digital strategy was presented prior to submission to Digital Transformation Group (DTG) and SMT. The final strategy will return in December with progress to date judged to be fully assured. **Digital Delivery Plan** The Digital Delivery Plan was judged to be partially assured as although the plan is complete, refinements are required around providing an indication of risk around timescale, resourcing is available. **Clinical Systems Strategy – Outline Business Case** The committee discussed the Clinical Systems Strategy Outline Business Case (OBC). It was noted that the OBC has not progressed due following submission to Senior Management Team, Clinical Policy Group and the business case group. The need update to paper and progress the OBC was noted as such this was rated as partially assured. **Service Key Performance Indicators** An updated KPI report was presented to provide digital performance assurance. It was noted this had previously			

<table>
<tr><td></td><td colspan="6">been reviewed at Digital Assurance Group and any operational escalations reported for action at SMT - prior to submission to the Digital Committee. Of note was the lack of progress on Information Risk Management which has been escalated with regular reporting to SMT.

A rating of <u>partially assured</u> was awarded as the targets need to be appropriately signed off. It was noted that significant progress has been again to the reporting broadening the data items and the depth of the data.

<u>Internal Audit Reports</u>
It was recognised that significant work had been undertaken on the open audit actions, as such a rating of <u>fully assurance</u> 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, <u>full assurance</u> 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
☒</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">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>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>
</table>

	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: 7iv

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☐
Committee Reporting Assurance:	People and OD Committee – November 2022			
Name of Meeting:	Trust Board			
Date of Meeting:	30.11.22			
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:	None			
Executive Summary: ***(outline assurances and gaps including mitigating actions)***	The key agenda items discussed were as follows: **Items referred from F&P Committee – Staffing Position in Theatres** The committee received an update on the interim arrangement that was now in place within Theatres and how well this had been received. The team have identified a number of KPIs which will be fully developed and monitored to carefully monitor impact **TOR Annual Assessment** The terms of reference were reviewed noting 3 items which are to be added to the cycle of business. **QEF Recruitment transferring to QEF** The committee received a report advising that a decision had been made to formally transfer the management of QEF recruitment directly to QEF and the transition plan prepared by the trust Executive Director of People and OD was noted. This plan clearly sets out the standards which must be met from both a legal, regulatory and sector perspective and work is underway to implement the transition plan, with handover expected in January. The committee discussed this at length noting that people assurance for QEF staff will now be formally provided via QEF Board and the incoming trust contract manager will include oversight and compliance reporting to the trust as part of the SLA; this will be via the Finance and Performance Committee.			

	Concern was raised with regards to the planned January handover and time lapse to expected commencement date for the contracts manager and subsequent development of KPIs and reporting c April. **People Strategy** A presentation was shared outlining the work to date and next steps. This was well received and is on track for approval in the new year. **Growing the workforce – *Absence & Supply*** The committee welcomed the summaries contained within the presentation and the ongoing development of this report. The committee noted the vacancy position with regards to registered nurses and the work ongoing with regards to both recruitment and retention. The Executive Director of People has now met with 3 business units to further explore ongoing recruitment and retention work in further detail. It was agreed that this item would focus on forecasting at the January committee and that the HR Analyst has been working on this as the next phase of work. **Update report from POD Portfolio Board** The Committee acknowledged the work underway within each programme of work with slight concern for the E-Rostering programme board due to meetings being stood down due to operational pressures. Progress on identifying additional space for junior doctors mess facilities were noted. Staff survey response rate is tracking just above the national average but is lower than last year. **Strategic Objectives** Understanding the work ongoing across the People and OD portfolio the committee noted actions were ongoing. **People & OD Metrics** A presentation was shared highlighting the key areas of focus across a number of areas. The work ongoing to manage sickness was noted, core skills compliance is improving however, appraisal rates are still well below the trust standard. Managing Well and Leading Well flagship programmes are both evaluating exceptionally well. **Industrial Action** An update was received and the risk was discussed. **Board Assurance Framework** BAF was discussed and updated. **People and OD Organisational Risk Register** The group were pleased the workforce risk had been reviewed and updated.

<table>
<tr><td>Recommended actions for Board</td><td colspan="6">Note main assurances against the strategic People and OD themes detailed and key associated risks.</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:
(Including reference to any specific risk)</td><td>Aim 1
☐</td><td colspan="5">We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>Aim 2
☒</td><td colspan="5">We will be a great organisation with a highly engaged workforce</td></tr>
<tr><td>Aim 3
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<tr><td>Aim 4
☐</td><td colspan="5">We will be an effective partner and be ambitious in our commitment to improving health outcomes</td></tr>
<tr><td>Aim 5
☐</td><td colspan="5">We will develop and expand our services within and beyond Gateshead</td></tr>
<tr><td>Financial Implications:</td><td colspan="6">No significant new financial implications to highlight to the Board.</td></tr>
<tr><td>Links to Risks (identify significant risks and DATIX reference)</td><td colspan="6">Three risks from the organisational risk register were reviewed:
2764 – Right People, Right place, Right skills – 16
2765 – Leadership and OD – 12
2759 – Health & Wellbeing – 12</td></tr>
<tr><td>People and OD Implications:</td><td colspan="6">As set out</td></tr>
<tr><td>Links to CQC KLOE</td><td>Caring
☒</td><td>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>

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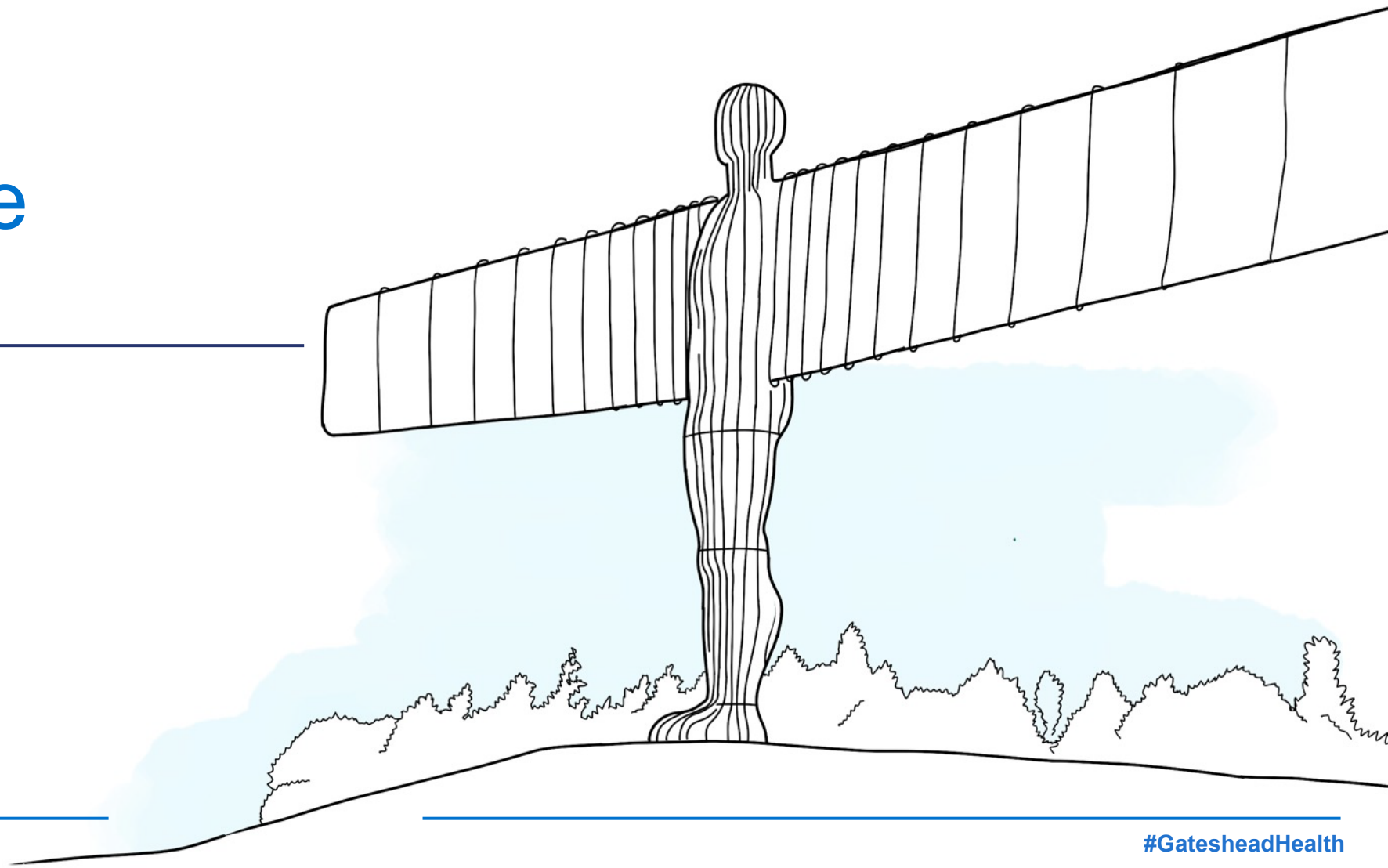
Chief Executive Update

Yvonne Ormston MBE

November 2022



Performance

Operational performance

Gateshead Health NHS Foundation Trust

Urgent and emergency care

- Footfall and patient numbers increased in October to 9497 from 9011 in September, and daily attendances averaged 25 per day more than October 2021 (representing an increase of 9.1%).
- 4-hour performance in October was 69.3% in October, deteriorating from 72.4% in September
- Average daily bed occupancy level was 96.8% in September and 96.7% in October, peaking at 99.3% one day
- Ambulance delays reported in October: 1112 between 30-60mins (up from 106 in September) and 110 delays >60 mins (down from 110 in September). However, continue to be the 2nd best performing Trust in NENC & NY re: Ambulance delays 30-60 mins, and 3rd for >60+
- The number of patients who do not meet the criteria reside in hospital remains high, with a daily average of 40 patients in October.

A&E Indicators	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Monthly Trend
Attendances: Type 1	5431	6091	6034	5950	5579	5796	6254	
Attendances: Type 3	3323	3625	3625	3457	3427	3215	3243	
Total Attendances	8754	9716	9659	9407	9006	9011	9497	
Total Breaches	2164	2148	2212	2116	2292	2484	2918	
Trust Total - % seen in 4 hours	75.3%	77.9%	77.1%	77.5%	74.6%	72.4%	69.3%	
National Rank (Accute trusts - Lower is better)	23	20	19	16	29	33	38	
12 hour trolley waits (DTA breaches)	71	4	11	18	36	164	134	
Volumne in department > 12hours	252	108	193	213	318	703	731	
A&E >12hour waits (target <2%)	2.88%	1.11%	2.00%	2.26%	3.53%	7.80%	7.70%	
Average bed occupancy	94.4%	92.8%	94.4%	95.1%	96.0%	96.8%	96.7%	

Ambulance Arrivals and handover delays	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Monthly Trend
No. Patients arriving by Ambulance	1619	1803	1733	1748	1760	1753	1705	
% of handovers <15 Minutes	44.1%	46.7%	45.1%	42.5%	45.8%	38.2%	34.7%	
% of handovers 30-60 Minutes	94.9%	98.4%	97.3%	95.9%	97.1%	93.0%	92.9%	
Number of >30 Minute Breaches	72	26	40	63	45	106	112	
Number of >60 Minute Breaches	62	10	17	37	36	123	110	

Performance benchmarking

Gateshead Health NHS Foundation Trust

	GHFT Benchmarking Figure							GHFT Benchmarking Position								
	May IOR	June IOR	July IOR	Aug IOR	Sep IOR	Oct IOR	NOV IOR	Rank out of:	Rank is better if:	May IOR	June IOR	July IOR	Aug IOR	Sep IOR	Oct IOR	Nov IOR	Trajectory (May to Oct)
A&E 4 hour waiting time target	75.3%	77.9%	77.1%	77.5%	74.5%	72.5%	69.3%	139 - All Type 1 NHS Providers	Lower	23	20	19	16	29	33	38	Worsened
Latest weekly PTL: patients waiting > 104 weeks	0	0	0	0	0	0	0	8 Providers in ICS	Lower	1	1	1	1	1	1	1	No change
Latest weekly PTL: patients waiting > 52 weeks	50	60	73	75	58	91	79	8 Providers in ICS	Lower	2	2	3	3	2	3	3	Worsened
Latest weekly PTL: patients waiting > 62 days for cancer treatment	63	65	57	68	64	63	62	8 Providers in ICS	Lower	1	1	1	1	1	1	1	No change
62 day backlog as % of waiting list	8.7%	9.1%	9.3%	10.2%	8.3%	6.7%	7.9%	139 - top 20 under NHSE/I scrutiny	Higher	73	75	69	59	83	106	99	Improved

Latest update:

- In 3 of the 5 metrics, we have either improved, or there is no change (in both metrics the Trust is ranking in the top position).
- The table continues to show a worsening picture in relation to our benchmarked position for A&E 4-hour target (reflecting the pressures being observed in A&E and for 52-week waiters.

General updates

System updates

- Integrated Care Board (ICB) has now formally met twice, with the next meeting scheduled for the end of November 2022.
- The Integrated Care Partnership (ICP) has appointed the ICB Chair, Sir Liam Donaldson, as its founder member.
- ICP Strategy has been consulted on – the draft is available here: icp-integrated-care-strategy-draft-20221021-003.pdf (northeastnorthcumbria.nhs.uk)
- NHS Provider Collaborative – approval and funding granted for a new aseptic unit to produce medical supplies including chemotherapy drugs. It will significantly increase production capacity and create a sustainable and efficient supply chain.
- Significant regional focus on preparing for winter - urgent and emergency care, discharge, bed capacity, ambulance handover delays.

Other key updates

- Our breast services team was a finalist for the HSJ Performance Recovery Award. They cleared a backlog of over 50,000 appointments in 18 months and delivered all cancer performance standards consistently throughout 2022/23.
- QE Facilities' Patient Transport team received their first CQC inspection and were awarded a rating of 'good'.
- Endoscopy services were awarded the Joint Advisory Group (JAG) accreditation for another year – demonstrates they meet best practice quality standards.
- Held our biggest ever Open Day in October and welcomed over 450 staff and members of the public.

General Update

- Visits:
  - Visit to physiotherapy with the Chair
  - Presentation to newly registered nurses
  - Emergency department
  - People and Organisational Development team
  - Ward 25
  - Main reception
  - Chaplains
- Meetings
  - Meeting with Gateshead system leaders
  - ICP CEO meetings
  - NENC System Learning event
  - Inclusive recruitment and career progression meeting
  - North ICP Local A&E Delivery Board meetings
  - Provider Collaborative Leadership Board
  - CSG away day
  - Meetings with consultants
  - National Pathology Assurance Standards meeting
  - NENC Urgent and Emergency Care Strategic Board meeting
  - NENC CEO winter resilience meeting
- Other
  - Star awards
  - Trust Open Day
  - Executive Director development days
  - Healthcare Support Worker conference

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 9

Report Title:	**Potential Industrial Action – update on planning**			
Name of Meeting:	Trust Board (Public)			
Date of Meeting:	30 November 2022			
Authors:	David Patterson, Emergency Preparedness, Resilience and Response and Business Continuity Manager & Amanda Venner, Deputy Director of People & OD			
Executive Sponsor:	Lisa Crichton-Jones, Executive Director of People & OD			
Report presented by:	Lisa Crichton-Jones, Executive Director of People & OD			
Purpose of Report	**Decision:** ☐	**Discussion:** ☒	**Assurance:** ☒	**Information:** ☐
	The purpose of this report seeks to provide an update on trust planning for potential Industrial Action across a number of different sectors			
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:	The information contained within this report has been discussed at the internal Planning Group.			
Key issues:	The Trust Board are asked to discuss and note the following update: **Current position** • A number of Trade Unions are currently balloting their members with regards to future industrial action. This includes the Royal College of Nursing (RCN); the Chartered Society of Physiotherapy; Royal College of Midwifes; GMB in all ambulance trusts and selected Trusts and NHS Blood and Transplant services; Unite and Unison • Locally and nationally the potential for industrial action is being discussed in a number of other sectors including education, transport and Local Authority which could all impact on our services. • All unions are at different stages of balloting. However, on 9 November 2022, **<u>the RCN returned a positive ballot for industrial action</u>** to take place at selected trusts nationwide including Gateshead. At this time of			

writing further information is still awaited on the confirmed periods of industrial action.

Internal planning

- A multi-disciplinary internal trust planning group led by Lisa Crichton-Jones as the Senior Responsible Officer (SRO), was established in the middle of September to ensure that the trust has undertaken the necessary planning with regards to potential industrial action across a range of sectors that may impact trust operations
- Focussed planning sessions have taken place to explore the planning, response and recovery elements of industrial action with reasonable worse case scenarios considered
- Trust business-critical services have been prepared before formal discussions on agreeing local derogations will take place with trade unions
- A work plan has been produced with a number of actions, lead officers and timescales
- An Industrial Action operational plan with coordination framework is being drafted, incorporating learning from the covid response, as to how operational the trust will run on periods of industrial actions period in command, control, coordination and communication (C4 structure)
- Our biggest risk is concurrent periods of industrial action across different sectors taking place and how as a trust there is minimal disruption to patient care and emergency services can continue to operate as normal.

National direction

The first formal communication from NHSE was received by the trust on 2 November 2022

https://www.england.nhs.uk/publication/preparedness-for-potential-industrial-action-in-the-nhs/

This includes guidance on:

- Supporting trusts to be prepared – a Self-Assessment Checklist has been developed to support trust preparations. If industrial action is confirmed, assurance will be undertaken against this checklist. At that stage, the trust will be asked to complete the checklist and ICBs will be asked to consolidate returns.
- Ensuring information on confirmed industrial action, including information on derogations, is shared appropriately across systems
- Testing preparedness as systems will be co-ordinated with wider winter planning and will seek to explore the health and social care response to multiple, concurrent operational and winter pressures, and the interdependencies with Local Resilience Forum (LRF) partners in responding to these pressures.

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

- Communications – internally with engagement and externally with the public
- Supporting system leaders (including Chief Nurses) with guidance and support for decision making around operational activity and engagement with staff taking industrial action
- Minimising the reporting burden – reporting once a day and using existing collections where possible.

This was followed up on 22 November with a first request for the trust to complete the self-assessment checklist:

https://www.england.nhs.uk/wp-content/uploads/2022/11/Preparedness-for-industrial-action-in-the-NHS-22-Nov-2022-Update.pdf

Summary
In summary, at this time of writing, there are still a lot of unknowns but there is assurance that our planning continues in a collaborative and multi-disciplinary approach to ensure that the trust is adequately prepared when industrial action takes place.
</td></tr>
<tr><td>Recommended actions for this meeting:</td><td colspan="6">The Trust Board are asked to consider the key issues in this paper</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>
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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"></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">There are a number of risks related to industrial action, ranging from dealing with isolated strikes, to concurrent strikes over a period of time, more than one union taking strike action on the same day(s), with the worst case of concurrent periods of industrial action across different sectors taking place.

As a trust we must mitigate these to ensure there is minimal disruption to patient care and emergency services can continue to operate as normal.</td></tr>
</table>

	The risk is compounded by the pressures the trust experience in terms of winter pressures at this time of year, has been added to the risk register.		
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒

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Report Cover Sheet Agenda Item: 10i

Report Title:	Organisational Risk Register (ORR)			
Name of Meeting:	Board of Directors			
Date of Meeting:	30th November 2022			
Author:	Marie Malone, Corporate and Clinical Risk Lead.			
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 Bi- 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* • *Quality and safety*	Seven Risks added to the ORR in period: Three risks have a current risk rating of 20: • 2558 (Medicine)- Risk of a 12-hour A&E wait in ED from arrival due to organisational pressures resulting in sub optimal patient care and risk of patient harm. CRR 20			

<table>
<tr><td>

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

</td><td colspan="5">

- 3057 (Surgery) Risk of ventilation failure to multiple theatres due to ventilation system for theatres being at end of life resulting in potential for infection risks, affecting staff and patient. CRR 20
- 3127 (Finance) There is a considerable risk that the trust will not be able to meet the required forecast outturn position of 1.6m surplus. CRR 20

Risk and action review compliance remains static, with current risk compliance of 69% and action compliance at 68%.

</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:

- 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="4">We will continuously improve the quality and safety of our services for our patients</td></tr>
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<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">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></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">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>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 (ORR) is compiled by the Executive Risk Management Group of those risks that impact on the delivery of strategic aims and objectives.

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

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 1st September 2022 to 15th November 2022 (extraction date for this report).

There are currently 16 risks on the ORR.

Organisational Risk Register – Movements

Following ERMG meeting in November, the following 7 risks have been added to the ORR:

- Risk **2558** (Medicine) *Risk of a 12-hour A&E wait in ED from arrival due to organisational pressures resulting in sub optimal patient care and risk of patient harm*. (CRR 20)

- Risk **3057** (Surgery) *Risk of ventilation failure to multiple theatres Due to ventilation system (air handling units) for theatres 1 -8 being at end of life and 1 unit supporting 2 theatres resulting in potential for infection risks, affecting staff and patients*. (CRR 20)

- Risk **3127** (Finance) *There is a considerable risk that the trust will not be able to meet the required forecast outturn position of 1.6m surplus. This is impacted by achievement of ERF, delivery of CRP, impact of inflation, funding available from DHSC, realisation of mitigations and cost of ongoing service pressures resulting from COVID and unscheduled care activity.* (CRR 20)

- Risk **3095** (POD) *Risk of Industrial Action affecting staffing levels and potential impact on patient care and quality*. (CRR 16)

- Risk **1490** (Digital*) If Information Asset Owners e.g. System administrators across business units and corporate services fail to manage their assets (e.g. patient data, staff data, corporate data, systems, and business continuity plans), there is a risk of inappropriate access/use/updating/disclosure of data*. (CRR 15)

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

- Risk **2318** (Finance) There is a Risk that the capital cost of delivery of the new operating model continues to increase resulting in revenue implications. (CRR 12)

Finance Risk **3127** above is a strategic risk relating to finance, and as a result 1 existing risks related to finance have been removed from the ORR and closed:

- **3093** (Finance) – *There is a risk that the Trust does not achieve its financial and capital plans due to the challenging level of CRP, increasing inflation and risk around achievement of ERF. Resulting in the failure to deliver sustainable services and deliver objectives.*

Three new additions have been escalated in score:

- **3057** (Surgery) *Risk of ventilation failure to multiple theatres due to ventilation system (air handling units) for theatres 1 -8 being at end of life and 1 unit supporting 2 theatres resulting in potential for infection risks, affecting staff and patients*.

Escalated from 6 to 20 due to potential financial risk to elective recovery plan and potential impact quality of care.

- Risk **2558** (Medicine) *Risk of a 12 hour A&E wait in ED from arrival due to organisational pressures resulting in sub optimal patient care and risk of patient harm*.

Escalated from 16 to 20 due to the current pressures in emergency department.

- Risk **1490** (Digital*) If Information Asset Owners e.g. System administrators across business units and corporate services fail to manage their assets (e.g. patient data, staff data, corporate data, systems, and business continuity plans), there is a risk of inappropriate access/use/updating/disclosure of data*.

Escalated from 12 to 15 due to lack of progress with each IAO taking ownership of their assets.

Risks closed in period

Two QEF risks have been closed:

- 3091 (QEF) Business Development - *Risk that we lose business or miss out on business opportunities to support growth*
- 3092 (QEF) *state infrastructure – There is a risk that we are unable to invest in our estate infrastructure*

Risk and action review compliance is currently at 69% and 68% consecutively, 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

Organisational Risk Register Report

Reporting Period: 01-Sep-2022 to 15-Nov-2022

Comparison Date: 15-Aug-2022

Gateshead Health NHS Foundation Trust

Risk Profile (Current/Managed)

Resources - 1

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

Wellbeing - 1

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

Business Continuity - 2

IMT 1490 - Failure to manage Information Assets (15)

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

Digital - 1

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

Finance - 1

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

Effectiveness - 1

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

Safety - 4

CEOL2 3029 - Covid - Risk of further waves/continued endemic Covid, which could impact operational delivery across the whole Trust. (12)

SURGE 3057 - Risk of ventilation failure to multiple theatres resulting in potential infection risks (20)

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

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

Compliance - 1

MEDIC 2558 - Risk of a 12 hour A&E wait in ED from arrival (20)

Delivery of Objectives - 3

COO 2868 - New Operating Model -Risk to the delivery of the new operating model resulting in adverse impact on performance & recovery plans (20)

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

FIN 3127 - There is a considerable risk that the trust is unable to meet the required forecast outturn positon of 1.6m surplus (20)

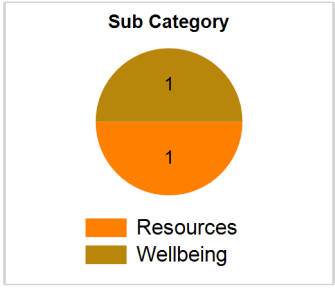
Organisational Risk Register Report

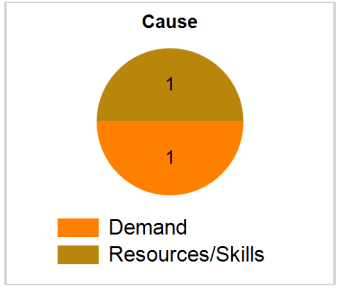
Reporting Period: 01-Sep-2022 to 15-Nov-2022

Comparison Date: 15-Aug-2022

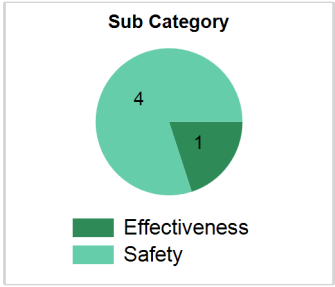
Gateshead Health NHS Foundation Trust

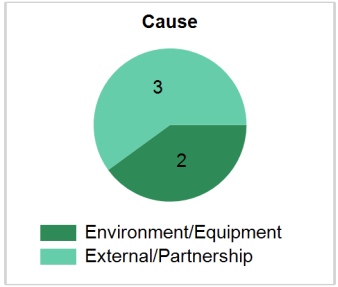
People & Resources



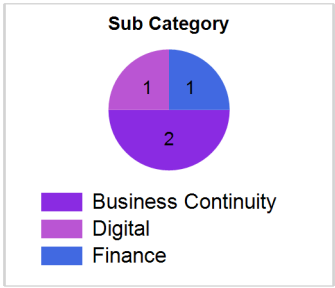


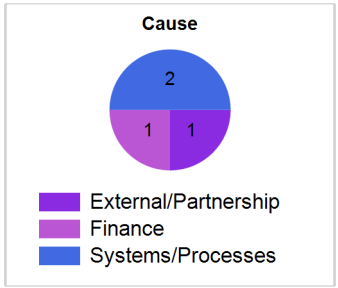
Quality Outcomes



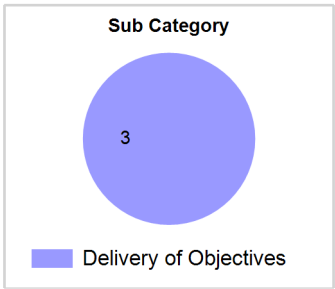


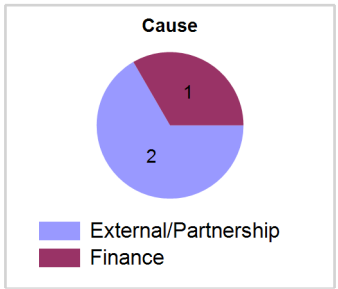
Finance & Efficiency





Regulation & Compliance





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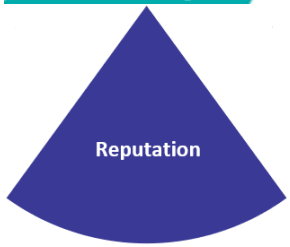
Business Intelligence

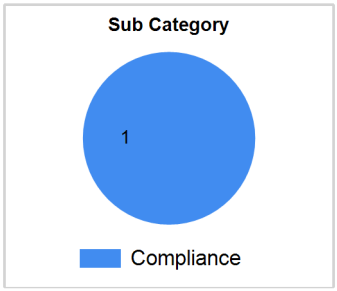
Organisational Risk Register Report

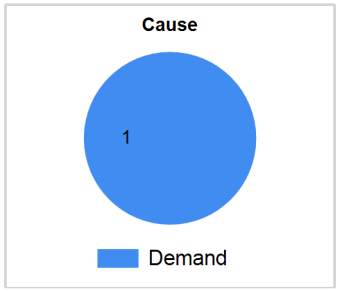
Reporting Period: 01-Sep-2022 to 15-Nov-2022

Comparison Date: 15-Aug-2022

Gateshead Health NHS Foundation Trust







Organisational Risk Register Report

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Gateshead Health NHS Foundation Trust

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

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2558 08/10/2019 Mark Dale Medical Services Med 1 28/10/2022 BU_DIR ORG	Risk of a 12 hour A&E wait in ED from arrival due to organisational pressures resulting in sub optimal patient care and risk of patient harm.	20	1. Site resilience meetings regularly and monitoring of breach times for any patients. 2. current Opel level framework to support escalation and management of breach times for patients. 3. SOP for escalation of breach times and to whom 4. Emergency Huddle	20			4	formal agreement at ERMG nov 22 to add to ORR

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Organisational Risk Register Report

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2868 27/04/2021 Joanne Baxter Chief Operating Officer 03/10/2022 BAF COO EPRR FPC ORG QGC SA3.1 Improve the productivity and efficiency of our operational services through the delivery of the New Operating Model and associated transformation plans	New Operating Model - Risk to the delivery of the new operating model and associated transformation plans due to the increase in activity and reduced workforce capacity (potentially due to covid waves), resulting in adverse impact 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. 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	20	triangulations of incidents and low staffing	Shelley Dyson 31/07/2022	6	risk reviewed and actions updated
					active recruitment to vacanices	Lisa Crichton-Jones 30/09/2022		
					international recruitment programme	Lisa Crichton-Jones 30/09/2022		
					WLI rate for theatre staffing to be determined	Helen Routh 30/09/2022		
					Review of temporary staffing solutions	Joanne Baxter (Completed 02/09/2022)		
3057 24/05/2022 Lois Lincoln Surgical Services Theatres & Anaesthetics 11/11/2022 BU_DIR HSC IPCC ORG	Risk of ventilation failure to multiple theatres Due to ventilation system (air handling units) for theatres 1 -8 being at end of life and 1 unit supporting 2 theatres resulting in potential for infection risks, affecting staff and patients.	8	Estates aware of the problem and prioritise any work on these. Regular maintenance. Theatres taken out of action if incident occurs on the day.	20	Replace and update air handling units in theatres	John Adamson 31/12/2022	2	formal agreement in Nov to add to ORR

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Organisational Risk Register Report

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3127 17/10/2022 Kris MacKenzie Finance Finance 17/11/2022 BAF BU_DIR FPC ORG SA3.2 Achieving financial sustainability	There is a considerable risk that the trust will not be able to meet the required forecast outturn position of 1.6m surplus. This is impacted by achievement of ERF, delivery of CRP, impact of inflation, funding available from DHSC, realisation of mitigations and cost of ongoing service pressures resulting from COVID and unscheduled care activity.	20		20			8	risk added following discussion with K Mac. risk 3106 (not on ORR) and 3093(ORR) combined to create new risk detailed here. mitigations and controls to be added. Added to ORR and BAF as per K Mac
2764 17/11/2020 Ferne Clements People and OD Human Resources 28/11/2022 BAF ORG HRC SA2.2 Growing and developing our workforce	Risk of not having the right people in the right place at the right time with the right skills across the organisation. Noting regional and national supply pressures, resulting in failure to deliver current and future services that are fit for purpose.	20	Staffing Reporting Task and finish group established International recruitment on track Domestic recruitment actively pursued and monitored Over recruiting to HCSW positions Recruitment process streamlined (RPIW) Dates for reamining Workforce planning with The Whole System Partnership to commence workforce planning SMT discussions on longer term strategic supply pipelines for Registered Nurses have commenced, inc Registered Nurse degree apprentices and Trainee Nurse Associates. Absence Management - Refreshed policy, roll out of training, enhanced support from POD team Local pay arangements for hotspot and winter working.	16	Forecasting workforce data	Ferne Clements 30/11/2022	8	Risk information, Existing Controls, Assurances, Gaps in Control, Gaps in Assurance and actions all updated
					Review of Retire & Return Policy & Process	Ferne Clements 30/11/2022		
					Robust Exit Interview process	Ferne Clements 30/11/2022		
					Transfer Window	Janet Thompson 30/12/2022		
					Workforce planning to be scoped and future resource/ways of working identified.	Ferne Clements 31/12/2022		
					Clinical Strategy	Andrew Beeby 31/12/2022		
					Health and Care Academy	Sarah Neilson 31/12/2022		

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2982 06/12/2021 Amy Muldoon Medical Services Medical Services - Divisional Management 07/12/2022 BU_DIR COO ORG	Risk of delay in transfer to community due to lack of social care provision and intermediate care beds, 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 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: 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	Daily meeting with LA to examine capacity in out of hospital system and match with demand for discharges. Target discharges of 40 per week to keep pace with demand. Monitoring of Delayed transfers of care twice weekly meeting Escalation of delays of care to the community BU and social services at twice weekly meetings. Monitoring of any levels of harm - Datix incidents. Monitoring of Breach levels and times. Monitoring of Ambulance delays. Monitoring increased LOS of medically optimised patients. Escalation of patients requiring social services support raised weekly at Discharge Systems group which includes Social services management and CCG representative. Medically Optimised meeting 2x week, passed to IPC/CCG ECIST work Pilot on 2 wards re improving discharges. Further social care provision for discharge purchased and in place from beginning of June 2022	16	System leadership post for discharge created and to be recruited to	Joanna Clark 31/01/2023	9	no change as discussed with AM. Work still ongoing between the local authority and us to look into challenges. There are weekly meetings and we review the position daily on patients who no longer meet the criteria to reside. New provider CHS coming online October 2022 to provide further capacity.

Organisational Risk Register Report

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3095 26/07/2022 Amanda Venner People and OD Workforce Development 02/12/2022 BU_DIR ORG	Risk of Industrial Action affecting staffing levels and potential impact on patient care and quality.	20	Industrial action working group established and meeting regularly. Focussed planning sessions have taken place to explore the planning, response and recovery elements of industrial action with reasonable worse case scenarios considered. A detailed work plan has been produced with a number of actions, lead officers and timescales citrep position updated daily Business continuity planning command and control structure will recommence in the event of industrial action	16			9	formal agreement at ERMG to add to ORR 8th nov 2022

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1490 11/03/2014 Nick Black Digital 20/10/2022 BU_DIR DIGC ORG SA1.3 Digital where it makes a difference	If Information Asset Owners e.g. System administrators across business units and corporate services fail to manage their assets (e.g. patient data, staff data, corporate data, systems, and business continuity plans), there is a risk of inappropriate access/use/updating/disclosure of data.	20	Named System Administrator and Data Manager for every system Actively managed Systems Specific Security Policy (SSSP) for all systems - reviewing user access levels, training, configuration, testing, upgrade management - including business process changes etc Service owned Business Continuity Plan should systems fail Disaster Recovery Plan - how to recover the system Signed user registration forms Formal ITIL best practice change control procedure in place Formal Business case and project acceptance route through HISG Audit programme underway, focussed on critical system	15	Getting IAOs to take responsibility of their information assets	Nick Black 31/12/2022	3	formal agreement at ERMG 8th nov to add to ORR. Strategic risk due to duplication of previous risk 3090.

Organisational Risk Register Report

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2398 28/12/2018 Kate Hewitson Surgical Services Obstetrics 01/12/2022 BU_DIR ORG	Due to the maternity estate being in a separate building from other acute services (main theatre/CCU/Paediatrics etc.) This was highlighted by recent HSIB reports reflecting delayed attendance times of emergency multi disciplinary teams to obstetric emergencies. Rising acuity of maternity patients and more frequent use of CCU, theatre staff and Paediatric teams creates additional likelihood of the need for these teams to attend the maternity department and delays to be incurred. Resulting in the risk of severe harm to mothers and babies.	20	Pre-assessment - Women deemed likely to require critical care after elective procedures have their operation in main theatre to allow swift access to critical care. This only applies to elective patients and not emergency procedures or those in spontaneous labour. Any incidents are investigated to identify potential learning.	15	2861 action re looking into estate options	Kate Hewitson 30/12/2022	5	formal agreement at ERMG to add to ORR

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2759 16/11/2020 Amanda Venner People and OD Human Resources 28/11/2022 BAF ORG HRC SA2.1 Protect and understand the health and well-being of our staff by looking after our workforce	Workforce Health & Wellbeing - Risk of adverse impact to staff health and wellbeing due to internal working conditions and pressures as well as external factors (demand, patient acuity, staffing levels, covid, civil unrest) resulting in increasing physiological and psychological harm.	16	Health and Wellbeing team established with Regional funding secured to fund the team until June 2023. Partnered with Talk Works to provide talking therapies and counselling services to reduce waiting times for counselling and psychological support services. Occupational health referral systems(self referral and management referral)and process in place. Occupation Health external review completed, with improvement plan now being implemented. Occupational Health Metrics discussed at POD Quality meeting. Physio appointed 24/7 catering/vending solution now in place and usage is positive Schwartz rounds commenced	12	Increase the number of Mental Health first aiders	Amanda Venner 30/12/2022	8	Slight rewording in risk title as agreed as part of strategic risk review. Formal agreement at ERMG 25/07/2022
					Relaunch Health and wellbeing check ins	Amanda Venner 30/12/2022		
					Engagement on HWB Strategy to be undertaken during May 2022, with strategy finalised and agreed in June 2022	Amanda Venner (Completed 31/08/2022)		
					Listening Space	Amanda Venner (Completed 31/08/2022)		

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2945 14/09/2021 Debbie Renwick Chief Operating Officer Planning & Performance 27/10/2022 BU_DIR ORG	Risk of ineffective and inefficient management of services due to availability and access to appropriate and timely business intelligence to deliver and improve services	15	Programme of work established to work on improving access to BI and improve board reporting along with service line access to quality performance and workforce data Project Manager appointed to lead on this work with support from NECS. Programme involves 3 projects Static reporting – Look back - this is what we achieved Live reporting – this is how we are doing now and where we need to intervene to prevent poor performance Forecasting – these are the trends to be able to plan services much more effectively to meet demand the later two points need further development Some BI available in sitreps and excel format	12	• Work with the BU managers looking at what is available and start to build what is needed and get rid of what is not used/helpful	Debbie Renwick 31/08/2022	4	no change to risk following consultation with DR
					• Improve data quality by working with teams and provide resilience to teams doing the RTT etc	Debbie Renwick 30/09/2022		
					project groups established and PID developed and plans developed for delivery	David Thompson 30/09/2022		

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3029 04/04/2022 Mr Andrew Beeby Chief Executive Office Medical Directorate 30/12/2022 BAF BU_DIR ORG QGC SA1.2 Continuous Quality improvement plan	Covid - There is a risk that there will be further waves of Covid, or continued endemic Covid, which could have an effect across the whole Trust (and the wider health and social care system) leading to workforce shortages, operational pressures because of the difficulty maintaining flow of patients presenting acutely and deflection from 'business as usual' activities and development / improvement work.	20	Business continuity and EPRR governance and resilience plans Staffing resilience and backup Service delivery plans IPC planning/ escalation/ reduction of PPE/ distancing Estate flexibility and planned escalation/ covid wards	12			8	We have developed a hybrid way of working which can accomodate Covid work with minimal disruption to other work. This is becoming the business as usual approach. The waves are smaller with less serious disease and we are no longer doing routince swabbing of all patients in hospital in keeping with national guidance there remains a risk that the disease may become more pathogenic
3089 25/07/2022 Gillian Findley Nursing, Midwifery & Quality Quality Governance 10/01/2023 BAF BU_DIR ORG QGC SA1.2 Continuous Quality improvement plan	Quality - There is a risk of quality failures in patient care (patient safety, patient experience and effectiveness) due to external causes such as delayed discharges and pressures from other Trusts resulting in patient harm, regulatory action, and reputational impact	15	Daily report provided detailing all delayed discharges within the Trust. regular meetings now established with social care. Discharge liaison staff available to support wards and facilitate earlier discharge.	12			6	NO change to risk or mitigations
3128 17/10/2022 Kris MacKenzie Finance Finance 17/11/2022 BAF BU_DIR FPC ORG	There is a Risk that the capital cost of delivery of the new operating model continues to increase resulting in revenue implications.	12		12			9	risk added following discussions with Kmac. controls and mitigations to be added. Added to ORR and BAF agreed with KMac and GF

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1636 10/11/2014 Dianne Ridsdale Digital IT 10/01/2023 DIGC MDMG ORG	UCRF R01/R03/R20/R23 Malware such as Ransomware Compromising Unpatched Endpoints, Servers, Equipment or due to Lack of Hardened Build Standards. There is a risk of potential exposure to published critical cyber vulnerabilities. Laptops, workstations and medical devices compromised by ransomware or botnets, due to endpoints being susceptible to compromise through the use of obsolete, old, or unpatched operating systems and third party software, including Java. Endpoints often not monitored for patch status. Endpoints compromised more easily through dangerous browser plugins (such as Java, Flash), or unsupported browsers. Servers compromised by ransomware, due to servers susceptible to compromise through the use of obsolete, old, or unpatched operating systems and software. Servers often not monitored for patch status. Due to failure to maintain all Digital assets, including installing Operating system patches, AV patches or other software and hardware updates across the IT estate, including network equipment and medical devices. Resulting in potential harm to patients, data leaks, impacts on service delivery.	**25**	AV on all end points AV up to date ATP in place site wide NHSD & Microsoft group policy templates Ongoing updates routinely planned as they are released Patching regime Network fully supported and maintained	**10**	Review trust asset register for EOL hardware/Software	Mark Bell 31/12/2022	**5**	Work has been completed to remove high level vulnerabilities such as out of date operating systems and hardware. IG monitoring IT collating
					Review trust asset register for EOL hardware/Software	David Thompson 31/12/2022		
					Cancelled - Complete Cyber Essential Plus Accreditation	Jon Potts (Completed 20/09/2022)		
					Manage replacement of End of life Network Hardware	Jon Potts (Completed 10/10/2022)		
2880 30/04/2021 Mr Andrew Beeby Chief Executive Office Medical Directorate 16/11/2022 BAF ORG QGC	Health Outcomes - Risk that Place/ICS/ICP strategy and plans do not fully align with our objectives and aspirations to tackle health inequalities due to different approaches resulting in slow or no progress against health inequalities.	**12**	Being involved with ICS / ICP / Place in the development of work (co-production) Health Inequalities Board established.	**9**			**6**	The ICB has now formed but there is much development work ahead so there has been no change to this risk yet

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Changes in CRR - Current/Managed Risks

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2868 27/04/2021 Joanne Baxter Chief Operating Officer 03/10/2022 BAF COO EPRR FPC ORG QGC SA3.1 Improve the productivity and efficiency of our operational services through the delivery of the New Operating Model and associated transformation plans	New Operating Model -Risk to the delivery of the new operating model resulting in adverse impact on performance & 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. 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	20	triangulations of incidents and low staffing	Shelley Dyson 31/07/2022	6	risk reviewed and actions updated	16
					active recruitment to vacanices	Lisa Crichton-Jones 30/09/2022			
					international recruitment programme	Lisa Crichton-Jones 30/09/2022			
					WLI rate for theatre staffing to be determined	Helen Routh 30/09/2022			
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3057 24/05/2022 Lois Lincoln Surgical Services Theatres & Anaesthetics 11/11/2022 BU_DIR HSC IPCC ORG	Risk of ventilation failure to multiple theatres resulting in potential infection risks	8	Estates aware of the problem and prioritise any work on these. Regular maintenance. Theatres taken out of action if incident occurs on the day.	20	Replace and update air handling units in theatres	John Adamson 31/12/2022	2	formal agreement in Nov to add to ORR	6

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IRR - Initial Risk Rating **TRR** - Target Risk Rating

Organisational Risk Register Report

Reporting Period: 01-Sep-2022 to 15-Nov-2022

Comparison Date: 15-Aug-2022

Gateshead Health NHS Foundation Trust

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
1490 11/03/2014 Nick Black Digital 20/10/2022 BU_DIR DIGC ORG QGC SA1.3 Digital where it makes a difference	Failure to manage Information Assets	20	Named System Administrator and Data Manager for every system Actively managed Systems Specific Security Policy (SSSP) for all systems - reviewing user access levels, training, configuration, testing, upgrade management - including business process changes etc Service owned Business Continuity Plan should systems fail Disaster Recovery Plan - how to recover the system Signed user registration forms Formal ITIL best practice change control procedure in place Formal Business case and project acceptance route through HISG Audit programme underway, focussed on critical system	15	Getting IAOs to take responsibility of their information assets	Nick Black 31/12/2022	3	formal agreement at ERMG 8th nov to add to ORR. Strategic risk due to duplication of previous risk 3090.	12

Organisational Risk Register Report

Reporting Period: 01-Sep-2022 to 15-Nov-2022

Comparison Date: 15-Aug-2022

Gateshead Health NHS Foundation Trust

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
3029 04/04/2022 Mr Andrew Beeby Chief Executive Office Medical Directorate 30/12/2022 BAF BU_DIR ORG QGC SA1.2 Continuous Quality improvement plan	Covid - Risk of further waves/continued endemic Covid, which could impact operational delivery across the whole Trust.	**20**	Business continuity and EPRR governance and resilience plans Staffing resilience and backup Service delivery plans IPC planning/ escalation/ reduction of PPE/ distancing Estate flexibility and planned escalation/ covid wards	**12**			**8**	We have developed a hybrid way of working which can accomodate Covid work with minimal disruption to other work. This is becoming the business as usual approach. The waves are smaller with less serious disease and we are no longer doing routince swabbing of all patients in hospital in keeping with national guidance there remains a risk that the disease may become more pathogenic	**16**
									5

Risks Moved to Managed in Period

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

Organisational Risk Register Report

Reporting Period: 01-Sep-2022 to 15-Nov-2022

Comparison Date: 15-Aug-2022

Gateshead Health NHS Foundation Trust

Handler BU Service Line Next Review Date BAF / Risk Register Objectives						Action Due	
							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
3091 25/07/2022 Rob Anderson QE Facilities Facilities 25/08/2022 BAF BU_DIR COO FPC ORG SA5.1 We will look to utilise our skills and expertise beyond Gateshead	Business Development - Risk that we lose business or miss out on business opportunities to support growth							Business development opportunities need to continue follow the QEF business development and business case process approved by SMG and or the board. Due to the nature of the commercial strategy of QEF all business development opportunities carry some risk which will be reviewed and assessed though the BC process however this risk can not be fully mitigated whilst QEF continue to undertake external BD opportunities	

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

Organisational Risk Register Report

Reporting Period: 01-Sep-2022 to 15-Nov-2022

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Gateshead Health NHS Foundation Trust

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
3092 25/07/2022 Rob Anderson QE Facilities Estates 25/08/2022 BAF BU_DIR FPC ORG SA3.1 Improve the productivity and efficiency of our operational services through the delivery of the New Operating Model and associated transformation plans	Estate infrastructure – There is a risk that we are unable to invest in our estate infrastructure	16	Capped annual Capital Budget Long term clinical lead estates strategy	9			6	Nothing further at this time can be done other than maximise to the full capital budget each year. As this is a perenial risk the risk has not been reduced	
									2

Risks Added in Period

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR	Latest Progress Note / Date Added to ORR
2558 08/10/2019 Mark Dale Medical Services Med 1 28/10/2022 BU_DIR ORG	Risk of a 12 hour A&E wait in ED from arrival due to organisational pressures resulting in sub optimal patient care and risk of patient harm.	20	1. Site resilience meetings regularly and monitoring of breach times for any patients. 2. current Opel level framework to support escalation and management of breach times for patients. 3. SOP for escalation of breach times and to whom 4. Emergency Huddle	20			4	formal agreement at ERMG nov 22 to add to ORR 09-11-2022

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Organisational Risk Register Report

Reporting Period: 01-Sep-2022 to 15-Nov-2022

Comparison Date: 15-Aug-2022

Gateshead Health NHS Foundation Trust

Risks Added in Period

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register / Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR	Latest Progress Note / Date Added to ORR
3057 24/05/2022 Lois Lincoln Surgical Services Theatres & Anaesthetics 11/11/2022 BU_DIR HSC IPCC ORG	Risk of ventilation failure to multiple theatres Due to ventilation system (air handling units) for theatres 1 -8 being at end of life and 1 unit supporting 2 theatres resulting in potential for infection risks, affecting staff and patients.	8	Estates aware of the problem and prioritise any work on these. Regular maintenance. Theatres taken out of action if incident occurs on the day.	20	Replace and update air handling units in theatres	John Adamson 31/12/2022	2	formal agreement in Nov to add to ORR 09-11-2022
3127 17/10/2022 Kris MacKenzie Finance Finance 17/11/2022 BAF BU_DIR FPC ORG SA3.2 Achieving financial sustainability	There is a considerable risk that the trust will not be able to meet the required forecast outturn position of 1.6m surplus. This is impacted by achievement of ERF, delivery of CRP, impact of inflation, funding available from DHSC, realisation of mitigations and cost of ongoing service pressures resulting from COVID and unscheduled care activity.	20		20			8	risk added following discussion with K Mac. risk 3106 (not on ORR) and 3093(ORR) combined to create new risk detailed here. mitigations and controls to be added. Added to ORR and BAF as per K Mac 17-10-2022
3095 26/07/2022 Amanda Venner People and OD Workforce Development 02/12/2022 BU_DIR ORG	Risk of Industrial Action affecting staffing levels and potential impact on patient care and quality.	20	Industrial action working group established and meeting regularly. Focussed planning sessions have taken place to explore the planning, response and recovery elements of industrial action with reasonable worse case scenarios considered. A detailed work plan has been produced with a number of actions, lead officers and timescales citrep position updated daily Business continuity planning command and control structure will recommence in the event of industrial action	16			9	formal agreement at ERMG to add to ORR 8th nov 2022 08-11-2022

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

Reporting Period: 01-Sep-2022 to 15-Nov-2022

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Gateshead Health NHS Foundation Trust

Risks Added in Period

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register / Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR	Latest Progress Note / Date Added to ORR
1490 11/03/2014 Nick Black Digital 20/10/2022 BU_DIR DIGC ORG SA1.3 Digital where it makes a difference	If Information Asset Owners e.g. System administrators across business units and corporate services fail to manage their assets (e.g. patient data, staff data, corporate data, systems, and business continuity plans), there is a risk of inappropriate access/use/updating/disclosure of data.	20	Named System Administrator and Data Manager for every system Actively managed Systems Specific Security Policy (SSSP) for all systems - reviewing user access levels, training, configuration, testing, upgrade management - including business process changes etc Service owned Business Continuity Plan should systems fail Disaster Recovery Plan - how to recover the system Signed user registration forms Formal ITIL best practice change control procedure in place Formal Business case and project acceptance route through HISG Audit programme underway, focussed on critical system	15	Getting IAOs to take responsibility of their information assets	Nick Black 31/12/2022	3	formal agreement at ERMG 8th nov to add to ORR. Strategic risk due to duplication of previous risk 3090. 09-11-2022

Organisational Risk Register Report

Reporting Period: 01-Sep-2022 to 15-Nov-2022

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Gateshead Health NHS Foundation Trust

Risks Added in Period

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register / Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR	Latest Progress Note / Date Added to ORR
2398 28/12/2018 Kate Hewitson Surgical Services Obstetrics 01/12/2022 BU_DIR ORG	Due to the maternity estate being in a separate building from other acute services (main theatre/CCU/Paediatrics etc.) This was highlighted by recent HSIB reports reflecting delayed attendance times of emergency multi disciplinary teams to obstetric emergencies. Rising acuity of maternity patients and more frequent use of CCU, theatre staff and Paediatric teams creates additional likelihood of the need for these teams to attend the maternity department and delays to be incurred. Resulting in the risk of severe harm to mothers and babies.	20	Pre-assessment - Women deemed likely to require critical care after elective procedures have their operation in main theatre to allow swift access to critical care. This only applies to elective patients and not emergency procedures or those in spontaneous labour. Any incidents are investigated to identify potential learning.	15	2861 action re looking into estate options	Kate Hewitson 30/12/2022	5	formal agreement at ERMG to add to ORR 09-11-2022
3128 17/10/2022 Kris MacKenzie Finance Finance 17/11/2022 BAF BU_DIR FPC ORG	There is a Risk that the capital cost of delivery of the new operating model continues to increase resulting in revenue implications.	12		12			9	risk added following discussions with Kmac. controls and mitigations to be added. Added to ORR and BAF agreed with KMac and GF 17-10-2022
								7

Organisational Risk Register Report

Reporting Period: 01-Sep-2022 to 15-Nov-2022

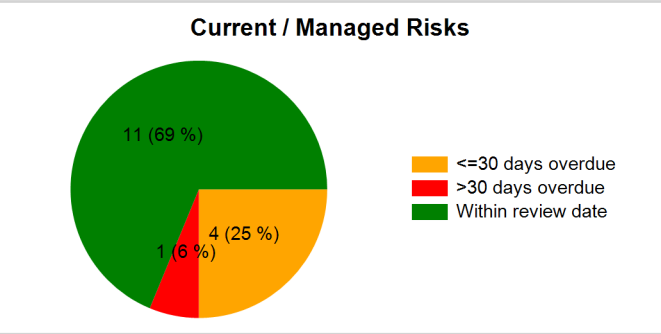
Comparison Date: 15-Aug-2022

Gateshead Health NHS Foundation Trust

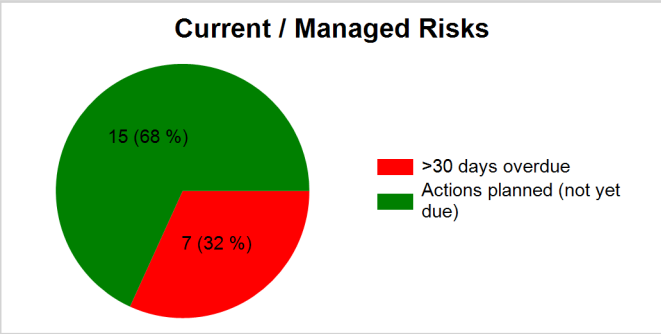
Risks Removed in Period

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR	Latest Progress Note / Date Removed from ORR
3093 25/07/2022 Kris MacKenzie Finance Finance 17/10/2022 BU_DIR SA3.2 Achieving financial sustainability	Finance – There is a risk that the Trust does not achieve its financial and capital plans due to the challenging level of CRP, increasing inflation and risk around achievement of ERF. Resulting in the failure to deliver sustainable services and deliver objectives	20		20			8	Risk closed and replaced with Risk 3127. 17-10-2022
								1

Risk Review Compliance



Risk Action Compliance



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

Reporting Period: 01-Sep-2022 to 15-Nov-2022

Comparison Date: 15-Aug-2022

Gateshead Health NHS Foundation Trust

Movements in CRR

				CRR		
BU	Service Line	ID	Risk Description	Sep-2022	Oct-2022	Today
Chief Executive Office	Medical Directorate	2880	Health Outcomes - Risk that Place/ICS/ICP strategy/plans do not align with our objectives to tackle health inequalities	9	9	9
		3029	Covid - Risk of further waves/continued endemic Covid, which could impact operational delivery across the whole Trust.	12	12	12
Chief Operating Officer		2868	New Operating Model -Risk to the delivery of the new operating model resulting in adverse impact on performance & recovery plans	20	20	20
	Planning & Performance	2945	Risk of ineffective and inefficient management of services due to availability and access to appropriate and timely BI.	12	12	12
Digital		1490	Failure to manage Information Assets	15	15	15
	IT	1636	UCRF R01/R03/R20/R23 - Malware such as Ransomware Compromising Unpatched Endpoints, Servers and Equipment	10	10	10
Finance	Finance	3127	There is a considerable risk that the trust is unable to meet the required forecast outturn positon of 1.6m surplus		20	20
		3128	Risk that the capital cost of delivery of the new operating model continues to increase resulting in revenue implications.		12	12
Medical Services	Med 1	2558	Risk of a 12 hour A&E wait in ED from arrival	20	20	20
	Medical Services - Divisional Management	2982	Risk of delayed transfers of care and increased hospital lengths of stay	16	16	16
Nursing, Midwifery & Quality	Quality Governance	3089	Quality - Risk of quality failures in patient care due to external causes such as delayed discharges and external pressures.	12	12	12
People and OD	Human Resources	2759	Workforce health & Wellbeing - Risk of adverse impact to staff health and wellbeing due to internal and external pressures	12	12	12

Organisational Risk Register Report

Reporting Period: 01-Sep-2022 to 15-Nov-2022

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Gateshead Health NHS Foundation Trust

Movements in CRR

				CRR		
BU	Service Line	ID	Risk Description	Sep-2022	Oct-2022	Today
People and OD	Human Resources	2764	Workforce - Risk of not having the right people in the right place at the right time with the right skills.	16	16	16
	Workforce Development	3095	Risk of Significant service disruption due to industrial action			16
Surgical Services	Obstetrics	2398	Risk that MDT are delayed to a maternity emergency/delayed CCU transfers for maternity patients due to separate buildings	15	15	15
	Theatres & Anaesthetics	3057	Risk of ventilation failure to multiple theatres resulting in potential infection risks	6	20	20

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 10ii

Report Title:	**Quality Account Priorities Update (Q2)**			
Name of Meeting:	Board of Directors			
Date of Meeting:	Wednesday 30th November 2022			
Author:	Jane Conroy, Head of Quality and Patient Experience; Lindsay Grieves, CQC Compliance Manager			
Executive Sponsor:	Dr Gill Findley, Chief Nurse and Professional Lead for Midwifery and AHPs			
Report presented by:	Dr Gill Findley, Chief Nurse and Professional Lead for Midwifery and AHPs			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
	This paper provides an update on the progress made in the year to date against the Quality Account Priorities 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*	This paper has been considered by the SafeCare/ Risk and Patient Safety Council on 14th November 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*	This paper provides an update on the progress made in the year to date against the Quality Account Priorities 2022/23. Excellent progress has been made in some of the priority areas across staff experience and patient experience as detailed in the report with some priorities already achieved in full or nearing completion.			

Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	The Board of Directors are asked to review the detail provided within this report for assurance.				
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)					
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒		

Quality Account Priorities Update

PATIENT EXPERIENCE						
Quality Priority	**What will we do?**	**How will we do it?**	**Expected Outcome?**	**How will it be measured?**	**Progress Update**	**RAG rating**
Reinvigorate the Volunteers Service (Lead: Jane Conroy)	Increase volunteer number by 100	New recruitment drive	Volunteer numbers will increase by 100	ESR data	Recruitment of volunteers is on-going and some of our volunteers who were stood down due to the pandemic are returning. Active volunteers recruited from 1 April 2022 = 35 Volunteers currently within the TRAC process = 18	
		Develop new volunteer's communications materials			New Comms material has been developed including Volunteer videos and features on social media.	
	Full evaluation of the 'Response Volunteer Programme' and 'Patient Experience	Volunteer and staff engagement events and surveys	Evaluation report for both programmes and associated action plan (as needed)	Monitor via bi-annual reports	This is on-going and information is provided when requested to regular meeting such as Safecare/Risk and Patient Safety Council and PCIEG. A formal evaluation feedback form is being developed.	

	Volunteer Programme'	Patient feedback			A formal evaluation feedback form is being developed.	
	Develop a contingency plan for the recruitment and mobilisation of external volunteers	Work collaboratively with external stakeholders to develop an external volunteer staff base as needed e.g., further Covid-19 wave	Contingency plan will be in place	Contingency plan will be in place (and this will be evaluated if it is utilised)	This has been reviewed by the Volunteers Manager and HR. Any recruitment with external providers will be advertised and prospective volunteers will go through the necessary NHS employment checks.	
	Ensure we identify service users	Review flagging and alert system to identify patients	Increase in the number of service users with flag and alert	Medway and EMIS BI reports	• Collaboration with the clinical coding team is in progress to ensure that codes for LD is matched with the LD alerts on Medway. • Ongoing meetings with ICB in relation to information sharing from the great north care record to improve clinical alerts. • Ongoing weekly meeting with the community LD team to link and improve potential alerts to be added. • Established relationships with pediatrics within the Trust to share with the LD Nurse the	

					names of children who have a formal identification of a learning disability and alerts to be added.	
	Understand the experiences of service users with Learning Disabilities and Mental Health needs and look at where improvements can be made	Co design work with service users to identify and implement where improvement can be made	Evidence that improvements have been made based on feedback from service users with Learning Disabilities and Mental Health needs	A minimum of one co-design workshop or improvement event will be held with this cohort of patients and point of care staff across 2022/23	Workshop with Lawnmowers; theatre production group ran by and for people with a learning disability was arranged after funding agreed of £1,500. Formal invitations were sent out to a total of 120 members of staff across the trust of all levels including management. Communications were shared throughout social media and within the trusts weekly newsletter This was to provide a training session and hear the voices of this client group from real life experiences. Unfortunately only 29 members of staff attended	
	Review patient information leaflets to identify core areas where easy read leaflets are needed	Mechanism to be implemented to enable staff to request a leaflet in easy read format	Increase the number of easy read leaflets	Patient Information Leaflet database and Trust website leaflet data	Ongoing work with an external design company to work on information leaflets to be made into easy read. Funding was agreed for £6,000 which has had to be shared between the leaflets being reviewed by a service user group and to ensure we get as many leaflets completed as we can- dependent on length of leaflet. We	

					also now have access to the Macmillan easy read leaflets and are accessible via Pandora on the intranet.	
		Explore the procurement of a software license with NHS approved images for easy read leaflets			No progress with this as of yet. A business case may need to be developed.	
		Develop a section on the Trust website where easy read leaflets are accessible for service users	Trust website will have a section where leaflets are held		No progress with this as of yet – this will be started once easy read have been developed to be accessed.	
	Provide easy read appointment letters	Develop template for use by Bookings and Referral team	Easy read appointment letter template will be implemented	Audit of the use of easy read appointment letters	No progress with this as of yet, but is scheduled to commence in Q3.	
		Review flagging system of AIS on Medway and EMIS to ensure that easy read is an available option for communication	Easy read will be an option for communication recorded and flagged on Medway and EMIS	Medway and EMIS BI reports	No progress with this as of yet, but is scheduled to commence in Q3.	

	Increasing biopsychosocial assessments to a minimum of 60%	Staff will be reminded of the biopsychosocial assessments that should be completed/under what circumstances	The number of biopsychosocial assessments will increase to meet or exceed the target	This will be monitored via the CQUIN	Kate Clark has met with IT who are amending the ICE referral form to enable us to gather the information we need. They had added a free text box but it was too spurious with what people were adding so this will be a drop down box that must be completed.	
		Review NICE guidance CG133	A multidisciplinary team will review the NICE guideline	Nice Guidance Compliance Monitoring	Nice Guidance review in date.	

Working with patients as partners in improvement (Lead: Jane Conroy)	Demonstrate that we value to contribution of our patient partners	Consider developing a Trust policy and process aligning with NHS policy 'Reimbursing expenses and paying involvement payments'	New policy developed	Implementation of the policy	The Patient Experience team have reviewed the national policy and note there will be financial implications associated with this, therefore a paper will be prepared for SMT to review.	

	Ensure the patient partner voice is heard	Inviting patients to sit on operational sub-groups and participation in ward accreditation visits	Patient will be within the core membership of a minimum of 5 operational sub-groups across the Trust	Number of patients on operational sub-groups	No update	
	To provide a forum for staff to seek feedback, engagement, and involvement from patient partners	Work collaboratively at an ICS level with the Gateshead PLACE team and reinvigorate the existing patient panels	The Trust will be a core member of all patient panels and Trust staff will be invited to join the appropriate panels to seek feedback, engagement, and involvement from patient partners	Number of forums attended by the Trust	This forum has now been established in collaboration with ICS and PLACE Team.	
				Number of projects taken to patient forums by Trust staff for patient feedback, engagement, and involvement	One project has been presented to the forum. Details of the Forum have been circulated to Business Units and via QE Weekly.	

STAFF EXPERIENCE						
Quality Priority	**What will we do?**	**How will we do it?**	**Expected Outcome?**	**How will it be measured?**	**Progress Update**	**RAG Rating**
We will focus on the health and wellbeing (HWB) of our staff (Lead – Health and Well being team and EDI Manager)	Being responsive to staff feedback	HBW check ins	Number of HBW check ins will have increased, and this will reflect in staff feedback	Monitored through the People and OD Committee	Work is underway to develop a plan to promote health and wellbeing check-ins across the organisation. Check-ins are now being promoted as the focal point of the health and wellbeing session at Managing Well with over 100 managers now having completed the programme. The L&D Team is currently reviewing its appraisal documentation and process; with plans to introduce a method to record whether a check-in has occurred over the previous 12 months both digitally and in documentation.	
		Review of Occupational Health and resolve key issues around progressing the	A review will have been undertaken and action plan implemented as deemed appropriate	Monitored through the People and OD Committee	Pre employment medical appointments are now offered on-site to allow the recruitment team to carry out ID checks at the same time. A full time Band 5 nurse has been recruited to increase the capacity	

		appointment of staff into posts			of the Occupational health nursing team and will be on post on 31st October 2022. This will allow greater flexibility and an increase in the number of pre employment appointments that can be offered, and also a quicker turnaround of interpreting blood tests carried out at pre employment medicals to enable to the fit slips to be created and forwarded to the recruitment team	
		Increase the uptake of Flu vaccination amongst point of care healthcare staff to 70%	Increase in the number of point of care healthcare staff vaccinated against Flu	This will be monitored via the CQUIN	A daily clinic is being ran from PCAS using PCAS staff to offer daily appointments for staff to attend to access their flu vaccination. "Ward walkers" have been employed on the bank to offer flu vaccinations on wards and departments and will be employed to work weekends and twilight shifts to increase the opportunity for night shift workers and weekend workers to access the flu vaccine. The uptake of the flu vaccine will be monitored by staff groups and wards and departments, to allow targeted work in areas with low uptake	

		HWB Initiatives will be rolled out across the Trust e.g., Out of Hours catering	Evidence that HWB Initiatives have been rolled out across the Trust in response to staff feedback	Monitored through the HWB Programme Board	Health and wellbeing initiatives continue to be planned, delivered and rolled out throughout the Trust in response to staff feedback. Recent examples of this include the roll-out of 24/7 catering offer and a trial of extended opening hours at Bensham. Work is underway to expand our menopause support offer by attaining menopause-friendly employer accreditation; which comes in response to a health needs analysis conducted in 2021.	
		Seek feedback e.g., bi-annually that health and wellbeing initiatives meet the needs of staff, can progress at pace, can be sustained into the future, and are evaluated	Evidence of staff engagement events with staff feedback generated	Monitored through the HWB Programme Board	A new organisational health and wellbeing strategy was recently launched. Ahead of its ratification, a period of consultation with staff served to verify that the priorities within were those which Gateshead colleagues. Staff advocacy across all seven priority areas were high, with an average score of 8.40/10 across our priorities; a score of 8/10 for what we identify as our key enablers and a score of 8.62/10 for what we identify as our key risks. Regular opportunities to provide	

					feedback can be found in the form of a digital (and now physical) suggestion box, while regular stalls at Trust events and meetings, in addition presentations at Managing Well, provide opportunities to provide feedback directly. Staff survey and quarterly Pulse results will always act as a key pillar when it comes to feedback; and provide us with a direction on a quarterly and annual basis	
		Develop and publish a HBW Strategy	A HBW Strategy will have been published	Progress updates against the Health and Wellbeing Strategy will be provided on minimum of a bi-annual basis	The organisation approved and ratified its health and wellbeing strategy at an SMT meeting in early September 2022. Work will now commence to promote the official launch of the strategy; and ensure its contents and the commitments within are accessible to all staff. While work is already underway across many of the actions listed within the strategy and its promotion; the task of developing and publishing is now complete, hence the rating provided.	
		Adopt a program of review and	Progress will be demonstrated in	WDES recommendations	An overarching Equality and Diversity Objectives and Action	

		development to include recommendations for change across all of the ten WDES indicators	working towards achieving the WDES recommendation	monitored through the People and Organisational Development Committee	Plan has been written covering the time frame for 2020 – 2024. This high level plan has been written to cover the specific WDES indicators. Updates in respect of these actions are presented to the HREDIG, POD Portfolio Board and POD committee.	
		Incorporate data from the WDES outcomes and develop a specific WDES action plan indicating all areas that need improvement	WDES action plan will be implemented		A detailed WDES action plan is part of the overarching EDI plan indicated above and is continually monitored. Examples of work around the Indicators are as follows: • Disability Recruitment event undertaken - due to pandemic, this was via a virtual basis. Take up was very low. This is being reassessed to be rolled out on a face to face basis later in year. • Links with community groups and local schools, colleges and universities established to increase the profile of the NHS and the Trust as an employer of choice • New R and S data collection (TRAC) has been implemented and analysis will be carried out	

					cross referenced to internally developed EDI KPI's and the WDES data that has been submitted. • Bitesize Recruitment and Selection training offered to all staff involved in recruitment processes. Training includes elements on diversity, inclusion, unconscious bias and fair recruitment practices. • D-Ability continue to promote role models, create myth buster, make videos, arrange group discussions to raise awareness and educate staff to be more inclusive and acceptable of differences. • As part of our absence management process the Occupational Health team work closely with managers and employees when providing recommendations for reasonable adjustments to be made. • The D-Ability Network has conducted a staff survey to obtain data and feedback from disabled staff, and this will be	

					used with national research to inform the D-Ability Staff Network plans for further actions and support.	
		Adopt a program of review and development to include recommendations for change across all of the nine WRES indicators	Progress will be demonstrated in working towards achieving the WRES recommendation	WRES recommendations monitored through the People and OD Committee	An overarching Equality and Diversity Objectives and Action Plan has been written covering the time frame for 2020 – 2024. This high level plan has been written to cover the specific WRES indicators. Updates in respect of these actions are presented to the HREDIG, POD Portfolio Board and POD committee. A detailed WRES action plan is part of the overarching EDI plan indicated above and is continually monitored. Examples of work around the Indicators are as follows: • Links with community groups and local schools, colleges and universities established to increase the profile of the NHS and the Trust as an employer of choice	

					• Reciprocal mentoring' programme offered within the Trust. • EDI KPI metrics have been developed. Information collection being re-assed to be collected digitally. • 9 Cultural Ambassadors have been trained to be utilised during disciplinary processes where BME members of staff are involved • Independent external panel member present during NED Appointment	
		Review and refresh the policy around Recruitment and Selection	A revised policy will be implemented around Recruitment and Selection		• Pilot of Values Based recruitment underway • Streamlining Job Descriptions • Reporting - 3 monthly rather than annually / Benchmarking / Improvements are in place	
		Undertake a Race Disparity Audit	A Race Disparity Audit will have been undertaken and action plan		This has not yet begun and will be re looked at in November 2022.	

			implemented as deemed appropriate			
		Engage with external development programmes	Evidence that Black, Asian and minority ethnic (BAME) staff members have had opportunities to engage with external development programmes		The BAME staff network publicises any external development programs that are advertised. Further detailed analysis will be undertaken to assess number of courses advertised and take up.	
		Work towards a Zero Tolerance policy	A Zero Tolerance Policy will be in place		Draft Zero Tolerance Policy has been developed, however this has not yet been ratified.	
		Hold a Nursing, Midwifery and AHP Conference	Nursing, Midwifery and AHP Conference will go ahead in 2022/23	Diversity of attendees at the conference and conference evaluation	AHP conference took place on 22nd September 2022. All AHPs, students and support workers eligible for a place. Conference evaluation yet to be completed. Diversity of attendees not recorded. 1 conference theme was antiracism.	
		As part of the Trust's strategic workforce plan, complete a self-assessment	Implement an action plan as deemed appropriate	Monitoring of Trust action plan	Self-assessment completed in phase 1, however gaps in ESR information resulting in lack of ability to compile appropriate	

		around AHP workforce including a review of Electronic Staff Record (ESR) AHP data			action plan without further data collection. Externally available data is available which does not connect with internal intelligence on AHP workforce and diversity of same.	
		Take part in the National Workforce Supply project	We will have taken part in the National Workforce Supply project and identified any relevant learning for the Trust	Participation in the National Workforce Supply project	Participation has been complete with 18 month strategic workforce plan submitted. Learning and further actions from the trust will be identified within the AHP 5 year strategy document being compiled within next 4 months.	
		Establish an AHP Leads Forum	Forums will be established	Number of forums that take place and assurance reports/annual review	AHP leads forum has been established. Actions and outcomes from this will be completed at annual AHP review.	
		Establish a minimum of five Subject Area Forums or Task and Finish Groups			No update. Lorna to pick up with Gill.	

		Hold awareness raising events covering a broad range of professions e.g. 'A day in the life of' and take part in National AHP Day	Awareness raising events will go ahead	Number of awareness raising events and diversity of professions featured	National AHP day campaign launched and due for celebration on 14th October with stands on display in the Hub and outside Costa. Also stand planned for Bensham. Discussions underway with comms linked to "day in the life of" work to highlight and raise the profile of different AHP staff groups. 3 career events in June/July 2022 have taken place which have highlighted to local school groups the diversity of AHP careers	
		Development and implementation of a Fellowship Scheme including AHP Fellows, Nursing Fellows and Midwifery Fellows, led by the Trust's Chief Nurse and Professional Lead for Midwifery and AHPs	5-10 staff members (who are within 5 years of professional registration and AFC Band 5-7) will take part in the fellowship scheme	Number of staff members taking part in the Fellowship Scheme from a diverse range of professions	No update.	

PATIENT SAFETY						
Quality Priority	**What will we do?**	**How will we do it?**	**Expected Outcome?**	**How will it be measured?**	**Progress Update**	**RAG Rating**
We will promote a just, open, and restorative culture across the organisation (priority carried over)	We will implement and embed all principles of a just culture across the organisation	Board Development Sessions around just culture	Staff will be empowered to speak up and identify risks to safety without fear of punitive response which will facilitate better outcomes for patients	Monitoring of staff survey results and any other safety culture assessment tools through the SafeCare/Risk and Safety Council and the People and OD Committee	There will be a dedicated session on PSIRF/LFPSE at a future Board development session. Awaiting confirmation of date.	
		As part of the People Portfolio Board, we will establish a Leadership and OD Programme of which Just Culture will be a core strand of work			This programme of work has been established and will focus more broadly on culture across the organisation. A culture steering group is being set up.	
		The Trust's Patient Safety Specialists will work with the People and OD team to ensure a Just Culture guide (or equivalent) is developed and			The Trust patient safety specialists will link in with the culture steering group.	

		formally adopted and built into the Trust's Human Resource (HR) and patient safety policies				
		We will ensure the safety sections of our recently published NHS Staff Survey results are reviewed and discussed, and triangulated with patient experience data and patient safety data in order to identify actions needed to improve patient safety culture			No update.	

To maximise safety in maternity services through the implementation of the Ockenden Recommendations	To fully implement all immediate and essential actions	We will comply with the Ockenden Recommendations	We will comply with the Ockenden Recommendations	Self-assessment against the Ockenden Recommendations	Ockenden supportive assurance visit completed by Regional maternity team on 16 June 2022. Assessment of compliance with 7 initial IEAs. Formal feedback received - positive visit, friendly, open & honest, transparent, open and responsive leadership team, engagement of all grades of staff, good communication & evidence of closing the loop with complaints, learning from incidents, positive learning culture, good relationship ward-to-board, co-production evident Recommendations: • consider audits • consider audit/guidelines midwife role	

					• consider how to involve service user voice in governance meetings • work on embedding MVP co-production • consider gaps in RCM leadership manifesto ensure all new staff aware of safety champions	
Staffing	We will calculate clinical staffing requirements based on patients' needs (acuity and dependency) which, together with professional judgement, will guide us in our safe staffing decisions	Implementation of the Safer Nursing Care Tool (SNCT)	Understanding of the link between patient acuity and dependency, workload, staffing and quality and demonstrating improvements over 2022/23	Organisational Nurse Sensitive Indicators (NSI) to monitor the impact of staffing on the quality of patient care and outcomes through triangulated staffing reports	A bi-annual assessment was undertaken in January and July 2022, this data is currently being reviewed by the newly appointed deputy chief nurse who is responsible for workforce planning with a plan to share further when appropriate.	
		Implement standardised Trust branded staffing display boards across all wards			Standardised display boards are being considered by the Matron teams. A new uniform boards has been development and will be shared in all area.	

					Further work is required on signage to all ward areas.	
		We will implement safe staffing reviews in other areas as suitable tools become available to us			The Shelford Group has since supported pilots with SNCT in the following areas: • Emergency Care • Mental Heath • Community This work is being led by the clinical lead for Healthroster.	
	Recruit 50 Nurses within 12 months	International Recruitment	50 Nurses will be in post at Gateshead Health NHS Foundation Trust	Number of vacancies filled	To date the Trust has welcomed 28 overseas nurses as part of the International Recruitment work. Cohorts are currently undertaken OSCE training and examinations to	

					successfully obtain their NMC pin is underway. The Trust has been successful in securing a further bid from NHSI to support an additional 21 international overseas nurses.	
Undertake improvement work to agree a safe method of processing clinical results	By March 2023 we will use recognised improvement methodology to design and agree a process for the safe management of clinical results across the organisation	Audit One to undertake audit of current processes and identify areas for improvements Commission a Rapid Process Improvement Workshop by end of Q2 to understand current processes and define which types of results should be reviewed, by who and define timescales Consultation with key stakeholders	New policy agreed and ready to be launched on 1st April 2023	Key Performance Indicators (KPIs) identified for various types of results and who will review and in which timescales	This piece of work is on Audit One's annual audit schedule, has not yet commenced – this may be superseded by the RPIW work.	

		Using change methodology (Plan Do Study Act cycles) test proposed concept on key areas				
		Develop Trust Wide Policy outlining expectations for all staff reviewing results, with KPIs identified for various types of results				

CLINICAL EFFECTIVENESS						
Quality Priority	**What will we do?**	**How will we do it?**	**Expected Outcome?**	**How will it be measured?**	**Progress Update**	**RAG Rating**
We will revisit the core fundamental standards of care	We will revisit the core fundamental standards of care	Band 7 and Matron Development Head of Nursing, Chief Matrons and Matrons will undertake the CQAF	Band 7's and Matron's feel confident in the promotion/ management and escalation around core fundamental standards of care	Number of Band 7 and Matrons who have taken part in development opportunities	There has been a revision of the CQAF programme which includes panel and assessors. Professional leadership and development days have been reinstated supported	

		programme to assess all clinical area.			by the Head of Nursing. Matrons are afforded the opportunity to codesign their development requirements in line with the NHSI Matrons handbook. This will support the revisit of the fundamental standards of care.	
				Evaluation of development programmes	Further development is being undertaken by the Head of Nursing to strengthen the panel as a development opportunity for senior nurses.	
			Improvements to the core fundamental standards of care	Trust CQC Compliance Tracker Document	Phases one to three have now been implemented**.**	

		A revised programme of Environmental Audits will be implemented	Revised programme of Environmental Audits will have been implemented and an associated action plan for improvement will be made and monitored	Monitoring paper to the SafeCare/Risk and Safety Council	A revised audit tool has been developed, consulted on and approved for use. This is currently being done through the matron monthly checks. This is due to be reviewed at Matron away day in Q4 ensure all questions are appropriate and applicable to all areas across the Trust including outpatient and maternity areas.	
		Implementation of the Trust's CQC Monitoring approach	Assurance of compliance with the Fundamental Standards and CQC Regulations	Trust CQC Compliance Tracker Document	Phases one to three have now been implemented**.**	
We will encourage, help, and support all staff to engage with research	We will embed research into our ways of working	Review how we notify staff of research projects that can be accessed To develop a research newsletter and web-based resource for staff	Increase in the number of staff actively involved in research	Number of staff actively involved in research	Members of the R&D Team have attended the Nursing & Midwifery, Patient Safety, Allied Health Professionals and the Health Care Support Workers (HCSW) conferences to raise awareness of the new research strategies that	

		To ensure that support is available in staff that are interested in undertaking research			have been launched over the last six months. They have also been widely promoting that **"Research is Everyone's Business"** and the different ways that staff can get involved through the "**Your Path In Research**" campaign and "**The Associate PI Scheme**" and how they can search for, and join relevant active NIHR portfolio research projects listed on the **Be Part of Research** database. We are also in the process of devising a research programme for HCSWs to enable them to become **Research Champions** for their Ward or Clinical Area. The R&D Webpage is a work in progress because the website is not currently satisfactory to our needs, but promotion of research	

					via social media has been very successful, especially following the launch of the R&D Twitter page **@QEHResearch** We have launched the **"Introduction to Research"** course on ESR. We continue to actively promote research through Annual Events such as **International Clinical Trials Day**, **#Red4Research Day** and **Your Path In Research**. In conclusion, whilst the majority of staff are keen to make research everyone's business, a common theme emerged from our discussions with staff that the biggest barrier to engagement is; research is not included in job descriptions and time is not allocated for research in job plans.	

We will support the continual improvement of clinical record keeping (both paper and electronic) throughout the Trust	Review and reinstate a revised programme of documentation audits	Review documentation audit criteria/ methodology	Documentation audit will be reimplemented and improvements will be identified and actioned	Monitoring via the SafeCare/Risk and Safety Council	A revised audit tool has been developed, consulted on and approved for use. A proposal detailing the methodology for the quarterly audit has been drafted and is scheduled to be discussed and agreed at the SafeCare/Risk & Patient Safety Council on 12th October 2022 with a view to this commencing in November 2022.	
		Review audit policy/Standard Operating Procedure (SOP)			To be finalised once the proposed methodology is approved.	
		Review monitoring approach			This was agreed by the Safecare Risk and Safety Council on October 2022.	
		Consider triangulation of this data			This will be considered once audit data is available.	

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Report Cover Sheet Agenda Item: 11

Report Title:	**Consolidated Finance Report – Part One**			
Name of Meeting:	Trust Board			
Date of Meeting:	30th November 2022			
Author:	Mrs Jane Fay, Acting Operational Director of Finance			
Executive Sponsor:	Mrs Kris Mackenzie, Group Director of Finance & Digital			
Report presented by:	Mrs Kris Mackenzie, Group Director of Finance & Digital			
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 corporate objectives and address financial risks			
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*	Not 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 October 22 the Trust has reported an actual deficit of £1.485m after adjustments for donated assets and gain & losses of asset disposal. This is a favourable movement of £0.655m from the adjusted deficit reported at the end of October mainly due to the recognition of new income streams. The reported deficit is an adverse variance of £2.993m from the Trust's planned surplus totalling £1.508m. For the period April to October 2022 the Trust has spent £3.278m (35%) of its approved annual capital programme totalling £9.326m.			
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	The recommendation to Board is to receive the report, discuss the potential implications and record partial assurance as a direct consequence of the reported year to date position.			

	To note the summary of performance as at 31st October 2022 (Month 7) 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:	Ensuring robust governance structures to enhance our productivity and efficiency to make the best use of resources				
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)	Financial Risks				
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 October 2022 (month 7) for the Group (inclusive of the Trust and QE Facilities, excluding Charitable Funds).

2 2022-23 Financial Framework

2.1 The financial framework for 2022-2023 is supported by the following principles:

- A continuation of the block contract values agreed in H2 2021-22 with an inflation uplift of 1.7% inclusive of a (1.1%) efficient target and an additional 0.7% for excess inflation released as part of the second round of financial planning.
- Activity growth of 2.3%
- Additional funding of 1.66% to fund the 22-23 pay award
- System funding inclusive of specific allocations for COVID, urgent care capacity and maternity investment funding
- The continuation of the Elective Recovery Fund (ERF) to support activity recovery in addition to system financial envelopes, with indicative ERF's baselines included in funding proposals to achieve financial thresholds equivalent to 104% of weighted 19-20 activity baselines
- Additional funding streams outside of system envelopes to fund COVID pathology testing on a pass-through cost basis and the staff vaccination programme on a cost per vaccination basis
- An Integrated Care System requirement to achieve a breakeven position

2.2 The Trusts 2022-2023 financial plan reports a surplus of £1.610m inclusive of the achievement of £10.939m cost reduction programme (CRP) target and ERF income totalling £6.226m.

2.3 Reporting for October is against the Trusts 2022-2023 financial plan submission.

3 Income and Expenditure

3.1 The Trust has reported a deficit of £1.246m for the period April to October 22 and £1.485m after the adjustment for donated assets, gains / loss on disposal of assets.

3.2 This is a year-to-date adverse variance of £2.993m against the Trusts financial plan as detailed on the Trust Statement of Comprehensive Income (SOCI) as presented in Table 1.

3.3 For the month of October 2022 the Trust has reported actual income of £31.366m, and an in-month favourable movement of £1.875m against the Trusts plan mainly due to pay award funding of £0.370m, funding for discrete developments £0.470m and funding to support the gynae oncology specialist pathway following the support provided to a neighbouring Foundation Trust of £0.320m. ERF income continues to be recognised at 100% in response to ICB confirmation that despite not achieving ERF income targets funding will not be retracted.

3.4 Total year to date income is £213.082m and a favourable variance of £6.648m from the year-to- date plan. The year-to-date variance is mainly due to £2.800m additional pay award funding, more income than planned for pass through drugs & devices £0.864m, income for specific one-off developments not included in the plan £1.092m, education & training income £0.626m and a one-off grant to fund the Trust de-carbonisation scheme £0.428m.

3.5 For the month of October 2022 the Trust has reported actual operating expenditure of £30.253m and in-month adverse variance of £1.265m against the Trusts plan mainly due to an over-spend against pay totalling £0.613m, drugs of £0.283m, outstanding debt provision of £0.170m.

3.6 Total year to date operating expenditure is £211.904m and an adverse variance of £9.911m from the year-to-date plan. The year-to-date variance is mainly due to the non-achievement of the CRP target across pay and non-pay totalling £3.886m, cost of the final pay award £2.987m, over-spends against drugs of £1.905m, clinical supplies & services of £0.816m and premises (including utility costs) £0.690m.

October 22-23	NHSE APRIL - MARCH 23 FINAL PLAN					VARIANCE		
	Annual Plan	Plan In Month	Actual In Month	Plan to Date	Actual to Date	Variance (Actual - Plan)	Previous Month Variance	Movement in Month
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Operating								
Operating Income from Patient Care activities								
Income From NHS Care Contracts	(320,909)	(26,741)	(28,022)	(187,187)	(192,322)	(5,135)	(3,855)	(1,280.6)
Income From Local Authority Care Contracts	(90)	(7)	(18)	(49)	(109)	(60)	(49)	(10.8)
Private Patient Revenue	(735)	(61)	(79)	(427)	(415)	12	30	(17.9)
Injury Cost Recovery	(290)	(24)	(14)	(168)	(331)	(163)	(173)	10.0
Other non-NHS clinical revenue	(850)	(71)	(28)	(497)	(402)	95	52	43.1
Total Operating Income From Patient Care activities	(322,874)	(26,904)	(28,160)	(188,328)	(193,579)	(5,251)	(3,995)	(1,256.2)
Other Operating Income								
Education and Training Income	(7,631)	(636)	(1,227)	(4,452)	(6,020)	(1,568)	(977)	(591.1)
R&D Income	(527)	(44)	(75)	(308)	(523)	(215)	(184)	(31.4)
Top up Income			0		0	0	0	-
Funding outside of System Envelope	(3,910)	(326)	(224)	(2,282)	(1,551)	731	629	101.7
Other Income	(18,609)	(1,551)	(1,679)	(10,854)	(10,981)	(127)	1	(128.1)
Donations & Grants Received	(366)	(30)	(0)	(210)	(428)	(218)	(248)	30.0
Total Other Operating Income	(31,043)	(2,587)	(3,206)	(18,106)	(19,503)	(1,397)	(778)	(619.0)
Total Operating Income	(353,917)	(29,491)	(31,366)	(206,434)	(213,082)	(6,648)	(4,773)	(1,875.2)
Operating Expenses								
Employee Expenses - Substantive	221,172	18,454	18,452	127,938	128,684	746	748	(2.7)
Employee Expenses - Bank	7,150	607	743	4,423	6,466	2,043	1,906	137.3
Employee Expenses - Agency	3,653	316	773	2,355	6,100	3,745	3,288	457.1
Employee Expenses - Other	1,187	99	121	693	535	(158)	(180)	21.9
Total Employee Expenses	233,162	19,476	20,090	135,409	141,785	6,376	5,762	613.5
Purchase of Healthcare - NHS bodies	6,076	506	562	3,542	3,987	445	389	55.8
Purchase of Healthcare - Non NHS bodies	2,348	196	292	1,372	2,254	882	786	96.3
Purchase of Social Care	0	0	0	0	0	0	0	-
NED's	188	16	14	112	96	(16)	(14)	(2.0)
Supplies & Services - Clinical	24,096	2,008	2,051	14,059	14,875	816	773	43.4
Supplies & Services - General	3,225	269	254	1,883	1,734	(149)	(134)	(15.0)
Drugs	18,339	1,529	1,811	10,703	12,608	1,905	1,623	282.2
Research & Development expenses	0	0	(0)	0	12	12	12	(0.5)
Education & Training expenses	1,089	91	140	637	995	358	310	48.6
Consultancy costs	143	12	(10)	84	296	212	234	(21.6)
Establishment expenses	3,209	268	345	1,876	2,204	328	251	76.6
Premises	17,041	1,420	570	9,940	9,699	(241)	609	(849.7)
Transport	1,628	136	139	952	926	(26)	(29)	2.7
Clinical Negligence	7,923	660	660	4,620	4,622	2	1	0.2
Operating Leases	2,604	217	101	1,519	572	(947)	(830)	(116.2)
Other Operating expenses	3,967	331	1,244	2,317	3,291	974	61	912.8
Cost Improvement Programme	0	0	0	0	0	0	0	-
Reserves	0	0	0	0	0	0	0	-
Operating Expenses included in EBITDA	325,038	27,135	28,262	189,025	199,956	10,931	9,804	1,127.1
Depreciation & Amortisation - Purchased / Constructed	8,238	687	663	4,809	4,474	(335)	(311)	(24.1)
Depreciation & Amortisation - Donated / Granted	366	30	23	210	189	(21)	(14)	(7.1)
Depreciation & Amortisation - Finance Leases	13,569	1,131	1,130	7,914	7,911	(3)	(2)	(0.9)
Impairment & Revaluation	61	5	175	35	(626)	(661)	(831)	169.7
Restructuring Costs			0		0	0	0	-
Operating Expenses excluded from EBITDA	22,234	1,853	1,991	12,968	11,947	(1,021)	(1,158)	137.6
Total Operating Expenses	347,272	28,988	30,253	201,993	211,904	9,911	8,646	1,264.6
(Profit)/Loss from Operations	(6,645)	(503)	(1,114)	(4,441)	(1,179)	3,262	3,873	(610.6)
Non Operating								
Non-Operating Income								
Finance Income	(105)	(9)	(85)	(63)	(351)	(288)	(211)	(76.2)
Total Non-Operating Income	(105)	(9)	(85)	(63)	(351)	(288)	(211)	(76.2)
Non-Operating Expenses								
Finance Costs	589	49	89	343	479	136	96	40.0
Gains / (Losses) on Disposal of Assets	0	0	0	0	12	12	12	-
PDC dividend expense	3,156	263	310	1,841	1,888	47	0	46.7
Total Finance Costs (for non-financial activities)	3,745	312	399	2,184	2,379	195	108	86.7
Other Non-Operating Expenses								
Misc. Other Non-Operating expenses			0		0	0	0	
Total Non-Operating Expenses	3,745	312	399	2,184	2,379	195	108	86.7
(Surplus) / Deficit Before Tax	(3,005)	(200)	(800)	(2,320)	850	3,170	3,770	(600.1)
Corporation Tax	1,395	116	83	812	397	(415)	(383)	(32.7)
(Surplus) / Deficit After Tax	(1,610)	(84)	(717)	(1,508)	1,246	2,754	3,387	(632.8)
(Surplus) / Deficit After Tax from Continuing Operation	(1,610)	(84)	(717)	(1,508)	1,246	2,754	3,387	(632.8)
Remove capital donations / grants I&E impact	0	0	(23)	0	238	238	261	(22.9)
Gain on disposal of assets	0	0	0	0	0	0	0	-
Impairements - AME	0	0	0	0	0	0	0	-
Loss on disposal of DHSC assets	0	0	0	0	0	0	0	-
Remove net impact of consumables donated from other DHSC bodies			0		0	0	0	-
Adjusted Financial Performance (Surplus) / Deficit	(1,610)	(84)	(740)	(1,508)	1,485	2,993	3,648	(655.7)

Table 1: Trust Statement of Comprehensive Income

4 Cost Reduction Programme (CRP)

4.1 Included in the Trusts 2022-23 financial plans is an annual CRP requirement of £10.939m with £7.088m planned to be achieved by October 22. As of October 22, £3.202m has been achieved with a year-to-date adverse variance of £3.886m. On a full year effect recurring basis, a total of £1.718m has been achieved.

	22-23 Annual Target £000's	22-23 YTD Target £000's	22-23 YTD Achieved £000's	22-23 YTD Variance £000's	22-23 Annual Achieved £000's	23-24 FYE Achieved £000's	% FYE Achieved of Target
Chief Executive	(87)	(57)	(96)	40	(143)	(111)	163.8%
Chief Operating Officer	(113)	(73)	0	(73)	0	0	0.0%
Clinical Support & Screening	(2,627)	(1,711)	(1,320)	(391)	(1,706)	(348)	64.9%
Community	(898)	(585)	(36)	(549)	(62)	(62)	6.9%
Director Of Nursing	(394)	(257)	(63)	(193)	(95)	0	24.2%
Estates & Facilities	(134)	(78)	0	(78)	0	0	0.0%
Finance & Information	(473)	(317)	(267)	(50)	(392)	(158)	82.9%
Medical Director	(17)	(11)	(23)	12	(23)	0	134.4%
Medicine & Elderly	(2,131)	(1,388)	0	(1,388)	0	0	0.0%
People & Organisational Development	(164)	(107)	(104)	(3)	(121)	(36)	73.6%
Surgical Services	(2,414)	(1,572)	(731)	(841)	(831)	(241)	34.4%
Trust Financing	(1,488)	(933)	(562)	(371)	(762)	(762)	51.2%
Total	(10,939)	(7,088)	(3,202)	(3,886)	(4,135)	(1,718)	37.8%

5 Cash and Working Balances

5.1 Group cash as at 1st April 2022 totalled £55.586m. The cash position of £53.708m as at 31st October is equivalent to an estimated 52.03 days operating costs (56.27 days September) and represents a £2.718m decrease from September 2022.

5.2 The liquidity metric has improved marginally by 0.05 days against September to +12.65 days, this is 4.41 days better than Plan (8.24 days).

5.3 The balance sheet is presented in Table 2.

Statement of Position - October 2022

	2022/2023 September 2022 Group	2022/2023 October 2022 Group	Movement from Prior Month	2022/2023 October 2022 QEF	2022/2023 October 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	136,415	136,425	10	1,310	135,115
Trade and Other Receivables, Net	2,037	2,026	(11)	814	1,213
Finance Lease - Intragroup				42,047	0
Trade and Other Receivables - Intragroup Loan	0	0	0		11,668
Total Non Current Assets	138,533	138,532	(1)	44,251	164,821
Current Assets					
Inventories	5,005	4,771	(233)	2,603	2,168
Trade and Other Receivables - NHS	8,927	8,774	(152)	569	8,205
Trade and Other Receivables - Non NHS	6,593	4,575	(2,018)	1,134	3,441
Trade and Other Receivables - Other	0	0	0		0
Prepayments	5,785	5,789	4	461	5,328
Cash and Cash Equivalents	53,708	50,990	(2,718)	5,824	45,166
Other Financial Assets - PDC Dividend	0	0	0		0
Accrued Income	2,242	2,311	69	1,685	626
Finance Lease - Intragroup				293	0
Trade and Other Receivables - Intragroup Loan					1,734
Total Current Assets	90,544	77,210	(5,049)	12,569	66,669
Liabilities					
Current Liabilites					
Deferred Income	7,895	11,004	3,110	170	10,834
Provisions	3,896	3,701	(195)	320	3,382
Current Tax Payables	5,909	4,753	(1,156)	433	4,320
Trade and Other Payables - NHS	2,086	1,663	(423)	635	1,028
Trade and Other Payables - Other	17,358	8,455	(8,903)	2,024	6,431
Trade and Other Payables - Capital	72	(109)	(181)	0	(109)
Other Financial Liabilities - Accruals	28,709	30,381	1,672	7,074	23,307
Other Financial Liabilities - Borrowings FTFF	499	499	0	0	499
Other Financial Liabilities - PDC Dividend	0	310	310	0	310
Other Financial Liabilities - Intragroup Borrowings	0	0		1,734	0
Finance Lease - Intragroup	0	0		0	293
Total Current Liabilities	74,708	60,657	(5,766)	12,390	50,294
NET CURRENT ASSETS (LIABILITIES)	15,835	16,553	718	178	16,375
Non-Current Liabilities					
Deferred Income	2,018	2,018	0	1,719	299
Provisions	3,123	3,123	0	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	13,011	13,011	0	0	13,011
Finance Lease - Intragroup				0	42,047
Total Non-Current Liabilities	18,152	18,152	0	13,387	58,480
TOTAL ASSETS EMPLOYED	**136,216**	**136,933**	**717**	**31,042**	**122,716**
Tax Payers' and Others' Equity					
PDC	145,470	145,470	0	0	145,470
Taxpayers Equity	0	0	0	0	0
Share Capital	0	0	0	16,824	0
Retained Earnings (Accumulated Losses)	(19,148)	(18,431)	717	21,393	(39,824)
Other Reserves	0	0	0	0	0
Revaluation Reserve	9,795	9,795	0	0	9,795
Misc Reserve	99	99	0	0	99
TOTAL TAXPAYERS EQUITY	136,216	136,933	717	38,217	115,540
TOTAL ASSETS EMPLOYED	**136,216**	**136,933**	**717**	**38,217**	**115,540**

Table 2 – Statement of Position

6 Capital

6.1 The Trusts 2022-2023 CDEL limit had been set at £8.419m, with contributions from capital grants of £0.427m and donated assets of £0.480m increasing capital resources to £9.326m as summarised in the below table: -

CDEL	£000's
Net Depreciation*	7,605
Internal Cash	464
Donation - Decarbonisation	427
Donated Assets	480
PDC	350
Total	9,326

* After Principal Loan Repayments of £0.999m

6.2 Capital spend up to the end of October was £3.278m, £2.433m below plan. Expenditure in the period was in respect of the Maternity Theatre, building maintenance, the New Operating Model, small schemes, and schemes from the 2021/22 programme which were carried forward.

7 Risk

7.1 There are a number of risks that must be noted alongside consideration of the reported financial position:

Risk	Rating
Efficiency requirements cannot be achieved due to ongoing operational pressures resulting from COVID, demand on unscheduled care and capacity to deliver transformation programme	20
Activity is not delivered in line with planned trajectories, leading to reduced access to ERF funding	15
The capital cost of delivery of the new operating model continues to increase resulting in revenue implications	12
Capital schemes are not in place in a timely basis to enable capacity required to manage surge	9
Financial mitigations assumed in plan are not realised in line with expected figures	9

Kris Mackenzie, Group Director of Finance & Digital
24th November 2022

NHS
Gateshead Health
NHS Foundation Trust

Report Cover Sheet Agenda Item: 16

Report Title:	**Digital Board Update**			
Name of Meeting:	Trust Board			
Date of Meeting:	30 November 2022			
Author:	Nick Black, Chief Digital Information Officer			
Executive Sponsor:	Kris Mackenzie, 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 digital assurance, digital strategy and the clinical systems outline business case; together with the visibility on delivery since the May report; and future plans for the coming 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*	Previous Digital Update & SIRO Report presented to May Trust Board			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	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 are routinely provided to the Digital Committee.			
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** ☐		

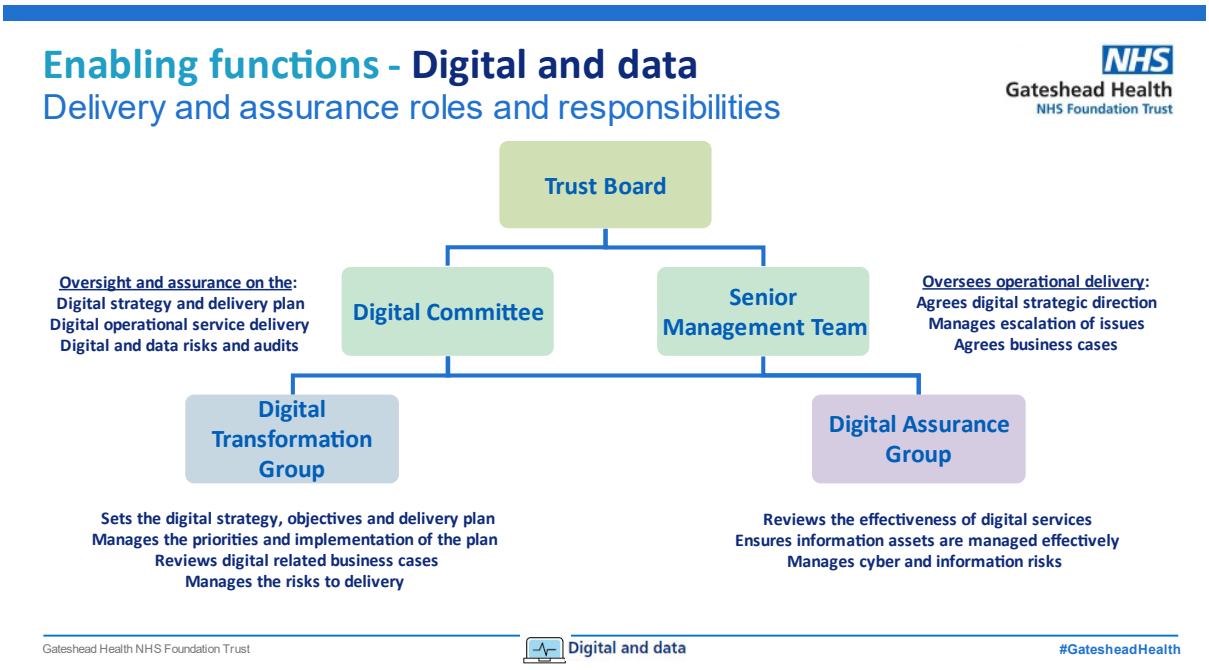
1. Digital Governance

The Digital Committee responsibilities are to provide oversight and assurance on the:

- Delivery of the strategic objectives mapped to the Committee
- Delivery of national and local-level strategies including the Digital Strategy
- Responsiveness and effectiveness of the digital services
- Management and quality of the Trust's Information Assets
- Compliance with the relevant Data Security and Protection toolkit standards
- Technology used and that is secure and up-to-date and that systems are protected from cyber threats

To support this role this Digital Committee has two groups reporting in; the Digital Transformation Group (DTG) (meets monthly) with responsibility for digital strategy and managing all digitally enabled transformation/change; and the Digital Assurance Group (DAG) (meets bi-monthly) with responsibility for managing cyber and information risks; together with overseeing operations digital services (systems, records, coding, infrastructure).

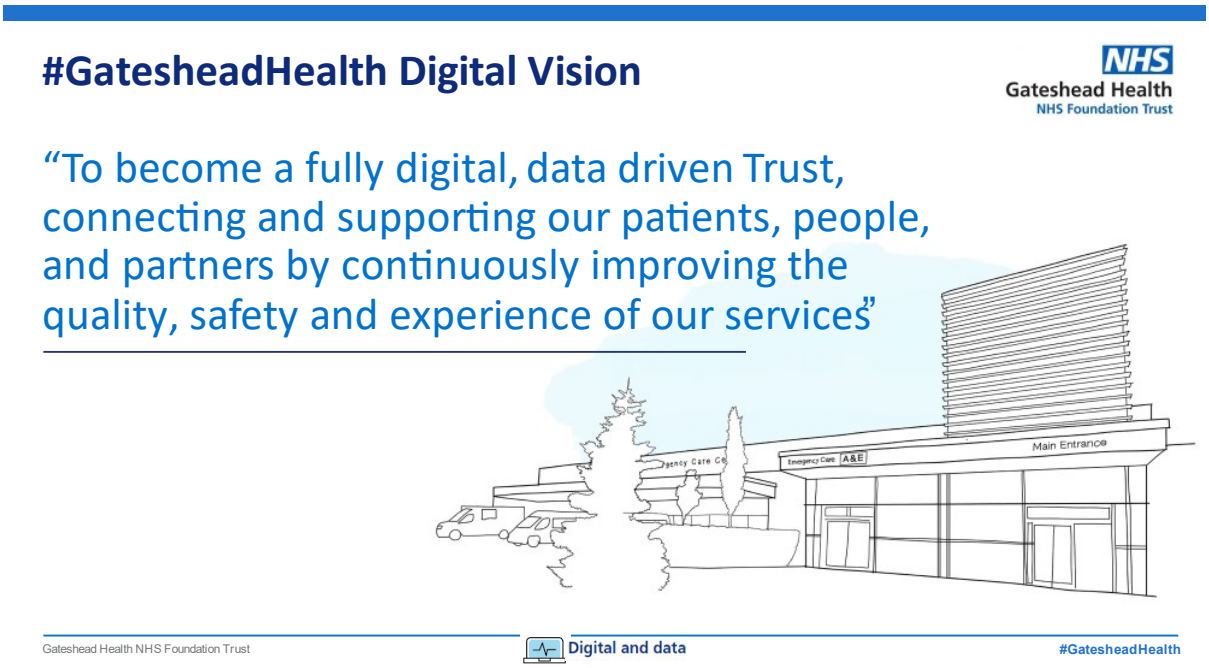
These groups also report into Senior Management Team so there is full ownership of the digital strategic direction and services; together with being an escalation point for any issues.



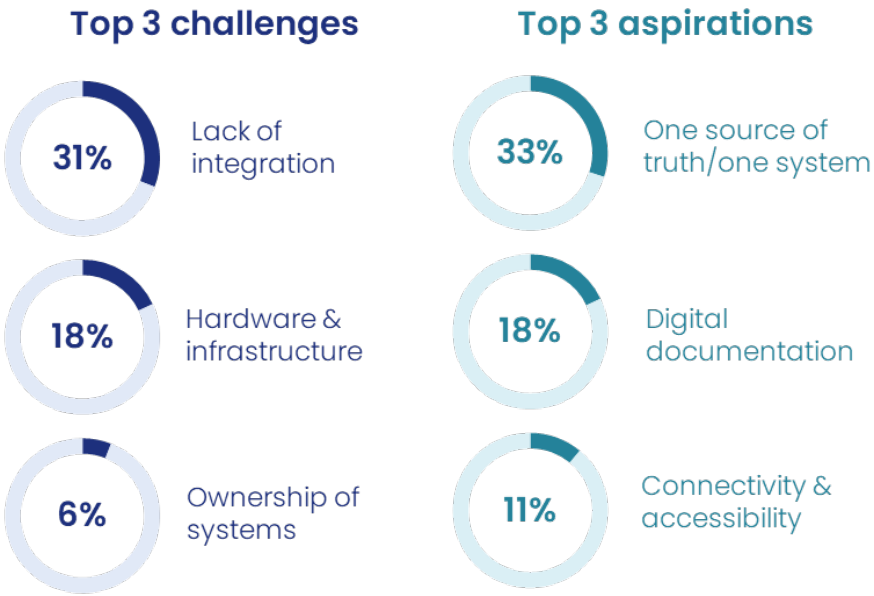
2. Digital Transformation Group (Strategy & Delivery)

The new corporate strategy was published earlier in the year and the refreshed digital strategy aligned to this, was agreed at DTG on 3 November. This was subsequently presented to SMT who were broadly happy with the content but asked for the addition of a digital delivery plan. The delivery plan is a changing document, agreed at DTG and formally managed through a change control process with progress monitored every month to DTG; and assurance presented to Digital Committee. The presentation of the delivery plan is currently being reviewed to align to the outcomes that the digital strategy is supporting and a snapshot will be added once completed. The latest draft digital strategy is attached in Appendix 1.

The overriding digital vision is shown below.

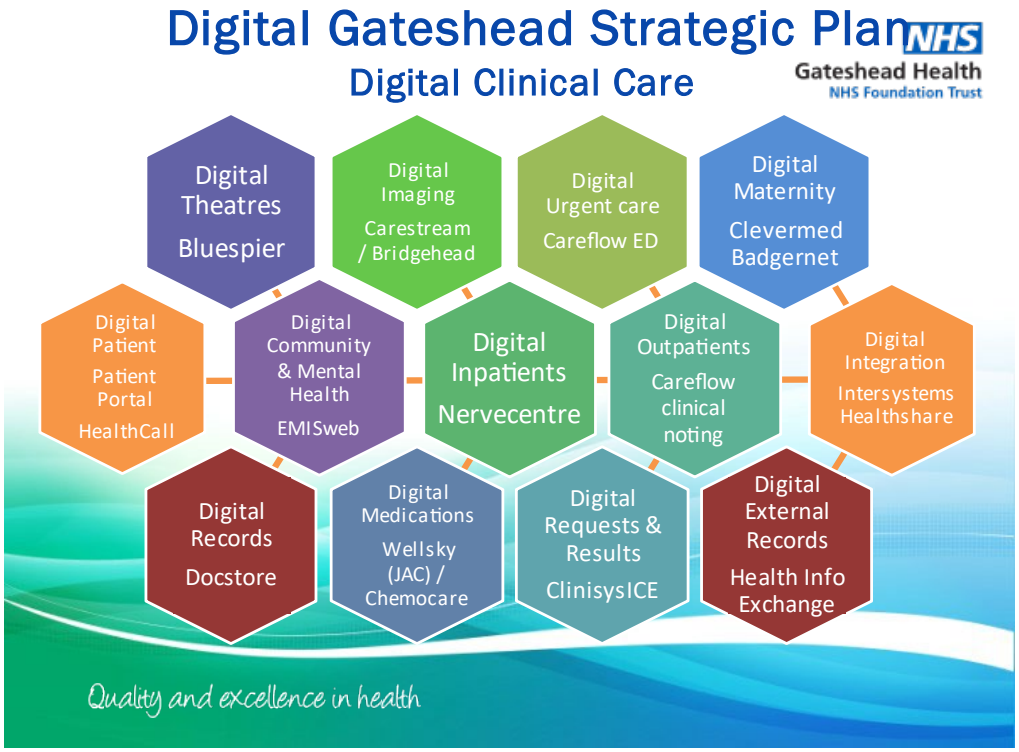


The delivery of this vision is inherently linked to the clinical systems outline business case (OBC) that was developed following the listening exercise Channel 3 undertook last year with 300+ stakeholders across Gateshead. The top 3 challenges and aspirations are outlined in the diagram below:



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

The OBC v1 was issued in June 2022 but has now been rewritten to align with the corporate strategy and focus on delivering Gateshead Health's ambition to become a fully digital Trust by 2025. This OBC builds on the key strategic direction and systems (shown below) delivered and improved as part of achieving the GDE programme.



Key to achieving this developing ambition is ensuring that the Electronic Patient Record (EPR) is an integrated system, which does not rely on any paper or manual processes as it does today.

The updated OBC has been prepared to underpin the investment required to make Gateshead's EPR fit to support a fully digital organisation and to improve the safety, quality and experience of services. It explores the preferred approach to achieving an integrated EPR in a supplier-agnostic manner, as supplier selection is expected to be achieved through the next phases suggested, through procurement and Full Business Case development.

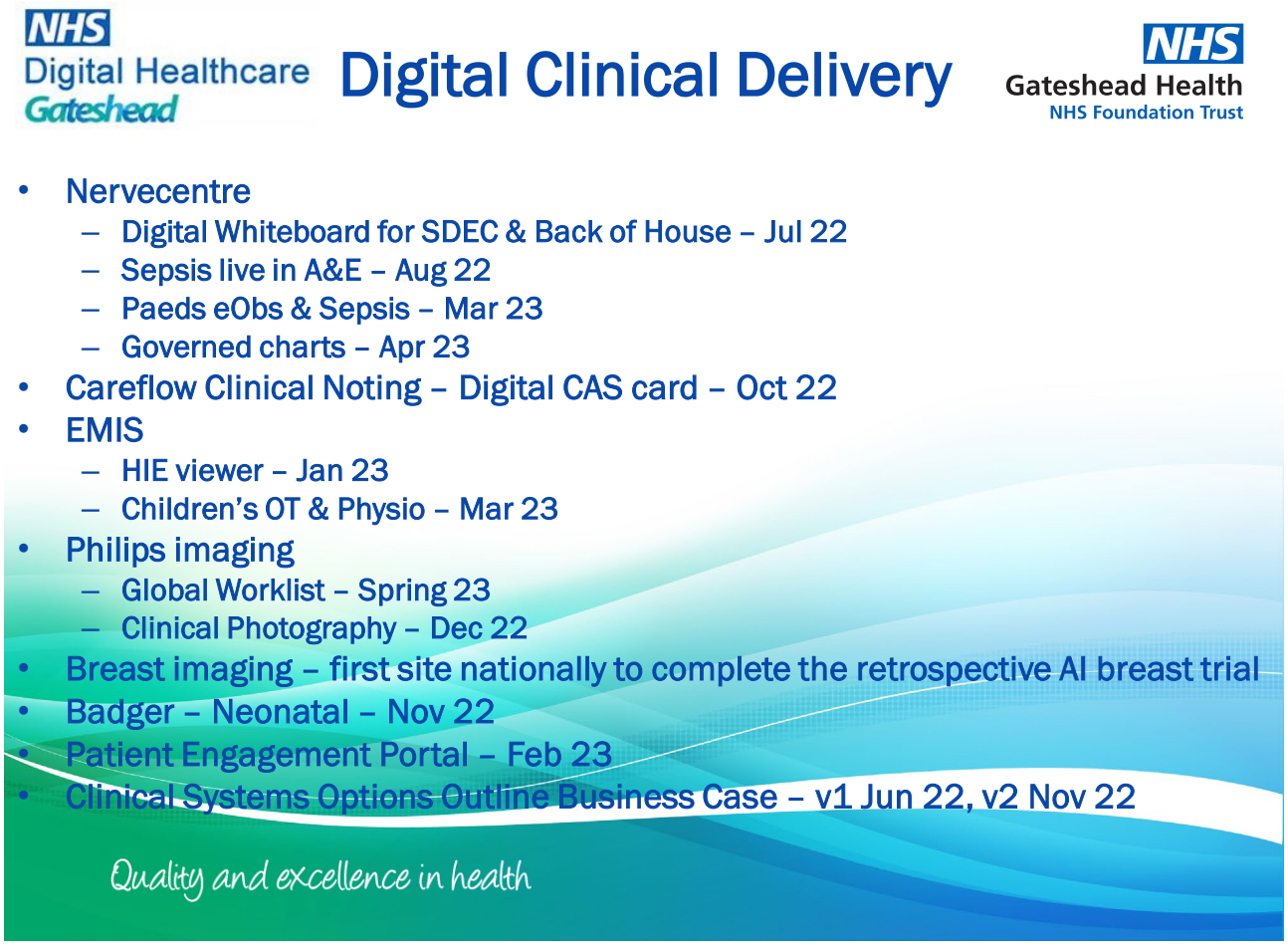
The recommendation from the OBC is for the Trust to move forward with the single integrated clinical record option (converging existing clinical systems and paper clinical documentation into one interface and/or system but without replacing the current core PAS immediately). This option presents better value for money to achieve Gateshead's required objectives and recommends selecting a preferred supplier through a mini competition using Gateshead's procurement framework.

The OBC in the current form has been shared with the digital leadership team, a few Senior Management Team and Executives, and once finalised will be submitted EMT for approval to proceed to FBC. The OBC has previously been presented at Clinical Policy Group and Digital Transformation Group to ensure full clinical ownership and technical assurance of any decision. Clinical ownership is fundamental to effective adoption and uptake of any solution.

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 key deliverables in the next few months.



- Digital whiteboards are now live in SDEC with the Back of House digital whiteboards rollout approximately 90% complete (waiting for estates work). These provide huge improvements in visibility of patients' status and delays in discharge.
- The use of Nervecentre continues to expand going live with sepsis in A&E, which build on the eObservations go live reported last time. The following the upgrade on the 24 Nov, resource will be allocated to reviewing the consistency and standardisation of use.
- 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 Wayfinder programme has commenced and is looking to pick up the delivery of the regional patient engagement portal. Gateshead are reviewing our previously tested position and will be enabling letter sharing when the capability is released, which can enable a saving in postage costs. To increase the benefits, the deployment of hybrid mail services across all clinics needs to be completed.

3.2 Digital Operations Delivery

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

- MS Teams continues to be the place to have digital interactions with colleagues from within and outside of the Trust. There have been 390 Teams created in our organisation, and a total of 653 Teams channels. We have had 1880 individual users engage with Teams since it was first implemented and has enabled 14371 individual calls, 11582 Teams meetings and 200549 chat messages. There is no dedicated support to exploit the capabilities of Teams although savings generated through the plans to move the telecommunications management from QEF into the Digital portfolio should fund some capacity to administer the system.
- 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.
- PC, Laptop and monitor replacements and upgrades have continued site wide to modernise and standardise the hardware in use – now to a maximum age of 5 years old.
- Careflow has recently undergone a successful major upgrade in support of the change to CDS standard V6.3
- Robotic Process Automation – five processes are now live, including maternity with their appointment booking automation and HR have agreed the scope for 2 ESR driven automations which are now progressing to the build stage
- The core performance/reporting dashboards provided on Yellowfin have been migrated to PowerBI and Yellowfin decommissioned.
- Attend Anywhere – the regional video consultation system contract has been extended until March 2023. The standardisation of systems across the ICS has not materialised although the Trust continues to engage.

3.3 Digital Service Assurance

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

- The DSP toolkit requirements for 2021/22 were submitted and audited in June 2022 – meeting all requirements except for the requirement to have an appropriately-qualified technical cyber security specialist staff and/or service. The departure of a key member of the IT team left a resource gap, which will be fully covered by February 2023.
- 100% of desktop devices are now on Windows 10 and 100% of Windows servers are on Server 2012 or above. Internet Explorer 11 has been decommissioned.
- The 1st phase of network infrastructure refresh replacing 91 edge switches was completed in August
- The full replacement of the Wi-Fi access points is currently being planned in after they the stock arrived on site this month, with a full site survey underway. These devices were ordered in January but due to global supply issue have taken 10 months to arrive; these lead times have led to CISCO reviewing and extending their EOL/EOS product timescales. This will inform the plans for the Core Network replacement which was due by summer 2023.

4. Risks

The digital service assurance provided through Digital Assurance Group is broadly improving with some pressures being flagged on:

- Trust wide Information Risk Management – ensuring that information assets are being appropriately managed by the departmental Information Asset Owners
- Supply of hardware – global silicon chip shortages are leading to supply difficulties which are pushing the alternative sourcing of hardware (currently considering the reconditioned kit market)
- The digital team are running with 13% vacancies and 3.5% sickness levels, which is requiring the team to focus on supporting the operational core business – delaying projects/additional work. The quality of applicants is also being impacted by large technology companies opening in the Newcastle area, the ability of full home working and the restrictions of the Agenda for Change pay bands.

Project risks that have been identified include:

- Virtual outpatient system replacement – it was intended to standardise across the ICS on a single system, however this has not progressed. The Trust are working closely with NuTH, CDDFT and North Tees to progress in this area.
- Image sharing across the ICS – The Global Worklist project to share images has been fraught with technical issues, both software and wide area network configuration – we are hopeful that North Tees and the supplier make some visible progress early in the new year.

5. 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

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 13

Report Title:	**Integrated Oversight Report**			
Name of Meeting:	Board of Directors – Part 1			
Date of Meeting:	30th November 2022			
Author:	Deborah Renwick and IOR Reporting Leads			
Executive Sponsor:	Joanne Baxter			
Report presented by:	Deborah Renwick			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☒	**Assurance:** ☒	**Information:** ☐
	To summarise performance in relation to 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 September and October 2022			
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 Finance and Performance 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*	Key points highlighted in the IOR: <u>**Safe (pages 7-13 of IOR)**</u> • 4 serious incidents reported in October, open and under investigation. 1 open patient safety alert showing on the national system as not completed by deadline, however the latest data on the system is still August 22 so National Team have been contacted for an update. No Never Events in the past 18 months. • Medication errors per 1000 FCEs triggering special cause variation. This represents an increased level of reporting and not changes in the pattern or types of incidents reported were observed. • The trust has had zero incidence of Healthcare Associated MRSA BSI in the preceding 12 months and one community healthcare associated MRSA BSI in October 2022. 15 Healthcare associated CDI cases since April 2022 (against the CDI threshold for 2022/23 of 32), 6 in October. The Trust has reported 2 Healthcare Associated MSSA BSI during October 2022. 4 Healthcare Associated E. coli during October 2022 – 1 HOHA's and 3 COHA's. The Trust has reported zero P. aeruginosa BSI during October 2022, and 1 HOHA and 3 COHA's Associated Klebsiella BSI.			

Effective (pages 14 - 20 of IOR)

- The Trust Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital Level Indicator (SHMI) both now shows deaths within the expected range.
- Positive assurance from Learning from Deaths review in Q2, 98.6% were definitely not preventable.
- Having seen a small improvement in the average number of long stay patients (LOS 21+) from 88.5 in August to 84.5 in September, the figure rose once again in October to 90.2.

Responsive (pages 21 - 35 of IOR)

UEC: Front of house performance measures continue to demonstrate both system and site pressures:

- 4-hour performance was 69.3% placing the Trust 38th out of 139 NHS Type 1 providers (72.4% & ranked of 33rd last month)
- 134 patients waited longer than 12 hours to be admitted
- 12 hour waits in department to discharge increased to 731 or 7.70% (703/7.8% in September)
- Ambulance handover delays are 112: 30-60 and 110: >60 mins
- Ambulance diverts increased to 58 in October, the majority from Durham
- Average bed occupancy 96.7% in October (96.8% in September) in September.

Indicative activity in October levels were overall below planned levels, with combined elective activity at 87%.

- Day cases: 92%
- Elective inpatients: 73%
- New outpatient attendances: 90%
- Follow-up attendances: 86%
- Diagnostics 111%

RTT:

- Increases in the patients waiting for treatment from 12,430 in September to 12,837 in October.
- 52-week waiters are above planned levels with 89 waiters over a plan of 20.
- 2 78-week waiter at the end of October
- October RTT <18 weeks waiter's final performance at 73.4%
- September RTT <18 week waiter's final performance at 74.3%

Diagnostics: DM01 6-week performance 81.2% in October (81.1% in September). Pressures in Audiology and echocardiology continue however, Echo recovery target was met for September and October at 39.1%.and 42.7% respectively. 9 out 12 specialities achieved the 2023 95% target in October.

Cancer: Performance measures:

- 2week wait performance 79.9% for September, 84.2% for October (indicative)
- Faster Diagnosis Standard at 75.2% for September, 83.2% for October (indicative)
- 31-day standard at 100% for September, 99.2% for October (indicative)
- 62-day cancer at 70.5% for September, 56.5% for October (indicative)

	• 62-day waiters are 57, above planned for levels of 55 • 104-day waiters decreased to 11 end October, from 14 end of September **Duty of candour:** Duty of Candour compliance still demonstrating concern for Jun-October, October compliance reduced to 75.0%, from 91.3% in September, below the 100% compliance required. **Informal Complaints -** The number of Informal complaints (PALS) is triggering special cause variation for concern. The figures have exceeded the 18-month average for 8 consecutive months. **<u>Well led (pages 36 - 39 of IOR)</u>** Core training - A further overall increase in compliance with a whole group compliance figure of 81.6% against the 85% target. Appraisals increased to 67.5%, against the 85% target. Absence rates increased to 5.8% in October, from around 5.2% in August and September. Since March 2022 bank spend continued to decrease however, a slight increase has been seen for the month of July and October. Agency spend has seen a slight decrease from July 2022 which reflects the withdrawal of HCSW agency. **<u>Benchmarking (page 10 of this report)</u>** The Trust remains in a relatively strong position against available benchmarking data. Table in page shows a worsening position in relation to our benchmarked position for A&E 4-hour standards and 52-week waiters when compared with the start of this financial year.
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 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 limited/partial assurance as a direct consequence of the workforce challenges, impact on activity recovery, long waiting times and performance.

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:	3.8 (F&P) Deliver operational transformation to improve productivity & efficiency 3.9 (F&P) Develop smart integrated reporting framework

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

<table>
<tr><th colspan="4">Risks / implications from this report (positive or negative):</th></tr>
<tr><td>Links to risks (identify significant risks and DATIX reference)</td><td colspan="3">• 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
• Staffing and workforce gaps in key areas (2956, 2942, 2514, 2946, 2938, 2953, 1675)
• Backlog reduction:
Cancer – Urology, Gynaecology (2514), LGI
Echocardiology (2730)
• Outpatient face to face capacity</td></tr>
<tr><td>Has a Quality and Equality Impact Assessment (QEIA) been completed?</td><td>Yes
☐</td><td>No
☐</td><td>Not applicable
☒</td></tr>
</table>

INTEGRATED OVERSIGHT REPORT – November 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 September and October reporting performance predominantly retrospectively where data is validated, signed off and submitted, as highlighted below. Where indicative data is provided in IOR it is identified.

IOR section	Data Item	Reporting Period	Data Quality Sign Off
Safe	SI's	September	***
Safe	Open Safety alerts	August (latest data not available as of 21/11)	***
Safe	Infection, Prevention and Control	October	***
Effective	HMSR	Apr 20 to Aug 22	***
Effective	SHMI	Feb 20 to Jun 22	***
Effective	Long Lengths of Stay	October CDS	***
Responsive	Community	October	**
Responsive	A&E	October	***
Responsive	RTT	October	**
Responsive	Cancer	Sept / Oct (provisional)	**
Responsive	Diagnostics	October final	***
Recovery	Activity	October (provisional)	**
Well Led	Sickness, Appraisals, training	October	***
*** 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:

- 1.8 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 Safe

2.1.1 **Trust level SI's (page 7):** Four incidents have been reported in October, a decrease from 12 in September, totalling 46 to date in this financial year. The four incidents in October resulted in severe/major harm, were the result of falls on the same level – cause unknown.

2.1.2 **Medication Errors (page 8):** Medication errors per 1000 FCEs returned to triggering special cause variation. Medication errors exceeded the upper process limit in October 2022, with a total of 88 medication errors observed in month, of which 69 were no harm and 19 low harm. Data for October has been analysed and no exceptions were found relating to the usual pattern of incidents across business units or in the type of incident reported, with the conclusion being the increase represents an increased level of reporting with low numbers

leading to harm. Indicating a positive safety culture for the reporting of medication related incidents. Medication incidents will continue to be analysed quarterly by the Trust Medicines Safety Officer for presentation and action at Medicines Governance Group.

2.1.3 Patient Safety Alerts (page 9): 1 open patient safety alert remains showing on the national system as not completed by deadline, however the latest data on the system remains the August position so is not up to date. The National Team have been contacted as part of the preparation of this report for an update as to when the data will be updated, but as of yet we have not heard back.

2.1.4 **Infection Prevention & Control (page 10-13):** Reporting IOR has been redesigned to now capture a more comprehensive set of metrics, and ensure data being presented is set against the IPC trajectories set by NHSE. Headlines from the slides: The trust has had zero incidence of Healthcare Associated MRSA BSI in the preceding 12 months and one community healthcare associated MRSA BSI in October 2022. 15 Healthcare associated CDI cases since April 2022 (against the CDI threshold for 2022/23 of 32), 6 in October. The Trust has reported 2 Healthcare Associated MSSA BSI during October 2022. 4 Healthcare Associated E. coli during October 2022 – 1 HOHA's and 3 COHA's. The Trust has reported zero P. aeruginosa BSI during October 2022, and 1 HOHA and 3 COHA's Associated Klebsiella BSI.

2.2 Effective

2.2.1 **HMSR (page 14):** The HSMR has returned to deaths 'as expected' with a score of 106.7 against the national average figure of 100. The SHMI is also showing deaths are within the expected range with the latest figure of 0.99 below the national average of 1.00.

2.2.2 **Learning from deaths quarterly update (page 15)** The review identified that of the 257 deaths reviewed in Q2, 98.6% were found to be definitely not preventable, and 1.4% with slight evidence of preventability. Therefore, strong assurance from the reviews, learning from the reviews are detailed in the body of the report.

2.2.3 **Clinical effectiveness (pages 16) –** Provides an update on the clinical outcomes from the GIRFT reviews in March - Lung Cancer and Critical Care in May with some good areas of practice identified – pathology turn around times, excellent results in the national lung cancer audit, with commendation for an engaged service. Opportunities were identified within Discharge and flow. Against 54 NICE Guidelines published April 22 -Sept 22 the Trust is compliant with 30, partially complaint against 4 areas and 20 remain under review. In guidance published prior to April the Trust is partially complaint against 43 sets of guidance.

2.2.4 **Discharge (page 17)** Discharging patients remains problematic as average admissions continue to exceed discharge. Pathways 1-3 account for 62% of the patients delayed and 69% of the bed days delayed. Weekend discharges are a particular challenge. The Trust performs well locally in discharges before 5pm. The Trust has embarked on a national improvement initiative to support flow and UEC.

2.2.5 **Long Length of Stay Patients (page 18)** - There is an expectation that the daily average number of patients staying 21+ days would not exceed 59. The ECIST existing target of 59 is subject to either pass or fail based on common cause variation. Having seen a small improvement in the average number of long stay patients (LOS 21+) from 88.5 in August to 84.5 in September, the figure rose once again in October to 90.2.

2.3 Responsive

2.3.1 **Urgent and Emergency Care (page 21 - 23)** – UEC continues to be under significant pressure. In September and October pressures have continued as a result of high bed occupancy, lower social care discharges and limited escalation area due to the work associated with the new operating model. The Covid position also escalated, causing additional challenges in the managing and placing of patients. As a result of significant daily

pressure, the trust remains at OPEL 3, where it has been throughout all of September and October.

Footfall and patient numbers increased in October to 9497 from 9011 in September, and daily attendances averaged 25 per day more than October 2021 (representing an increase of 9.1%). September and October have been a particularly challenging month for ED performance, headlines include:

- 4-hour performance in October was 69.3% in October, deteriorating from 72.4% in September
- At 69.3% this placed the Trust 38th out of 139 NHS Type 1 providers, which is a deterioration from 33rd last month
- 134 patients waiting longer than 12 hours to be admitted in October, down from 164 in September
- 12 hour waits in department from arrival to discharge increased to 731 in October, from 703 in September
- 731 is equal to 7.7% of all attendees, down from 7.8% in September, but well above the 2% target
- Ambulance delays reported in October: 1112 between 30-60mins (up from 106 in September) and 110 delays >60 mins (down from 110 in September)
- However, continue to be the 2nd best performing Trust in NENC & NY re: Ambulance delays 30-60 mins, and 3rd for >60+
- Having reduced in September, October saw high volumes of ambulance and regional diverts received, 58 in total, the majority from Durham
- Average daily bed occupancy level was 96.8% in September and 96.7% in October, peaking at 99.3% one day
- Acuity of patients in hospital is high. HED benchmarking tool indicates that the Trust is averaging a high Charlson co-morbidity score of 6 (placing the acuity of patients in the top decile with an increased risk of death within 1 year of admission).

2.3.2 **Pressures (page 24):** Even with the significant increases in handover delays, in October the Trust remained 2nd top performing Trust in the (ICS) region for 30-60m Ambulance hand-over times and improved to 4th for 60+ minute delays. There was a significant increase in Ambulance diverts received and supported by the Trust in October to 58 (56 of which were from Durham Hospital). Patients who no longer meet the criteria to reside remain problematic, averaging daily 40 in October, an improvement from 52 September. Out of area patients (from Sunderland, Durham and Northumberland) continue to account for notable numbers of patients and blocked beds (majority pathway 1). Additional beds are open over planned levels to accommodate patients who we are unable to discharge. The Trust had the highest bed occupancy levels in ICS (Oct 22), Bed occupancy average 96.7% in October (peaking at 99.3%).

2.3.3 **Community Teams (page 25):** Continue to support secondary care services by keeping patients in their own home. Community teams, including children's services saw 49,658 contacts in October, averaging 1601 per day, compared with 45,355 contacts in September, averaging 1511 per day. The Rapid Response team responded to 88 two-hour crisis response referrals in September and achieved a validated compliance rate of 67.0% for patients seen within 2 hours, slightly below the 70% compliance target. Indicative (currently being validated) performance for October is 115 referrals with a compliance rate of 53.0%. The requirement is to achieve this standard by Q3 2022.

2.3.4 **Elective activity and recovery (pages 26):** The expectation is to reach 104% of activity value of the 2019/20 plan. October (draft) combined **elective activity is at 87%** of 2019/20 baseline activity, which is below planned level, and lower than September. Overnight elective activity reduced to 73% from 86% of baseline year. Day case treatments fell slightly from 103% in September to 92% in October. Outpatient attendances are at 90% for new 86% follow-up attendances.

The Trust's elective recovery programme has been severely impacted by workforce pressures in recruitment and retention. Delivery of planned activity levels has been precarious throughout the year due to reduced theatre staffing levels. The theatre staffing team is currently running with a 19% vacancy rate, 3.6% of staff on maternity leave, 9.2% sickness rate and a 17% attrition rate. Mitigating actions include WLI's and continued use of bank and agency in the short-term. However, from November activity levels should be back to pre-covid levels as a short-term revised payment/incentive scheme is now in place to relieve staffing pressures, and a longer-term recruitment and retention. strategy currently being worked through.

Patient Initiated Follow-up (PIFU) attendances increased from 2.34% to 2.59% in October, below planned levels of 3.1%. The Trust achieved 18.8% of remote outpatient appointments against the transformational requirement of 25%, which is a reduction from 24.5% in September.

Diagnostic activity levels were 111% in October and continue to be above planned for levels. Modalities achieving their activity targets include CT 127%, colonoscopy 112%, flexi-sigmoidoscopy 109% and Endoscopy. Flexi Sig and Echo having both achieved planned for levels in September, failed to achieve them in October.

2.3.5 **Diagnostics (page 27 - 28):** Performance for the Trust improved to its highest rate so far this year, in October, although the improvement was less than the previous month. Performance stood at 81.2% in October from 81.2% in September. Overall, Trust performance remains below both 99% and 95% targets. However, Trust performance is in line with the latest NENC average of 81.3% and above national average of 70.2%. In October 6 out of 12 specialities achieved the 99% target, and 9 the 2023 95% target.

Numbers waiting for a diagnostic test fell from 5681 in September to 5325 in October (356 reduction in month). The number of patients waiting >6 weeks fell from 1074 in September to 1003 in October. Echocardiography and Audiology continue to contribute to risk in achieving this standard, audiology performance falling to 48.9% in October, the lowest so far this year. Echo noted a significant 9% increase in overall performance in September to 39.1%, increasing again to 42.7% in October. Echocardiography recovery plan aims to recover the long waiters by February 2023, to date September and October target has been achieved. Audiology improvement trajectory plans for standards to be achieved by summer 2023, some current delay in achieving trajectory due to maternity leave

2.3.6 **RTT (page 29):** Continued focus on increasing capacity to reduce patient backlogs and waiting times. Lower activity levels and increased referrals have increased the number of patients waiting for hospital treatment from 11,336 waiting at the end of April to 12,837 at the end of October (indicative), up from 12,430 at the end of September. Weekly reviews of the PTL demonstrate a week on week increase of patients waiting and a corresponding growth in over 52-week waiters, increasing from 52 at the end of April to 91 in September, this number fell slightly to 89 at the end of October. 78-week waiters increased to 5 at the end of September, but reduced to 2 at the end of October (indicative).

73.4% of our patients were waiting less than 18 weeks at the end of October, a reduction from 74.3% in September. At 73.4% Trust performance was above latest national average 59.4% (Sept 22), and ICB average of 71.1% (Sept 22).

'Super September' is now running into October and November. The focus is upon validation, clinical prioritisation, reviewing outpatient capacity and maximising utilisation rates by preventing DNA's. Providing 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. Weekly patient level reviews continue to with a focus on long waiters and proactive care management.

2.3.7 **Cancer (pages 30 – 33)** Continued focus on clinical prioritisation and increasing capacity to reduce patient backlogs and waiting times.

2 week waits - Indicative performance for October is 84.2%, a 4.3 percentage point increase from 79.9% in September. 84.2% remains below the 93% target. 84.2% is above the latest national average 72.6% (sept 22) and NENC average 72.6% (sept 22). Breast and Testicular tumour sites exceeding the 93% target since June, however Breast did not achieve the standard in October (indicative). Pressures in September and October for most other tumour sites. Activity volumes for most tumour sites in September and October higher than 19/20 levels, with the exception of lower GI.

Faster diagnostic standard – Trust has achieved 75% target all months since June 22. Indicative performance for October is 83.2%, a 8 percentage point increase from 75.2% in September. 83.2% is above the latest national average 67.2% (sept 22) and NENC average 72.9% (sept 22). This measure will replace the 2 Week wait in future. Performance Risks across most specialties - Particular challenged specialties Lung, Gynae, Lower GI, Urology and Upper GI, Testicular. Breast and Symptomatic Breast sites exceeding the 75% target in each of the last 7 months.

The trust is performing well in **the 31day standard** measuring the taken from diagnosis to treatment. Trust has exceeded the 31-day standard every month this year. Trust's performance for October is 99.2% (indicative) against the 31 Day standard, with the Drug and Surgery subsequent treatment also achieved. 99.2% is above the latest national average 91.1% (sept 22) and NENC average 89.1% (sept 22). September and October data is indicative and is subject to change following sharing of information between Trusts and breach data being confirmed across pathways. All tumour sites have achieved the target in the last 2 months

62-day cancer treatment - Performance improved to 70.5% in September, the highest since April but reduction to 56.5% (indicative) in October (indicative). Latest national average 60.5% (sept 22) and NENC average 63.1% (sept 22). The Trust reported 57 patients waiting over 62 days on a 2ww classic pathway (7.9% of the total waiters on a 62-day 2ww classic pathway) (139 on all pathways (15.4% of total waiters)). Within the operational guidance 'Systems are being asked to plan to restore >62-day backlogs to the relative backlog using urgent suspected cancer referral volumes seen in Q3 2019/20 compared to the overall national backlog for the w/e 16th February'; for Gateshead this was a position of 55 however due to the pressures supporting the ICS the Trust submitted figure of 57 for the month, just above planned for levels. The number of long waits (>104 days) on a 62 day (2ww) pathway at the end of October had decreased to 11 patients (1.5% of total waiters on a 62 day 2ww classic pathway) (30 on all pathways (3.3% of total waiters).

2.3.8 **Verbal Duty of Candour (page 34):** Duty of Candour compliance still demonstrating concern for Jun-October, October compliance reduced to 75.0%, from 91.3% in September, below the 100% compliance required. In October there were 10 cases reported as non-compliant incomplete none of which was there still time to gain compliance.

2.3.9 **Informal Complaints (page 35):** The number of Informal complaints (PALS) is triggering special cause variation for concern. The figures have exceeded the 18-month average for 8 consecutive months. 72 were received in October 2022. A shift in the number of informal complaints has been observed from March 2022, which coincides with increased family members visiting patients on site as Covid-19 restrictions lifted, themes noted for the October complaints included communications (29), facilities (20), clinical treatment (7), Appointments issues (5) and values and behaviours (5).

2.4 Well Led

2.4.1 **Workforce (pages 36 - 39):** Sickness absence levels in September improved to 4.8% from 5.2% in August. Both QEH and QEF also demonstrated improvements to 5.0% and 3.4% respectively. Trust level appraisal compliance increased to 68% in September from 66% in

August but continues to be below the 85% target. Core training data also continues to display special cause variation improvement with performance at 80.8% in September from 78.9% in August, demonstrating a positive improvement trend from 68.5% in April.

A first set of additional workforce data has been included to report activity against plan for recruitment of staff, agency spend and vacancy rates. This data will be continue to be developed. The report sets out how there is significant activity in relation to supply, recruitment and retention ongoing across the organisation to reduce vacancies, the impact being a reduction in reliance on the flexible workforce and agency and a more sustainable core group of employees. NHS England have also implemented agency controls on price caps and off framework usage from September which will impact agency usage. There is ongoing collaborative work with People & OD, Finance and Business units on reinstating the agency expenditure controls.

2.5 Benchmarking

2.5.1 The table below has been adapted from previous reports to give an indication of trend in the benchmarking position the Trust is achieving. The table below provides the position and indication of trajectory based on the data in the last 5 IOR reports, including this month:

2.5.2 The table shows the Trust remains in a relatively strong position against available benchmarking data. In 3 of the 5 metrics, we have either improved, or there is no change (in both metrics the Trust is ranking in the top position). The table continues to show a worsening picture in relation to our benchmarked position for A&E 4-hour target (reflecting the pressures being observed in A&E. And 52-week waiters. Note: for 62-day cancer backlog the methodology has changed nationally – now backlogs <150 are excluded from rankings for the top 20, meaning GHFT cannot enter the top 20. The 'Top 20' trust rankings are adjusted with several trusts excluded – those ranked in the table this are not adjusted and represents our position nationally for all Trusts.

	GHFT Benchmarking Figure							GHFT Benchmarking Position								
	May IOR	June IOR	July IOR	Aug IOR	Sep IOR	Oct IOR	NOV IOR	Rank out of:	Rank is better if:	May IOR	June IOR	July IOR	Aug IOR	Sep IOR	Oct IOR	Nov IOR	Trajectory (May to Oct)
A&E 4 hour waiting time target	75.3%	77.9%	77.1%	77.5%	74.5%	72.5%	69.3%	139 - All Type 1 NHS Providers	Lower	23	20	19	16	29	33	38	Worsened
Latest weekly PTL: patients waiting > 104 weeks	0	0	0	0	0	0	0	8 Providers in ICS	Lower	1	1	1	1	1	1	1	No change
Latest weekly PTL: patients waiting > 52 weeks	50	60	73	75	58	91	79	8 Providers in ICS	Lower	2	2	3	3	2	3	3	Worsened
Latest weekly PTL: patients waiting > 62 days for cancer treatment	63	65	57	68	64	63	62	8 Providers in ICS	Lower	1	1	1	1	1	1	1	No change
62 day backlog as % of waiting list	8.7%	9.1%	9.3%	10.2%	8.3%	6.7%	7.9%	139 - top 20 under NHSE/I scrutiny	Higher	73	75	69	59	83	106	99	Improved

3. Recommendations

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

I. Verbal duty of candour remains problematic and process reviews are ongoing. Informal complaints are also triggering concern, thematic analysis indicates that communication issues, facilities management issues and medical clinical treatment remain the key areas of note.

II. Workforce challenges in recruitment and retention prevail across the Trust, work continues to include oversight and management of the challenges by the operational teams and extracting the level of detail to enable sufficient triangulation between the performance,

quality and safety and workforce pressures. Effective rostering systems to manage and reduce agency spend whilst implementing NHSE controls to support the process is a key priority. Workforce supply continues to be a core priority whilst also working on a range of retention issues.

III. Discharging patients and pressures across the Trust continue to impact on the Trust's ability to maintain patient flow. Beds blocked due to patients no longer meeting the criteria to reside coupled with an exceptionally high volume of ambulance conveyances from patients living out of the areas has again resulted in delayed discharges and more beds open against planned levels which will ultimately impact on Trust expenditure.

IV. Theatre staffing pressures have continued into October with elective activity levels below plan. Activity levels are planned to reach pre-pandemic levels in November to reinstate theatre schedules at pre-pandemic levels to maximise theatre productivity. Work is ongoing to model the impact on to the waiting list to provide assurances for year end recovery targets.

V. Whilst challenged cancer pathways continue to demonstrate pressures in against 2 week waits and 62 day treatment measures, the Trust has achieved cancer targets against Faster Diagnostics and 31 day treatment targets, and planned long waiters are just below planned levels.

VI. Diagnostic activity continues to perform well, and the Community Diagnostic Centre continues to support ICS improvement trajectories. Improvement trajectories for echo cardiology forecast compliance in this modality in February 2023, with current performance above planned levels.

VII. Positive clinical outcomes assurance in learning form deaths, and areas of good practice found in GIRFT reviews in Lung cancer. Excellent results obtained in the lung cancer audit, commendation for the passionate lung cancer team and our pathology service was highlighted with excellent turn around times.

NHS
Gateshead Health
NHS Foundation Trust

Integrated Oversight Report

November 2022 Committees

Data: September / October 2022

Contents	Pages
CQC rating	**3**
Summary exception indicators KLOE	**4 - 5**
Safe	
Serious Incidents reported to StEIS	**7**
Medication errors per 1000 FCEs	**8**
Patient Safety Alerts not completed by deadline	**9**
Infection Prevention & Control	**10 - 13**
Effective	
Hospital Standardised Mortality Ratio and Summary Hospital Level Mortality Indicator	**14**
Learning From Deaths Reporting Q2 2022-23	**15**
Clinical Effectiveness – Softer intelligence	**16**
Discharge & Long Length of stay patients	**17 - 18**
Efficiency and Productivity - Length of Stay (Surgery) / Theatre Productivity	**19 – 20**
Responsive	
Urgent & Emergency Care	**21 – 23**
Pressures	**24**
Community Teams	**25**
Elective Recovery	**26**
Diagnostics	**27 – 28**
RTT	**29**
Cancer	**30 – 33**
Duty of Candour Verbal Compliance	**34**
Informal Complaints	**35**
Well Led	
Workforce	**36 - 39**

NHS Gateshead Health NHS Foundation Trust

CQC Rating

Gateshead Health NHS Foundation Trust

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

KLOE Summary: Indicators triggering concern or displaying Special Cause Variation

Gateshead Health NHS Foundation Trust

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.

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

Responsive
23 of 41 applicable indicators triggering SPC/underachieving against targets

Effective
1 of 6 applicable indicators triggering SPC/underachieving against targets

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

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

KLOE Summary

Safe

- Total number of **Trust reportable SI's:** 4 are reported in month, open and under investigation
- There is currently **one open patient safety alerts** not completed by deadline
- **No Never Events** in the passed 18 months
- **Medication errors** per 1000 FCEs triggering special cause variation. This represents an increased level of reporting and not changes in the pattern or types of incidents reported were observed.

Effective

- The Trust **Hospital Standardised Mortality Ratio** (HSMR) and Summary Hospital Level Indicator (SHMI) shows deaths within the expected range.
- The **Long Length of stay** greater than 21 days indicator has triggered special cause variation. There was a deterioration in the average number of Long stay patients (LOS 21+) from 84.5 in September to 90.3 in October.

Caring

- There are **no caring indicators triggering concern**.

Well Led

- **Core training -** A further overall increase in compliance with a whole group compliance figure of 81.6% against the 85% target. **Appraisals** increased to 67.5%, against the 85% target.
- **Sickness** absence rates increased to 5.8% in October, from around 5.2% in August and September.

Responsive

- **UEC:** October 22 Performance against the 4 hour standard is 69.31%. Overall activity remains (12%) below pre-covid levels. Footfall through UEC increased to 9,488 in October from 9,011 attendances in September. October activity is on average 25 attendances per day more than last year (9.1% increase). The latest national benchmarking data (October – performance of 69.3%) places the Trust at 38th of 139 Type 1 providers. The Trust reported 112 30-60 minute and 112 over 60 minute ambulance delays in October. The Trust also reported 134, 12 hour waits from decision to admit to leaving ED and 731 (7.7%) 12 hour waits in the ED (from registration to left department).
- **RTT:** September 22 Performance against the 18 week standard is 73.4% with an increase of patients on the RTT waiting list from 12,430 to 12,837 and a reduction to 89 patients waiting over 52 weeks, two of which were waiting for more than 78 weeks.
- **Cancer: 2ww Cancer referrals -** remain higher than pre-pandemic levels which creates challenge in achieving the 2 Week Wait Standard. The indicative Trust position against the target in October is 84.6%, below the 93% standard. In October 1,266 Two week wait referrals were received which shows a decrease of 5.5% in comparison to the same period last year and up by 18.3% on the same period in 2019. **62 day treatments -** The Trusts position against the 62 day standard showed a deterioration in performance in September reporting performance at 70.5% with Gynaecology, Lower GI, Upper GI, Haematology and Urology tumour site below the performance standard of 85%.
- **Diagnostics:** The Trust failed the diagnostic standard in September reporting 81.09% of patients seen with 6 weeks of referral. Echocardiography continues to be the main challenge at 39.05% and Audiology is also reported below target at 54.92% and highlighted as an area of concern.
- **Informal complaints:** The number of informal complaints is triggering due to increased volumes for the last 8 months. Main themes are calls from switchboard where patients or family members cannot be access the appropriate area / staff. And concerns raised by patients relating to Parking Eye.
- **Duty of candour:** Verbal Duty of Candour compliance is displaying special cause variation for concern from April 2022 Verbal DOC is currently recorded from the date of the incident being reported and not when the organisation agrees a notifiable patient safety incident has occurred, and to some extent this means they are often not completed within the ten day requirement set in the system. The DOC allocation responsibility within the DATIX system often sits with matrons and SLM's and not the attending clinicians There are some identified themes in relation to the overdue notifications which are being addressed

NHS
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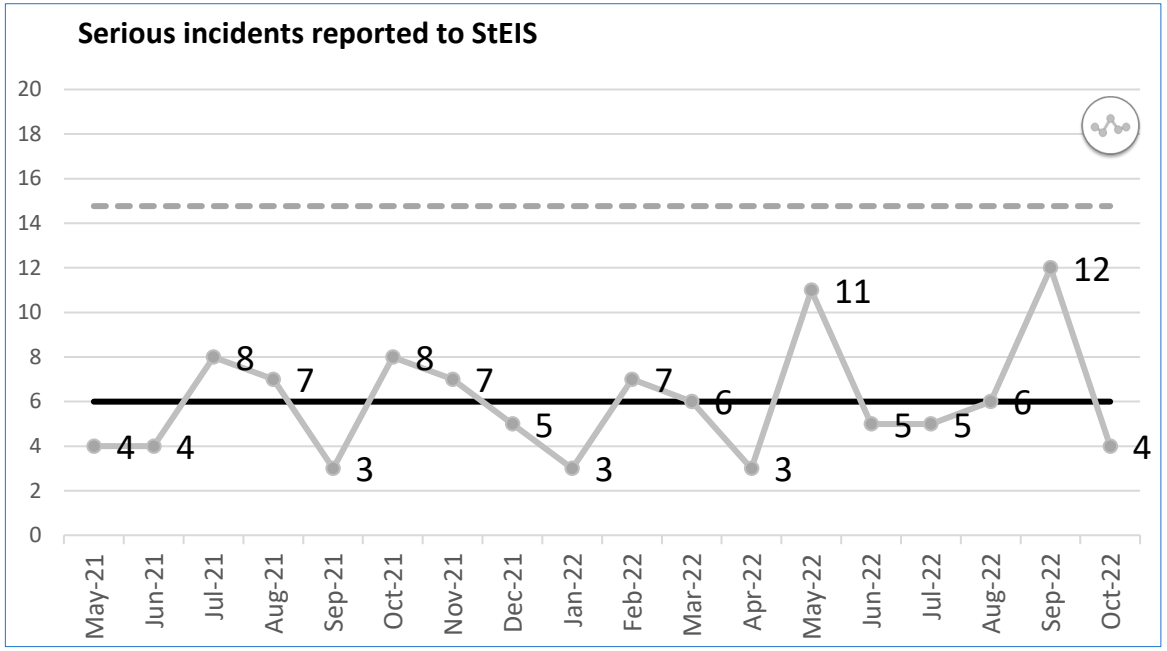
The following section includes detailed reports for a range of key measures, reported for each domain. These metrics might include indicators triggering concern or displaying Special Cause Variation and spotlights requested specifically by Committee or Board.

Serious Incidents reported to StEIS

Safe

Gateshead Health NHS Foundation Trust



Aim: to ensure SI's are identified, reported and investigated appropriately. Identifying and sharing learning to prevent future occurrence.

Operational Definition: Serious Incidents and never events as defined NHS Improvement's Never Events Policy and framework (Jan 2018) reported on to STEIS.

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.

Consequence: of Failure: Patient safety, quality, Trust reputation, scrutiny from regulators.

There were 4 SI's declared in October – themes are listed below:

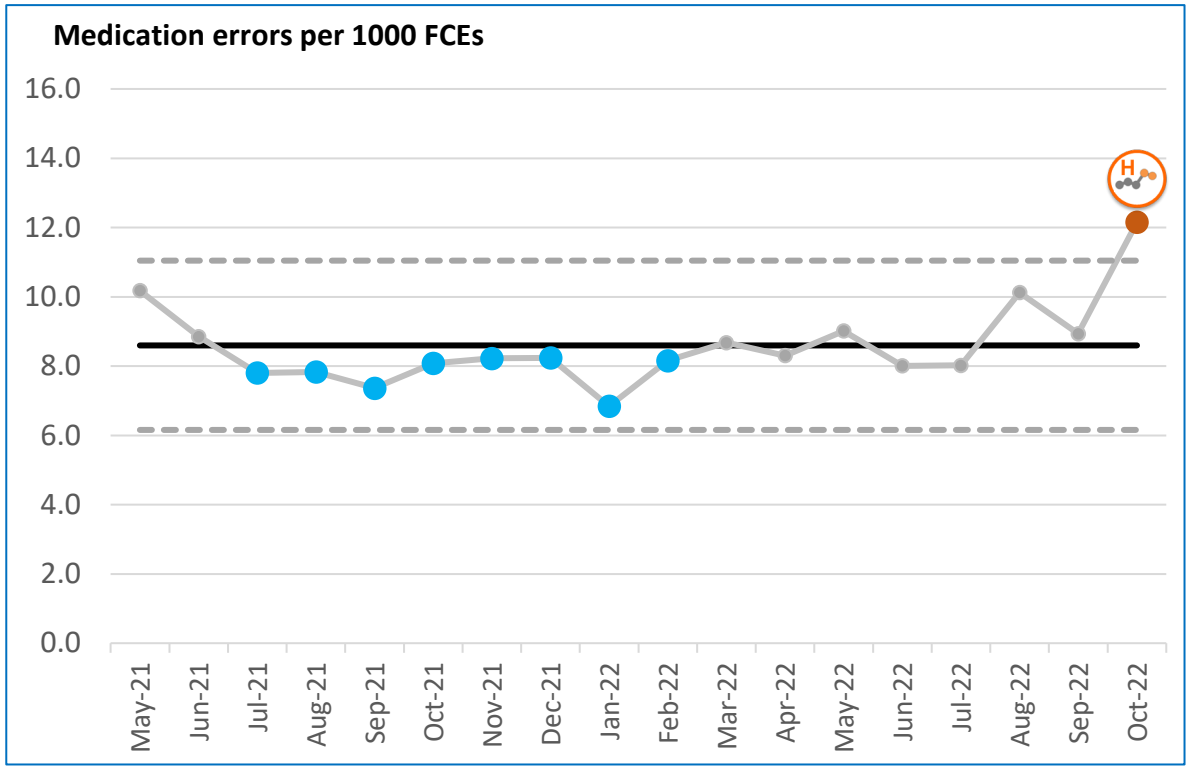
Severe / Major Harm
4 x Fall on same level - cause unknown

Medication errors per 1000 FCEs

Detail on this measure is included because return to common cause variation from special cause variation identified in last months report .

Safe

NHS Gateshead Health NHS Foundation Trust



Situation

- Special cause variation in October 2022 with 12.2 medication errors per 1000 finished consultant episodes (FCEs.)

Background

- Medication error rates are monitored each month as part of a set of safety metrics. There is currently no national benchmarking of this metric. This is monitored based on comparison of the Trust incident trends.

Assessment

- Medication errors exceeded the upper process limit in October 2022
- A total of 88 medication errors were observed in October 2022.
- 69 No harm, 19 low harm.
- This represents an increased level of reporting with low numbers leading to harm. Indicating a positive safety culture for the reporting of medication related incidents.

Actions

- Medication incidents are analysed quarterly by the Trust Medicines Safety Officer for presentation and action at Medicines Governance Group.
- Data for October has been analysed and no exceptions were found relating to the usual pattern of incidents across business units or in the type of incident reported.
- Increased incident reporting presents a resource challenge in ensuring timely investigation and action, this has been shared with the patient safety team for awareness and individualised support offered to areas where incident reporting levels have increased or are maintained.

Recommendations

- The Trust continues to support the reporting of all medication incidents and near miss events so that opportunities for learning can be identified and shared.

Report by exception: Patient Safety Alerts not completed by deadline

Safe

Gateshead Health NHS Foundation Trust

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

Background

The Central Alerting system produces a range of alerts, and the Trust receives these via a central email address for review, appropriate circulation and action.

The information being pulled for the IOR is incomplete- as its drawn from the national system and appears to only show National Patient Safety Alerts, and even these are not congruent with information held within the Trust.

The organisation received a range of other alerts via the system that are not represented here, but are detailed monthly in the paper presented to Safecare council.

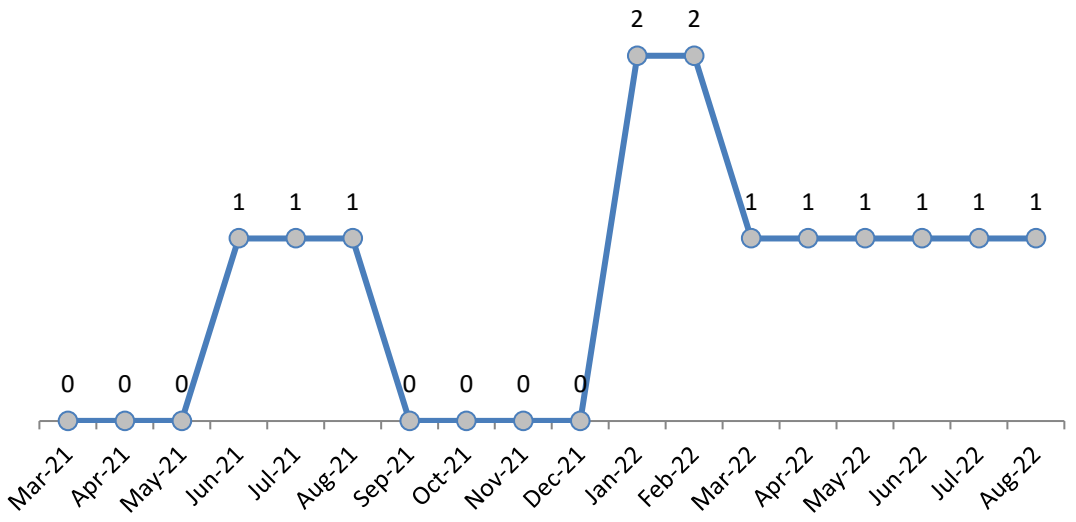
It is suggested that work is undertaken to determine whether the IOR requires work to enable data to be drawn from a source that is congruent with internally held data, as manual transcription is lengthy and would not be able to be contained in a single slide

NB it should be noted that the information above is derived from a national data base and is not congruent with the information held in Ulysses at a Trust level**

Recommendation

- Work is undertaken to enable data to be drawn from a source that is congruent with internally held data

Number of NHS England or NHS Improvement patient safety alerts outstanding in most recent monthly snapshot



Source: https://www.cas.mhra.gov.uk/Help/AlertComplianceData.aspx

Note: August 22 latest data available on the national database – last checked 21/11. Have emailed helpdesk to ask when data will be updated. Awaiting a response.

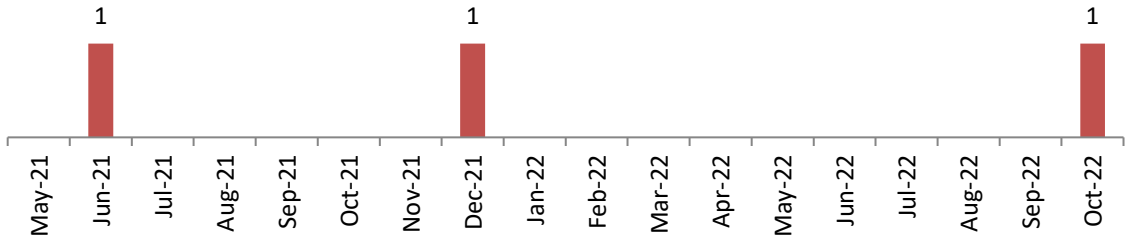
Infection Prevention & Control – Healthcare Associated Infections - MRSA & nosocomial COVID-19

Safe

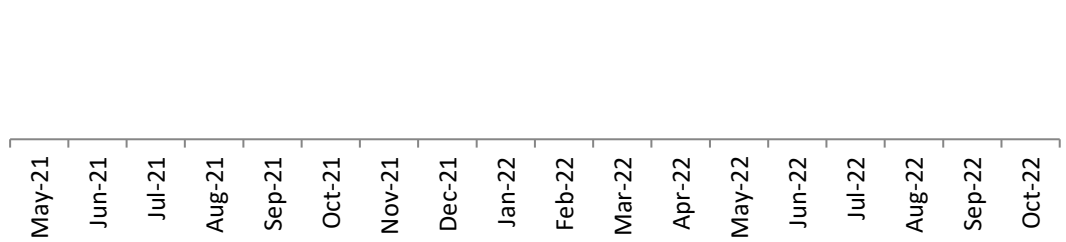
Gateshead Health NHS Foundation Trust

The Trust adopts the national aspiration of a zero MRSA blood stream infections (BSI).
The trust has had zero incidence of Healthcare Associated MRSA BSI in the preceding 12 months and one community healthcare associated MRSA BSI in October 2022.

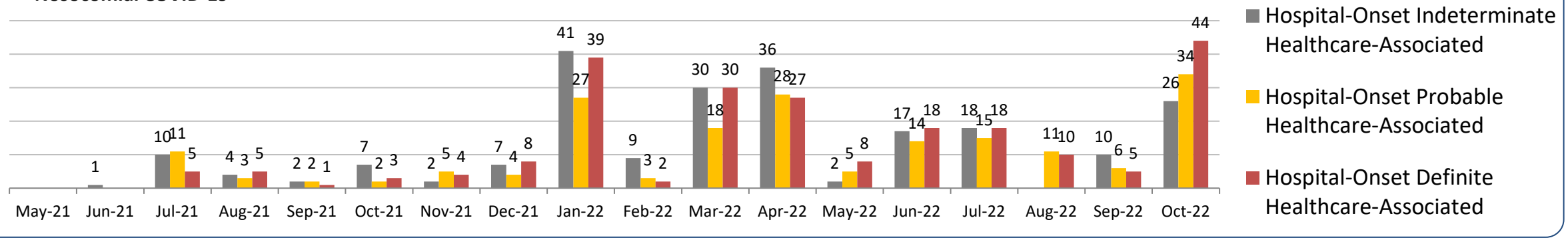
MRSA -Community Associated



MRSA- Healthcare Associated



Nosocomial COVID-19



Nosocomial COVID 19 cases
All Healthcare associated COVID cases are reported and investigated through the DATIX system.
The incidence of nosocomial cases in October have risen in line with local prevalence. Learning from previous outbreaks advised to minimise onward transmission.

Infection Prevention & Control – Healthcare Associated Infections - Clostridiodes Difficile Infection

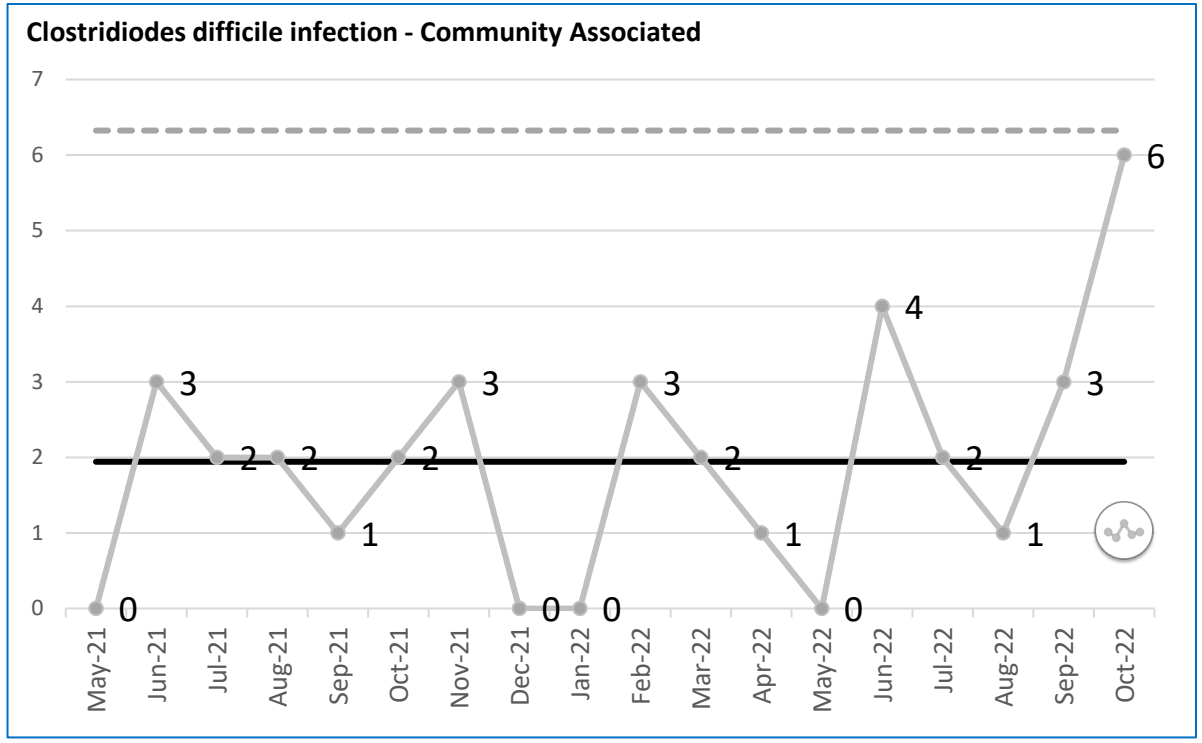
Safe

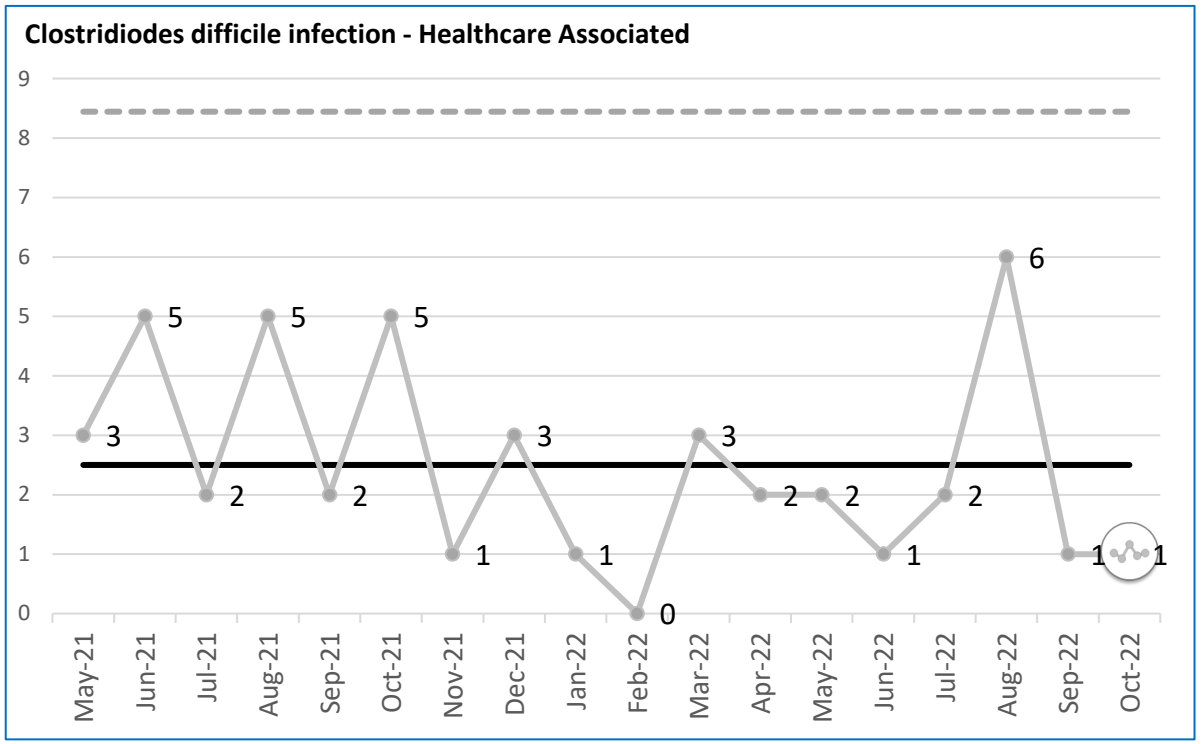
Gateshead Health NHS Foundation Trust

The Trust has reported 15 Healthcare associated CDI cases since April 2022 against the CDI threshold for 2022/23 of 32.

The Trust had:

- 1 Healthcare Associated case in October 2022.
- 5 Community Onset Community Associated (COCA)
- 1 Community Onset Indeterminate Associated (COIA)



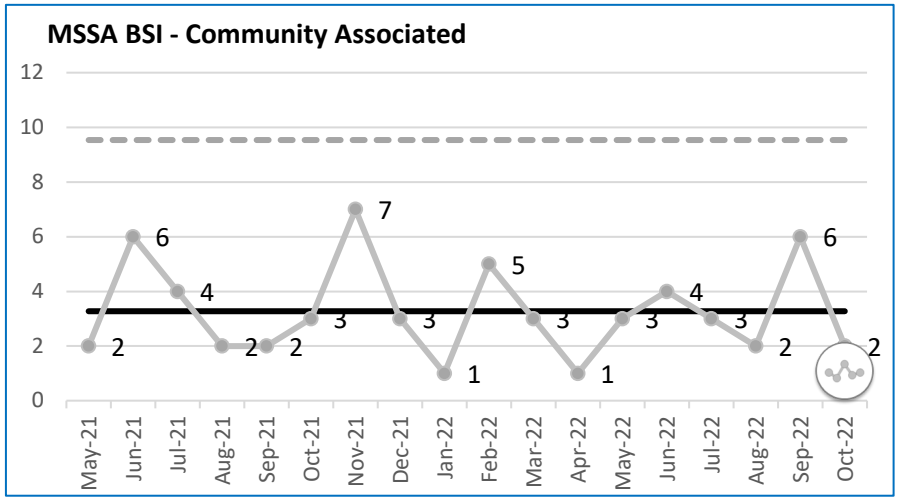


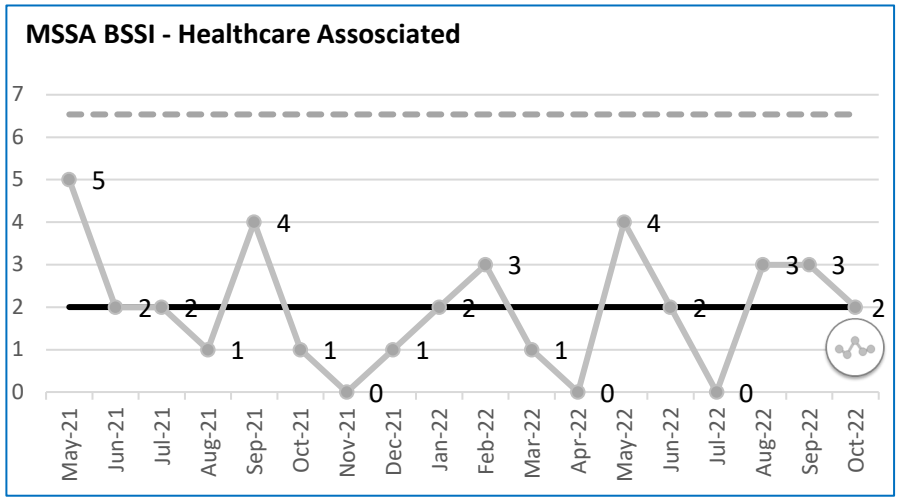
Infection Prevention & Control – Healthcare Associated Infections - MSSA & E Coli

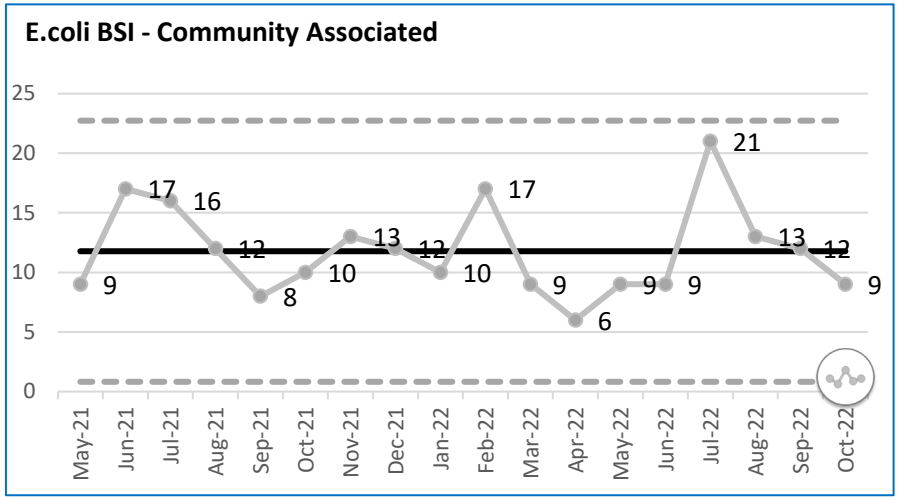
Safe

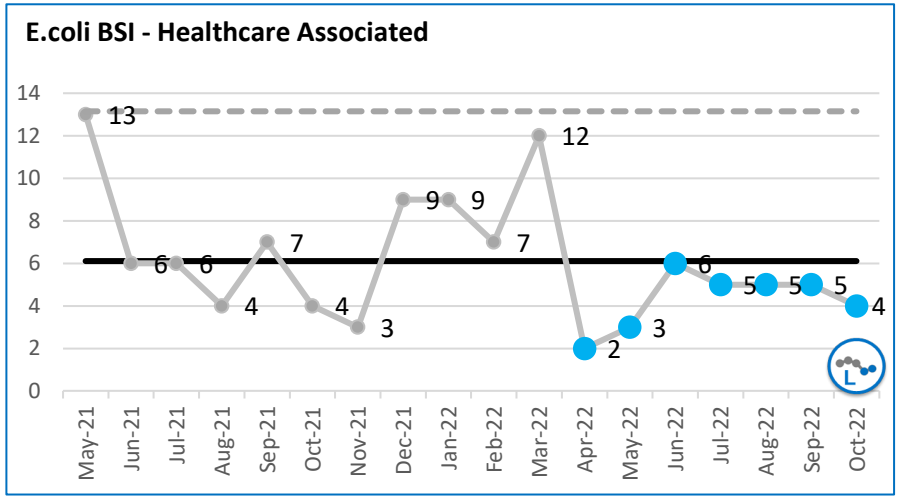
Gateshead Health NHS Foundation Trust

- All Healthcare associated BSI are reviewed and actions are initiated if necessary.
- NHS England has not set an Healthcare Associated MSSA BSI threshold for 2022/23
- The Trust has reported 2 Healthcare Associated MSSA BSI during October 2022
- NHS England has set the Trust a threshold of 68 Healthcare Associated E. coli BSI for 2022/23
- The Trust has reported 4 Healthcare Associated E. coli during October 2022 – 1 HOHA's and 3 COHA's.
- The trust has seen a slight decrease in community E.coli BSI, possibly associated with seasonal variation.





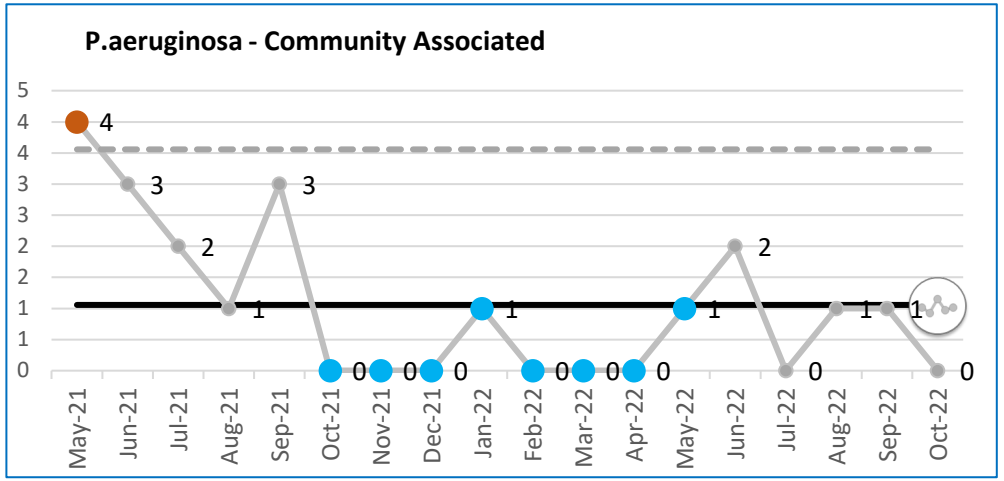


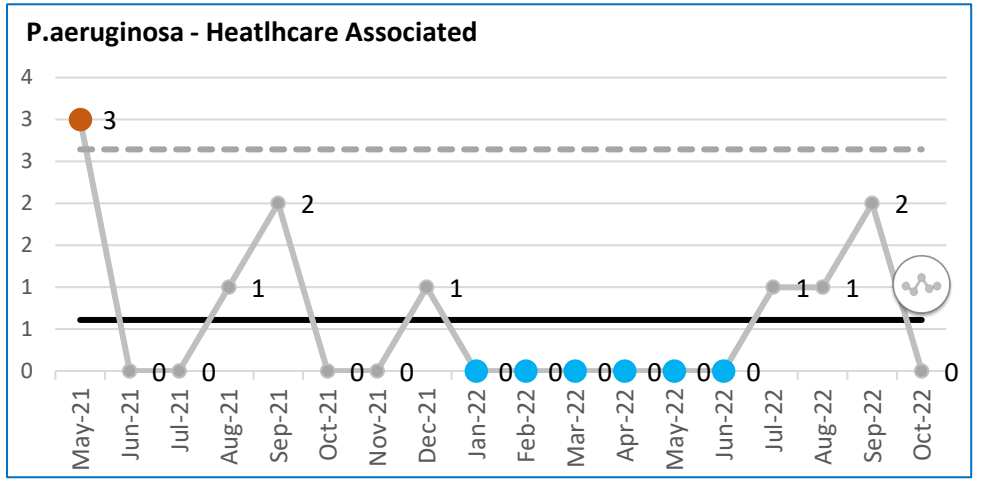


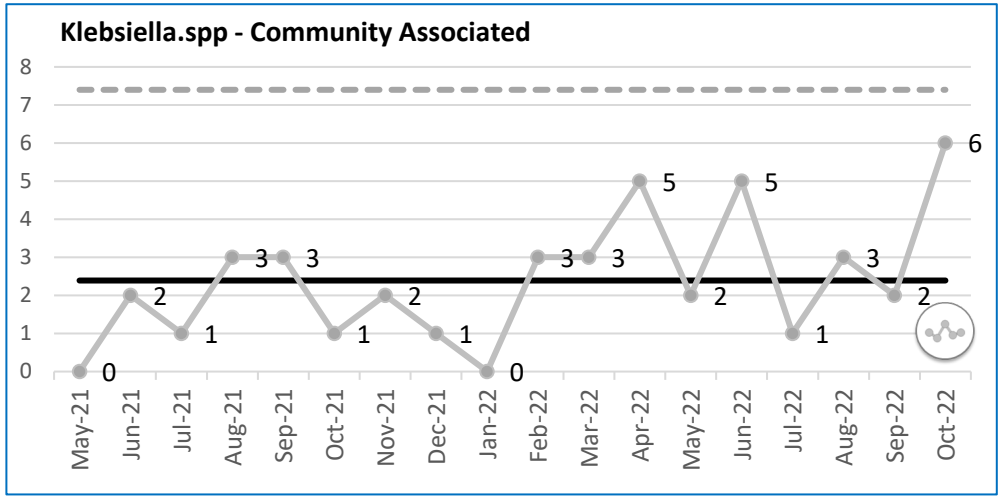
Infection Prevention & Control – Healthcare Associated Infections - P. aeruginosa & Klebsiella spp.

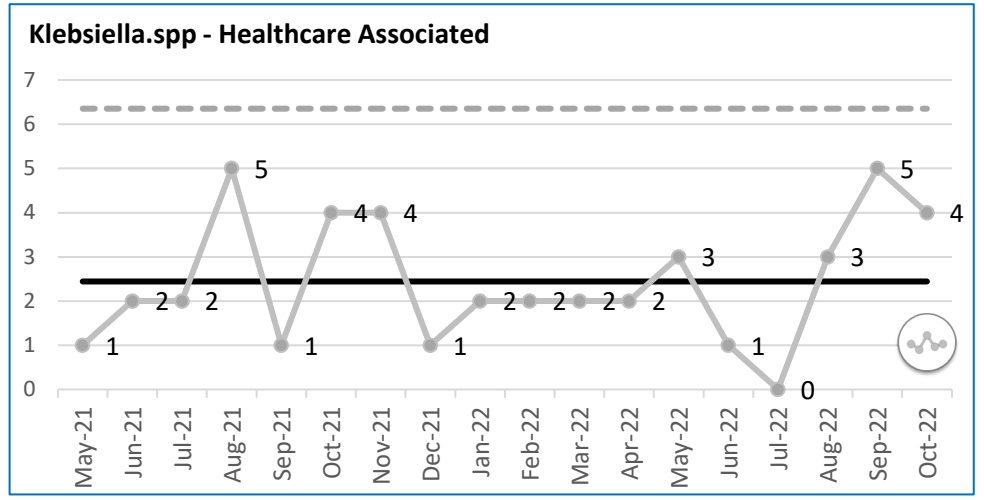
Safe

NHS Gateshead Health NHS Foundation Trust







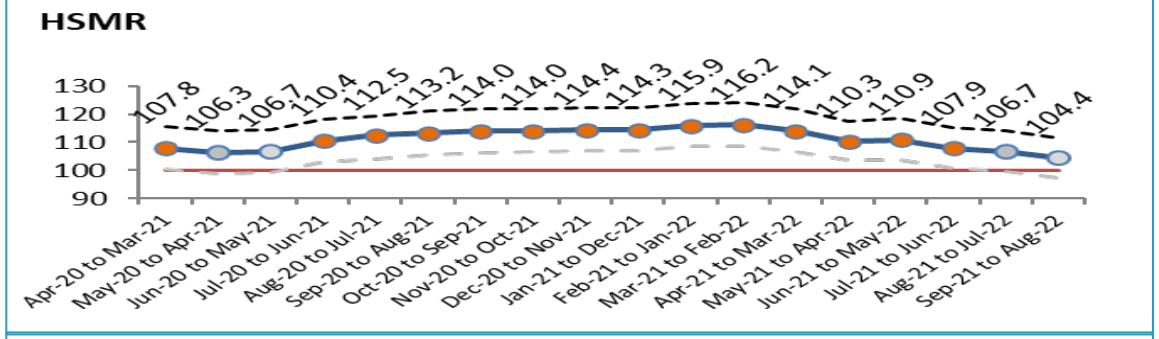


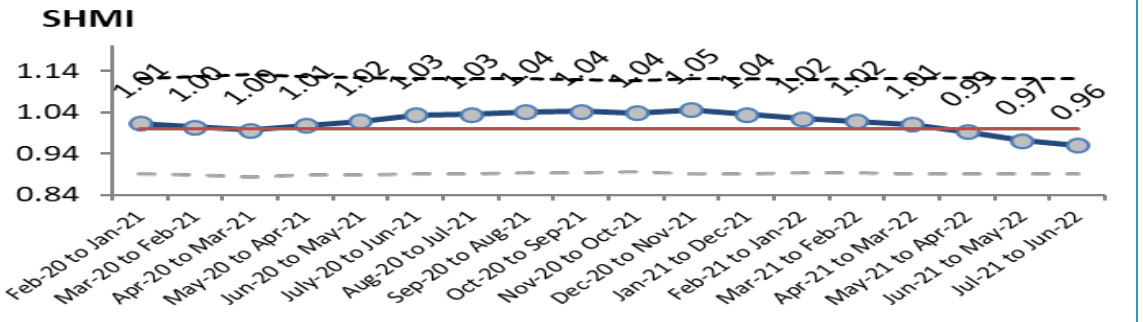
- All Healthcare associated BSI are reviewed and actions are initiated if necessary.
- NHS England has set the Trust a threshold of 8 Healthcare Associated P.aeruginosa BSI and 26 Healthcare Associated Klebsiella spp. BSI for 2022/23
- The Trust has reported zero P. aeruginosa BSI during October 2022.
- The Trust reported 1 HOHA and 3 COHA's Associated Klebsiella BSI during October 2022.

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

Effective

Gateshead Health NHS Foundation Trust





Deaths 01/10/2021 to 30/09/2022

Deaths in period	Deaths reviewed by Medical Examiner	Learning Disability Deaths reviewed at Mortality	Severe Mental Illness deaths reviewed at Mortality Council
1159	1158	7	16
Denominators	1159	14	22
	99.9%	50.0%	72.7%

The scores below relate to reviews undertaken by either the Ward Based Team and /or Mortality Council. Mortality Council review score supercedes Ward Based Team review score where both have taken place.

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
98.2%	1.4%	0.4%	0.0%	0.0%	0.0%

Potentially avoidable deaths (Hogan 4 and above)
0.0%

NCEPOD Score 1 Good Practice	NCEPOD Score 2 Room for improvement - Clinical Care	NCEPOD Score 3 Room for Improvement - Organisational Care	NCEPOD Score 4 Room for Improvement Clinical and Organisational	NCEPOD Score 5 Less Than Satisfactory	NCEPOD score 6 Insuficient data
88.3%	1.4%	8.3%	1.8%	0.2%	0.0%

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 .
The HSMR remains with deaths 'As Expected' with a score of 104.4 against the national average figure of 100. The SHMI is showing deaths are within the expected range with the latest figure of 0.96 below the national average of 1.00.

The Trust continues to trigger for patients with a congestive heart failure diagnosis on admission. Cases prior to the most recent trigger are to be reviewed by the Trusts mortality Council. Further learning disability and severe mental Illness cases have recently been reviewed at mortality council with the remaining cases to be prioritised for future meetings.

Mortality review data for the last 12 months demonstrates that 98.2% 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, all deaths are reviewed and cases may be escalated for additional investigations i.e. Mortality Council, patient safety investigation.

Actions

- Potential issues identified with clinical coding shared with the clinical coding team for further investigation.
- 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. UPDATE – new process went live on 3rd October 2022.
- 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 – completed reviews undertaken and action plan developed
- 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.

Learning From Deaths Reporting Q2 2022-23

Effective

Gateshead Health NHS Foundation Trust

The Trust is required to publish this quarterly information.

Period: 01/07/2022 to 30/09/2022

Q2 2021-22	Deaths in period	Deaths reviewed*	%
Medical Examiner Service	257	257	100.0%
Ward Based Team	257	74	28.8%
Learning Disability Patients	1	0	0.0%
Severe Mental Illness	4	1	25.0%

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
98.6%	1.4%	0.0%	0.0%	0.0%	0.0%	0%
-	-	-	-	-	-	0%
100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0%

*Deaths reviewed at level 1 or Level 2 for all deaths, reviewed at level 2 (Mortality Council) for Learning Disability and Severe Mental Illness. Deaths are not currently scored by the Medical Examiner Service

- 4 Learning disability and 3 severe mental illness (SMI) cases were reviewed throughout July to September by the Mortality Council – however these were for patients who did not pass away in the period. The remaining cases are to be discussed at future meetings. The care of the patient with a learning disability who passed away during quarter 2 is scheduled to be reviewed by the Mortality Council on 22nd November 2022.
- 11 deaths investigated under the Serious Incident framework (and declared as serious incidents)
- Two extraordinary meetings of the Mortality Council took place on (29th September and 4th October) to review the backlog of 20 SMI cases. Cases will then be added to the agenda as they arise thereafter.
- The revised learning from deaths process went live across the organisation at the beginning of October 2022 – therefore data reported in Quarter 3 will reflect this.

Themes and issues identified from review and investigation/Actions taken in response, actions planned and an assessment of the impact of actions taken

Good practice identified:

- Evidence of joint working with mental health care for patients with severe mental illness.

Learning themes identified:

- **Delayed diagnosis of lung cancer**
  - A checklist is now in place to ensure all of the chest is reviewed.
  - A repeat x-ray should be recommended if there is any doubt in the cause of changes.
- **Enhanced care tool**
  - The enhanced care tool does not have sufficient sensitivity for patients at risk of falling. The AFLOAT tool is more focussed on medications/frailty level, this will be introduced as an addition to the enhanced care tool.
- **Lengthy admissions**
  - Consider additional full review of patients with a long admission.
- **Admiral Nurse Service**
  - The Admiral Nurse Service is being set up for patients with Alzheimer's or dementia to provide support to care homes around end of life. This service is provided by Dementia UK and the staff will be employed by the Trust. There will be two nurses for community and two and a half for inpatients. It is anticipated that the service will be up and running by May 2023.

Clinical Effectiveness – Softer intelligence

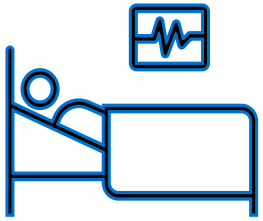
Effective

Gateshead Health NHS Foundation Trust

GIRFT
GETTING IT RIGHT FIRST TIME

16 deep dive visits have taken place to date: *138 actions identified, 61 of which have been implemented.* The Trusts most recent deep dive visits are summarised below:

Critical Care – May 2022



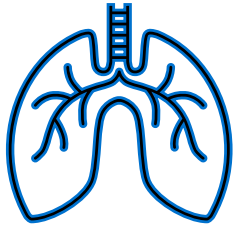
Good Practice identified

- The team identified the rehab nurses taking patients out into the garden as an area of good practice.

Opportunities for improvement:

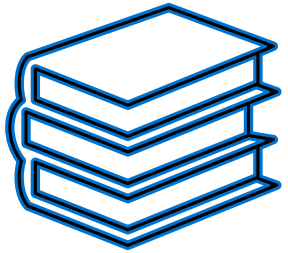
- Staffing problems/recruitment – need to increase the recruitment of staff,
- Bed shortages – looking to manage bed capacity in the aftermath of Covid,
- Discharge issues – delayed discharges and patient flow remains an issue.

Lung Cancer – March 22



- The specialist nursing service have achieved excellent results for patient contacts in the National Lung Cancer Audit and have implemented an email alert system to ensure they are notified of in-patient admissions.
- The team have a passionate and proactive approach to tobacco addiction with well-developed internal and external referral pathways.
- The pathology service provides an excellent turnaround time for biopsies which was recognised and welcomed by the clinical team, and although the external molecular service has been slow, this has improved to around 10 days..

NICE National Institute for Health and Care Excellence



104 pieces of NICE guidance published between April and September 2022; *54 of these were applicable to the organisation,* current compliance status is:

- Fully compliant – 30
- Partially complaint – 4
- Remain under review – 20

We remain partially compliant with 43 pieces of NICE guidance published prior to April 2022.

Clinical Audit 2022/23 to date;

- In 2021/22 Trust participated in 85% of National Audits (35/41), year to date 22/23 improved to 90% (38/42)
- 97% of the stated audit programme has been registered (76/78)
- Additional 71 projects also started
- 20 audits have been completed:
  - ✓ 18 demonstrated full compliance with standards
  - ✓ 2 indicated areas for improvement – subsequent actions have been identified.

Risks

- 69 clinical audits are overdue
- None of the completed projects identified a risk score of 12+, any audits identified a risk of 12+ are escalated as per policy to the Business Unit audit lead

Discharge & Delays

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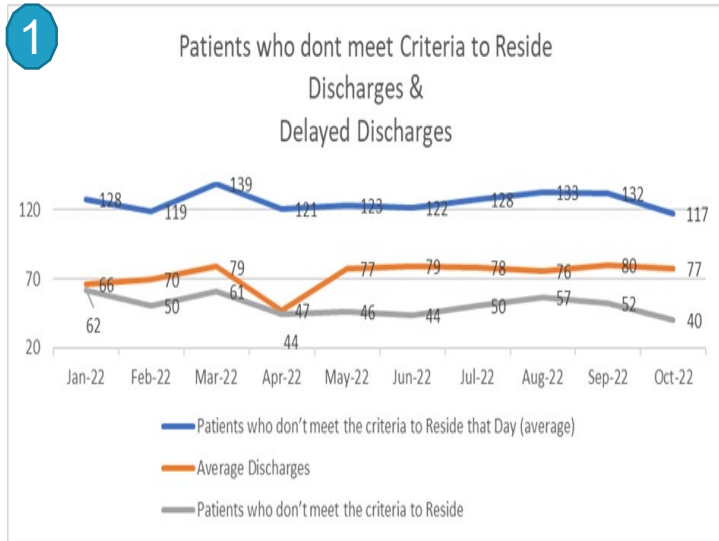
NHS Gateshead Health NHS Foundation Trust

1



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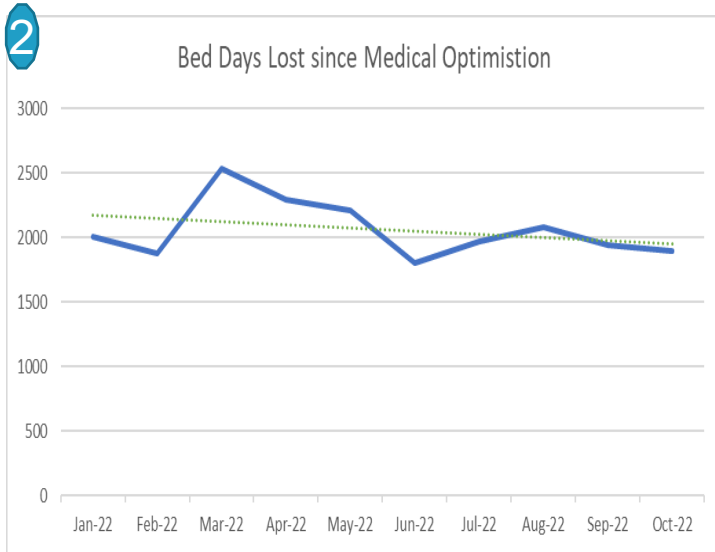
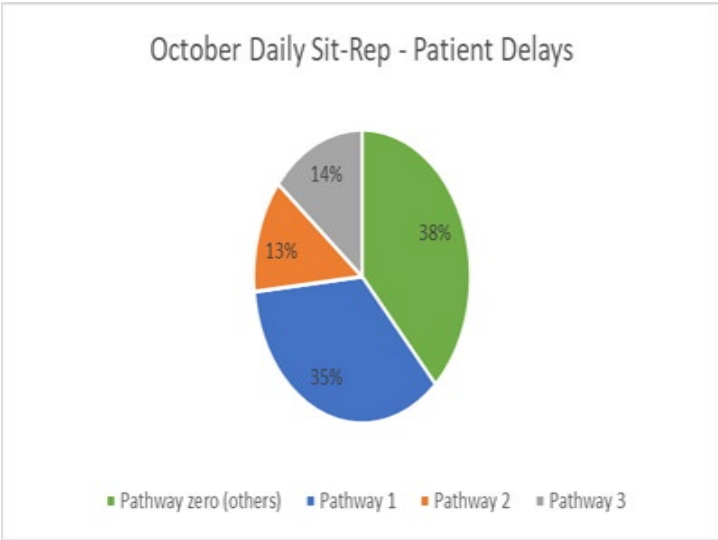




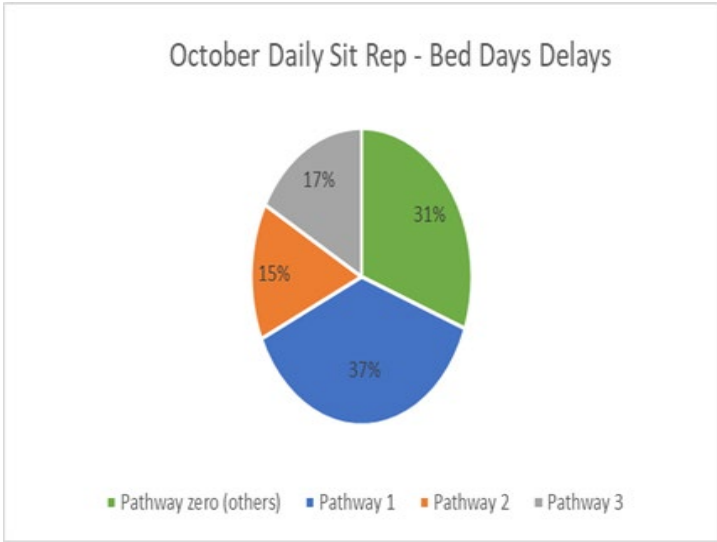


Figure 1 - Year to date Review:

At the start of the day (on average) 126 patients who don't meet the criteria to reside

We discharge on average 73 of these patients per day (58%)

- 52% of the discharges occur before 5pm (circa 37 patients).
  - 10% of these discharges occur before 12 noon (7 of the 37patients)
- 48% of the discharges occur after 5pm (36 patients)
- 42% of the remaining patients continue to occupy a hospital bed.
- The bed days lost since medical optimisation is on a downward trend – figure 2.

October Update:

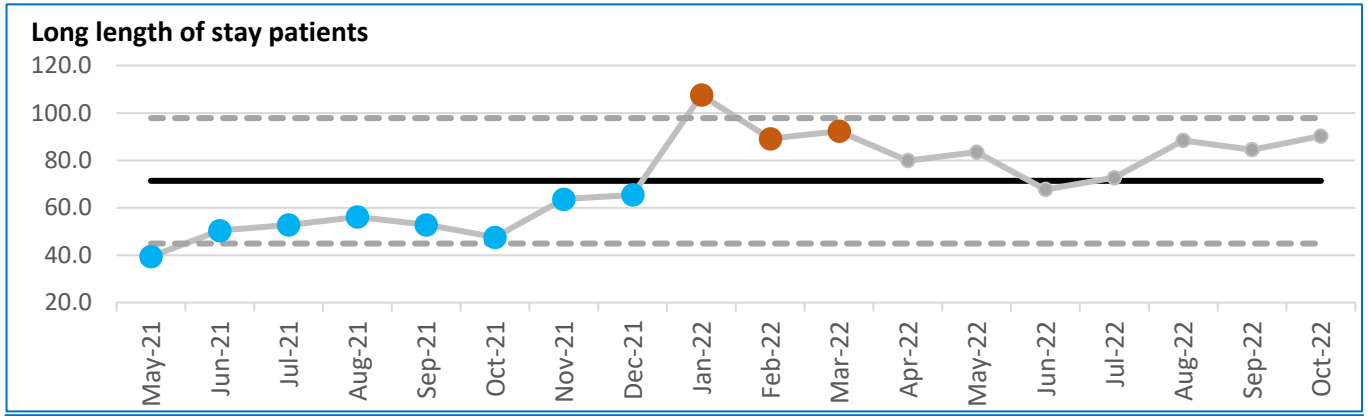
- Average Admissions: 92 per day (peak 118)
- All discharges average 89 per day (range 32 – 130)
- Average Occupancy levels 96.7%
- CtR average discharges - 77 per day
- 54 % of discharges occur before 5pm - Trust performs well in ICS
- Figure 3 & 4 demonstrate that Pathways 1-3 account for 62% of the patients 69% bed day delays
- Internal Delays & 'Others' account for 38% of the patients and 31% of the bed days delayed.

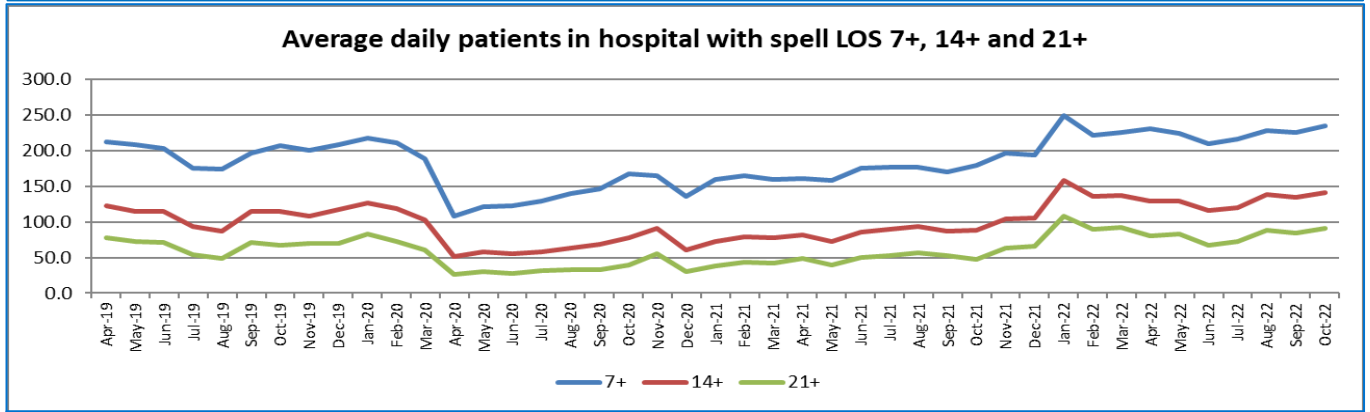
- Weekend discharges remain low 6.2% (ICS range 6.2% - 10.5%)
- Operational challenges continue in the daily review of Medically Optimised patients.
- Red to green day pilots have started on Ward 12.
- Data challenges persist: collecting pathway zero as part of clinical workflow remains a priority.
- Trust is now participating in a national 10 week rapid Improvement event to support UEC and flow pressures. Involving rapid PDSA cycles.

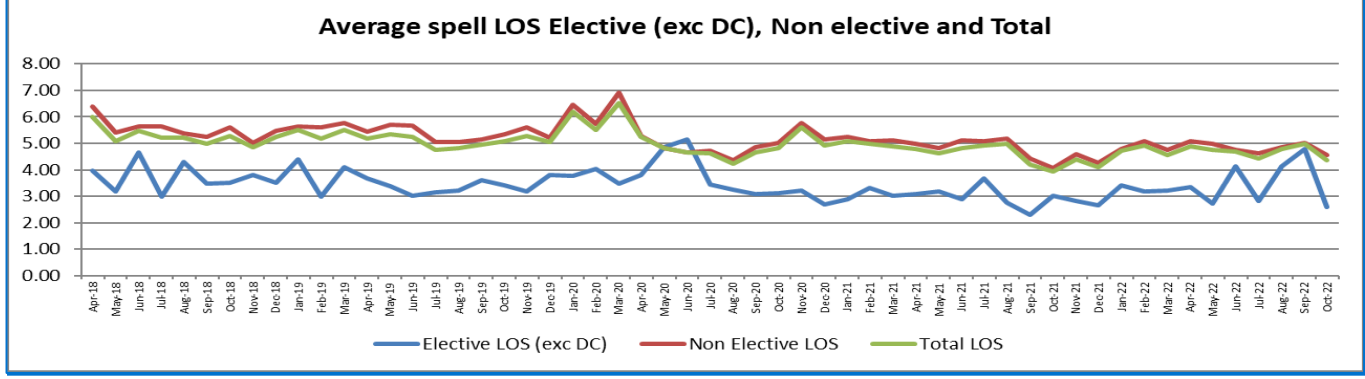
Report by exception: Long Length of Stay Patients

Effective

Gateshead Health NHS Foundation Trust







Situation

- The average number of patients in hospital with 21+ days LOS is currently triggering special cause variation (concern). A reduction since January 2022 is observed however the 2022 figures are above the upper process limit.

Background

- An expectation that the daily average number of patients staying 21+ days would not exceed 59.
- The ECIST existing target of 59 is subject to either pass or fail based on common cause variation.
- Having seen a small improvement in the average number of Long stay patients (LOS 21+) from 88.5 in August to 84.5 in September, the figure rose once again in October to 90.2.

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 criteria to reside in hospital. 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.
- The number of patients who do not meet the criteria reside in hospital remains high, with a daily average of 40 patients in October.
- 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.

Efficiency and Productivity – Length of Stay (Surgery)

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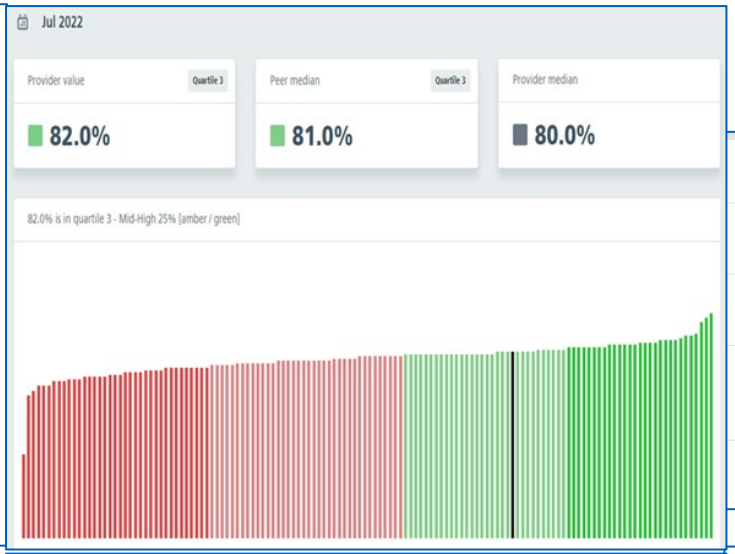
Gateshead Health NHS Foundation Trust

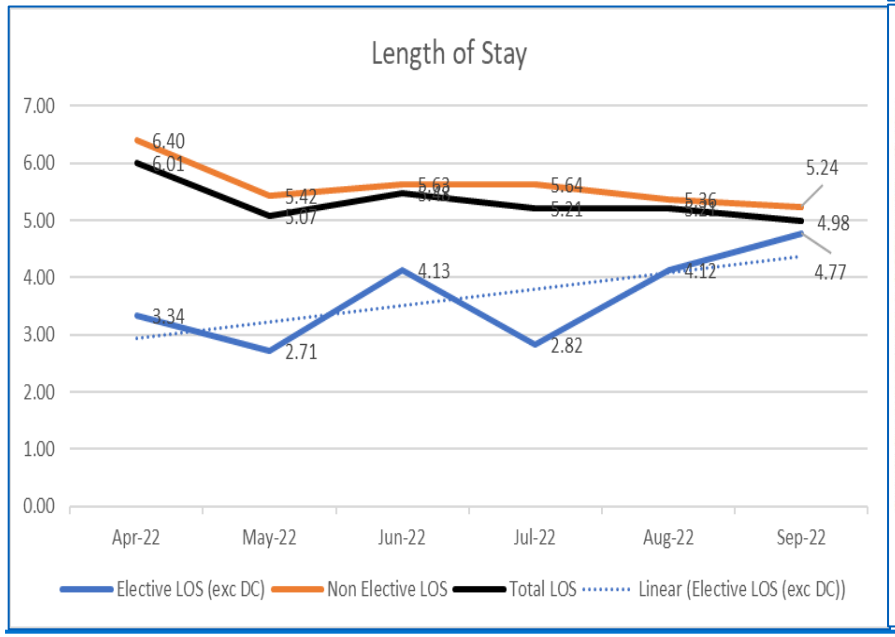
Assessment
- Day case rates in mid-high performing quartile (82%)
- Conversion from daycase to inpatient in the top quartile
- Breast services benchmark very well across the Board
- Average Length of Stay for Elective Inpatients is increasing

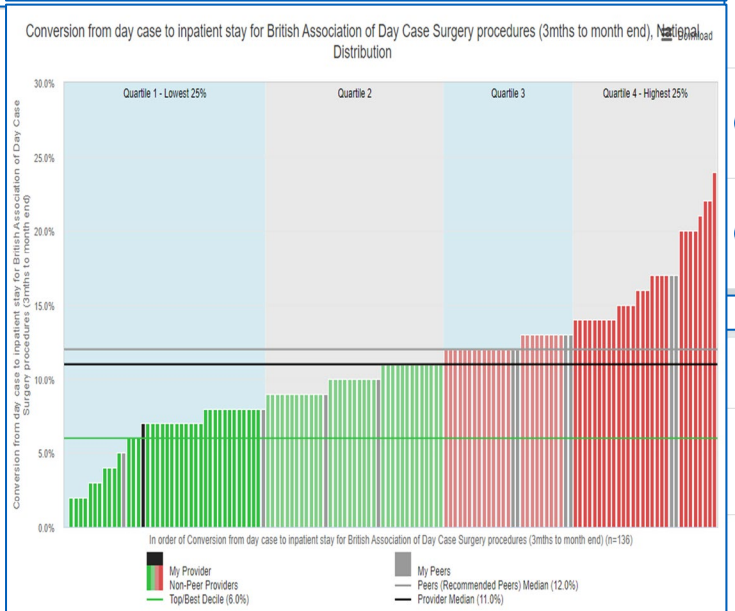
Business Unit are committed to reviewing opportunities for improvement as part of the overall recover plan:
- Review day of surgical admission
- Review of long stay patients
- General surgery length of stay
- General surgical inpatients with no procedure
- General surgical Long stay elective admissions > 20 days / opportunities
- Primary knee replacements

Non Elective :
- Review NEL urology pathways



Length of stay for Elective admissions	Data period	Provider value	Peer median	Provider median	Chart	Actions
% of elective admissions with the length of stay of 1 or 2 days	Aug 2022	50.0%	55.7%	50.6%		
% of elective admissions with the length of stay > 6 days	Aug 2022	11.5%	8.0%	9.7%		
% of bed days that are due to elective patients staying beyond > 6 days	Aug 2022	67.7%	48.0%	54.7%		
% of elective admissions with the length of stay > 20 days	Aug 2022	2.6%	1.1%	2.0%		





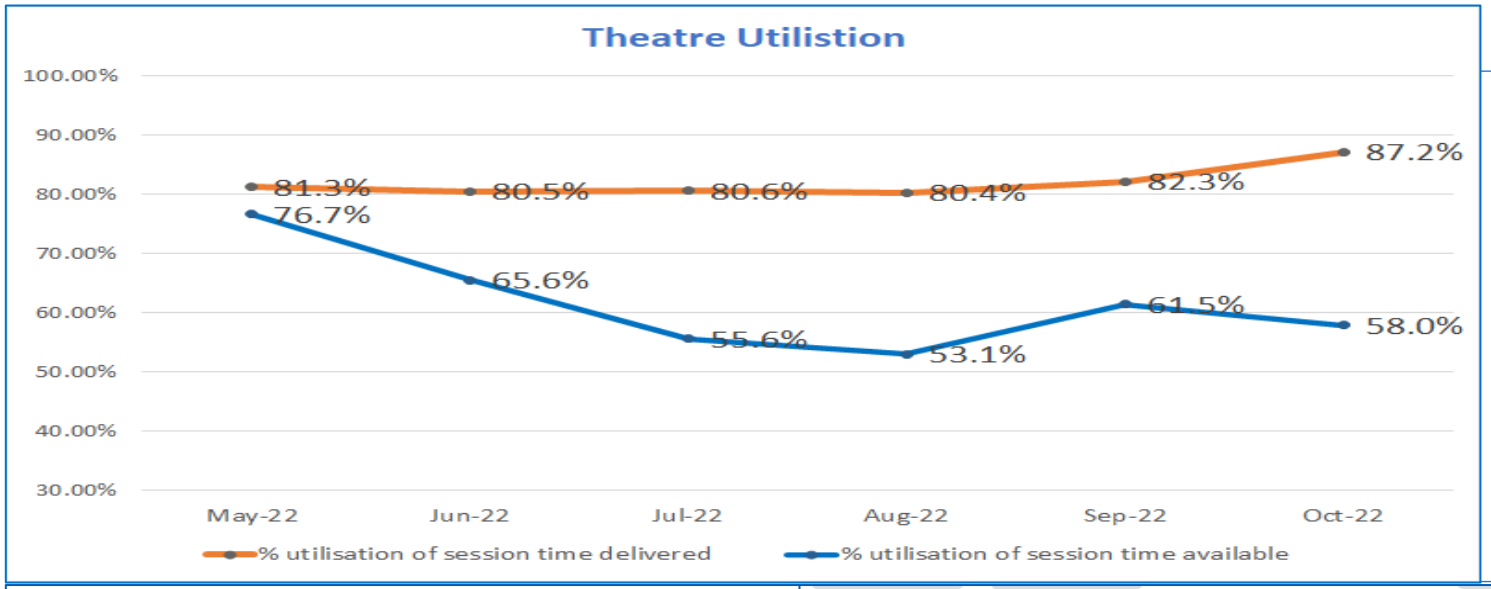
Average length of stay (excluding short stays)	Data period	Provider value	Peer median	Provider median	Chart	Actions
Average length of stay for elective admissions (days) - rolling 6 months	Aug 2022	4.0	2.5	3.0		
Average length of stay for emergency admissions (days) - rolling 6 months	Aug 2022	10.5	10.1	10.5		

Elective procedures	Data period	Provider value	Peer median	Provider median	Chart	Actions
Surgery on Day of Admission rate for elective admissions – rolling 6 months	Aug 2022	82.2%	95.7%	93.2%		
% of short staying elective admissions with no procedure - monthly	Aug 2022	8.4%	9.7%	9.1%		

Efficiency and Productivity – Theatres

Effective

Gateshead Health NHS Foundation Trust



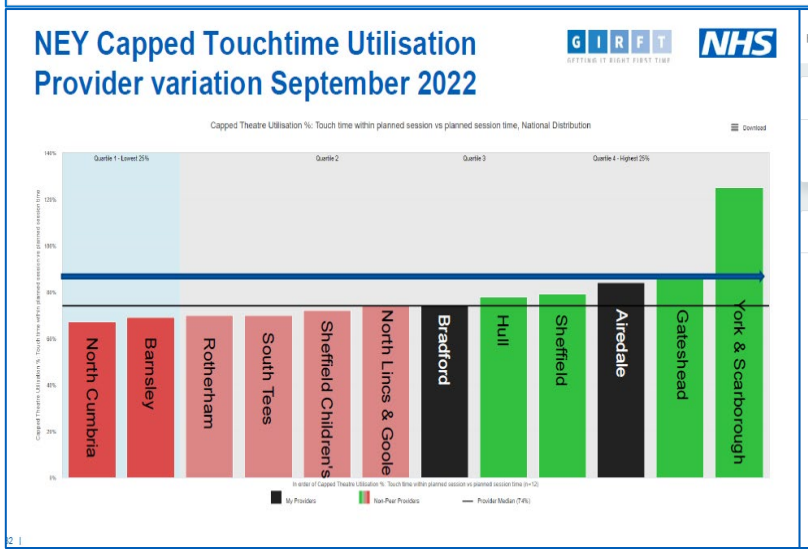
Improving theatre productivity to drive elective activity plays a crucial role in reducing our patient waiting times and eradicating our backlogs.

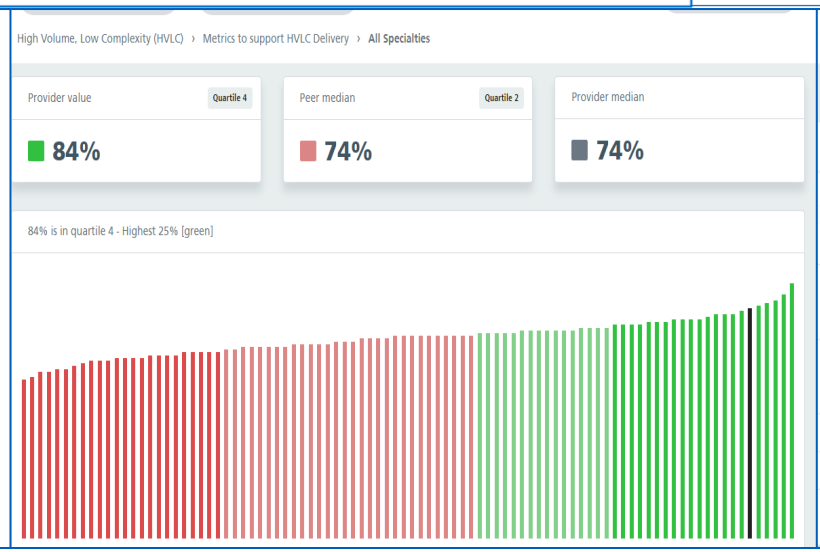
GIRFT Targets:
Maximise our running theatre sessions > =85% with appropriate volumes of cases per list. In Q2 the Trust was below the threshold but benchmarked well. The Trust is currently compliant with this target & has increased utilisation in Oct-22 to 87.2%. Early finishes is an area of potential improvement.

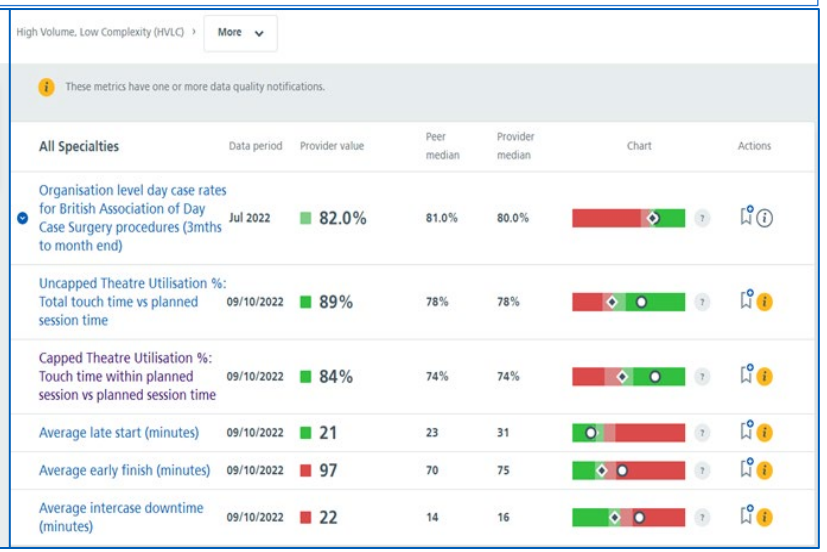
Maximising the use of the theatre suits is an area of improvement in Q2 with Q2 running at 57% utilisation.

85% of all elective surgery should default to a day surgery pathway

Performing well (top quartile) in delivery of High volume low complexity procedures at 84% - which places the Trust in the top quartile.







UEC Measures

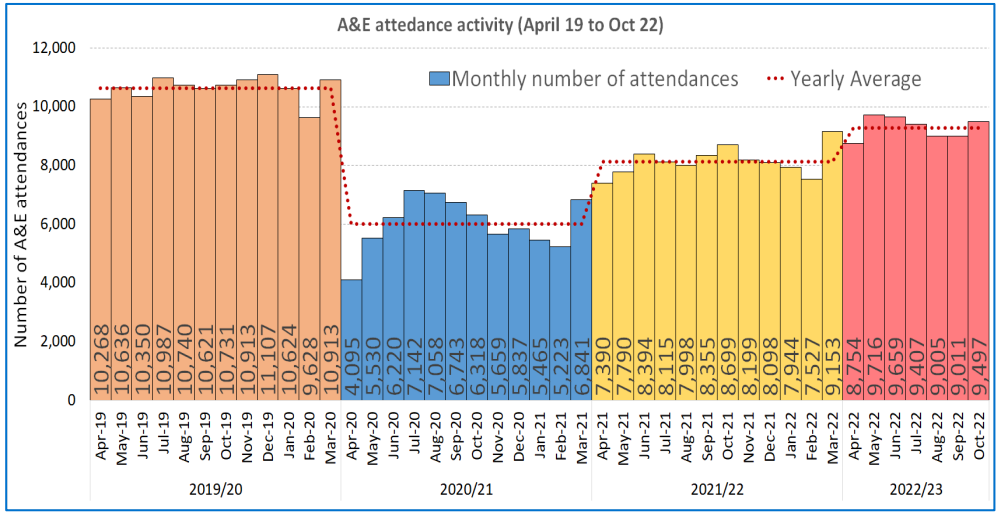
Responsive

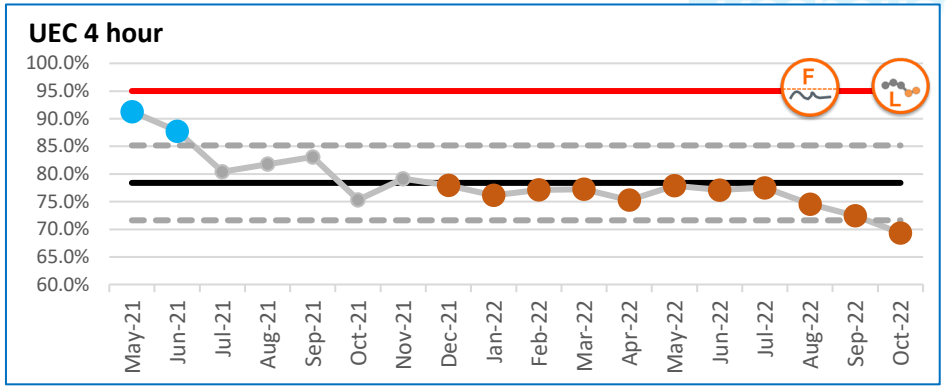
Gateshead Health NHS Foundation Trust

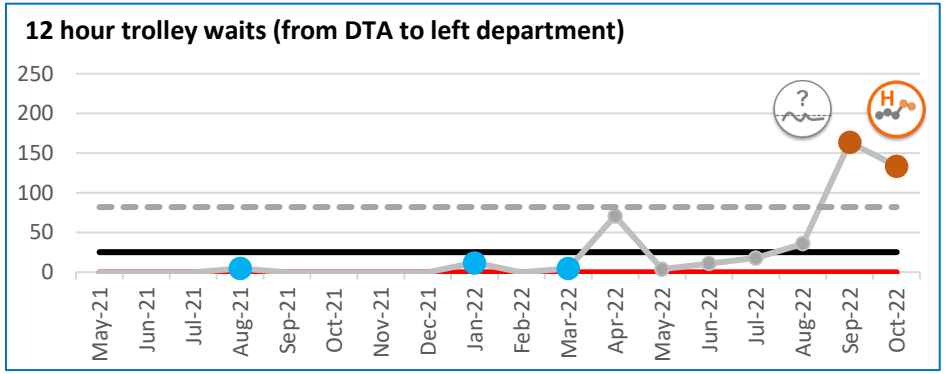
NHSI SOF Operational Performance & National Operational Standards

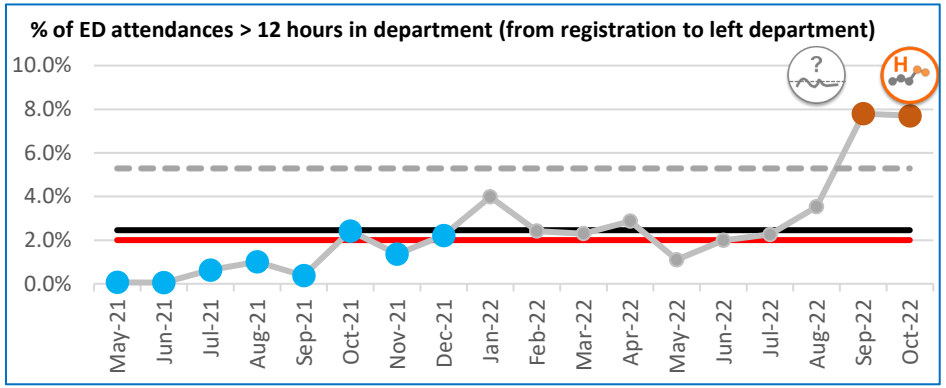
1. % of patients who spend 4 hours or less in A&E (target 95%)
2. National rank 4-hr performance our of all trusts
3. No. of attendances
4. No of waits in department > 12 hours
5. No of waits in department waiting longer than 12 hours for a bed

A&E Indicators	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Monthly Trend
Attendances: Type 1	5431	6091	6034	5950	5579	5796	6254	
Attendances: Type 3	3323	3625	3625	3457	3427	3215	3243	
Total Attendances	8754	9716	9659	9407	9006	9011	9497	
Total Breaches	2164	2148	2212	2116	2292	2484	2918	
Trust Total - % seen in 4 hours	75.3%	77.9%	77.1%	77.5%	74.6%	72.4%	69.3%	
National Rank (Accute trusts - Lower is better)	23	20	19	16	29	33	38	
12 hour trolley waits (DTA breaches)	71	4	11	18	36	164	134	
Volumne in department > 12hours	252	108	193	213	318	703	731	
A&E >12hour waits (target <2%)	2.88%	1.11%	2.00%	2.26%	3.53%	7.80%	7.70%	
Average bed occupancy	94.4%	92.8%	94.4%	95.1%	96.0%	96.8%	96.7%	









Situation

- Footfall and patient numbers increased in October to 9497 from 9011 in September, daily attendances averaged 25 per day more than October 2021 (representing an increase of 9.1%).
- The target for 12 hr dept times of no more than 2% of all attendances has not been met in October (7.7%, 731 cases), and has not been met since June.
- Overall time in the department remains high, (non-admitted 2 hours 59 minutes, admitted 10 hours)
- 134 x 12 hour trolley breaches recorded in the month, a reduction however from 164 in September.
- Bed occupancy levels are high averaging 96.7% in October, with a daily peak of 99.3% on the 16th October.

Context:

- Urgent and Emergency Care remains under significant pressure
- **In October pressures have continued to be acute as a result of high bed occupancy, lower social care discharges, reduced escalation area due to the work associated with the new operating model, and covid causing additional challenges in the managing and placing of patients**
- As a result of significant daily pressure the trust remains at OPEL 3, where it has been throughout all of September and October.

UEC Measures - Ambulance Handover Delays

Responsive

Gateshead Health NHS Foundation Trust

NHSI SOF Operational Performance & National Operational Standards
1. No. of ambulance delays
2. No. of ambulance diverts

Ambulance Arrivals and handover delays	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Monthly Trend
No. Patients arriving by Ambulance	1619	1803	1733	1748	1760	1753	1705	
% of handovers <15 Minutes	44.1%	46.7%	45.1%	42.5%	45.8%	38.2%	34.7%	
% of handovers 30-60 Minutes	94.9%	98.4%	97.3%	95.9%	97.1%	93.0%	92.9%	
Number of >30 Minute Breaches	72	26	40	63	45	106	112	
Number of >60 Minute Breaches	62	10	17	37	36	123	110	

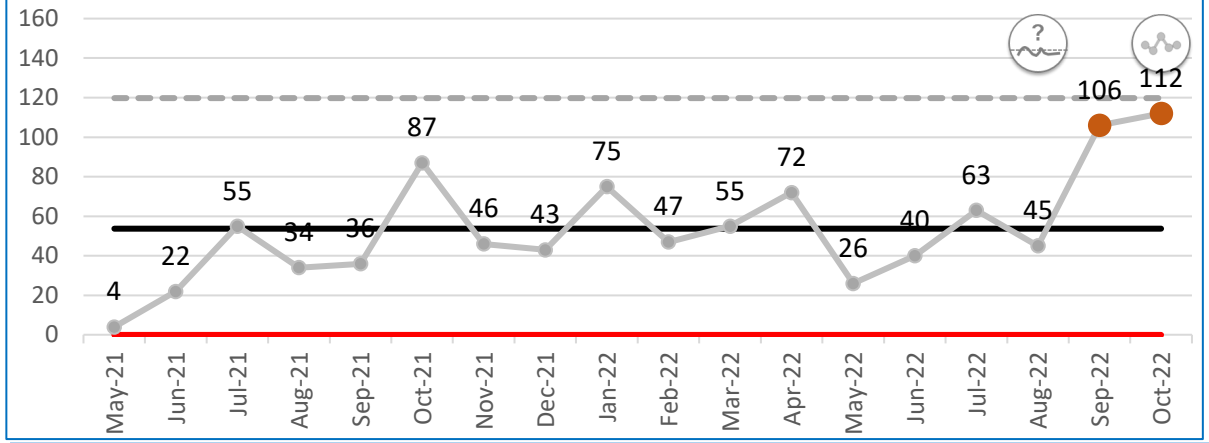
Background
The NHS Long Term Plan set out a vision to reduce Ambulance delays. Ambulance delays are risky as they delay assessment and treatment for those waiting in an ambulance queue. Delays can compromise safety in the community by reducing the number of ambulances available to respond to emergencies.

There is now greater focus on reducing ambulance delays following AACE publication of clinical review 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.

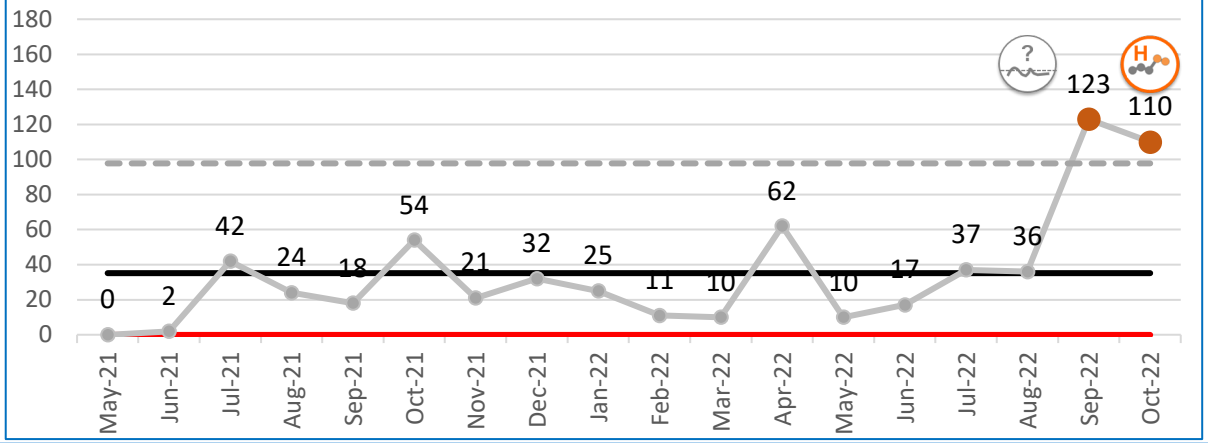
Situation
A noticeable increase in handover delays can be observed from July 2021. Special cause variation is observed for 30-60 minute delays with the number of delays above the mean for seven consecutive months between October 2021 and April 2022. This increased again in October 22, with 112 reported. Over 60 minute delays is displaying common cause variation with 110 delays in October 22.

Recommendation
NHS England visit took place in September to review good practice around ambulance handovers and fit to sit. Finance & Performance Committee continue to receive updates from service.

Ambulance handover delays 30-60 minutes



Ambulance handover delays 60 minutes +



UEC activity heatmap – last 2 months

Responsive

NHS Gateshead Health NHS Foundation Trust

Gateshead UEC and Acute Activity - Daily

September

	Thu-01/09/2022	Fri-02/09/2022	Sat-03/09/2022	Sun-04/09/2022	Mon-05/09/2022	Tue-06/09/2022	Wed-07/09/2022	Thu-08/09/2022	Fri-09/09/2022	Sat-10/09/2022	Sun-11/09/2022	Mon-12/09/2022	Tue-13/09/2022	Wed-14/09/2022	Thu-15/09/2022	Fri-16/09/2022	Sat-17/09/2022	Sun-18/09/2022	Mon-19/09/2022 (BH)	Tue-20/09/2022	Wed-21/09/2022	Thu-22/09/2022	Fri-23/09/2022	Sat-24/09/2022	Sun-25/09/2022	Mon-26/09/2022	Tue-27/09/2022	Wed-28/09/2022	Thu-29/09/2022	Fri-30/09/2022
No. of A&E Attendances	290	283	276	330	300	307	304	263	277	282	291	340	326	316	317	292	285	294	270	296	274	282	305	294	316	337	319	320	344	281
No. of admissions	103	84	83	69	87	101	124	96	104	71	60	92	113	104	99	111	83	63	73	104	88	93	91	67	68	83	116	100	103	98
No. of discharges	92	107	67	59	89	87	121	92	114	67	46	81	118	94	110	117	91	43	70	90	95	106	108	67	39	97	122	92	109	107
No. of emergency admissions	76	76	81	65	75	75	107	76	89	70	59	72	96	89	79	102	83	63	61	83	74	78	85	63	64	75	104	87	95	89
No. of emergency admissions via A&E	54	52	65	46	45	52	58	44	54	56	49	47	62	57	49	72	63	52	47	52	48	60	60	48	50	55	69	53	62	61
No. of patients arriving by Ambulance	67	54	64	65	45	61	67	53	55	67	54	58	58	63	72	61	58	46	55	54	47	51	64	65	57	50	60	61	55	66
Ambulance handover delays of 30 to 60 minutes	0	7	12	7	4	2	8	5	0	3	1	1	3	3	6	3	0	2	0	2	0	5	3	4	6	5	1	4	7	2
Ambulance handover delays of over 60 minutes	5	0	4	0	4	10	7	2	0	8	0	2	10	5	13	0	2	0	0	1	1	3	5	0	4	4	7	3	18	5
No. of 4 Hour Wait Breaches	82	68	97	104	89	90	105	85	87	81	64	95	88	97	89	78	74	45	43	63	76	88	98	89	66	85	83	78	86	89
4 hour performance	71.7%	76.0%	64.5%	68.2%	69.7%	70.7%	64.5%	67.3%	68.2%	70.6%	78.0%	71.8%	73.0%	69.3%	71.9%	73.3%	73.3%	84.7%	84.1%	78.7%	72.3%	68.8%	66.9%	69.7%	79.1%	74.5%	73.7%	75.0%	75.0%	68.0%
No. of waits for admission 4-12 hours from DTA	29	35	38	27	16	20	27	28	35	29	24	33	43	27	38	46	15	10	30	31	26	29	22	36	29	18	42	39	21	31
No. patients waiting over 12 hours in department	4	11	18	2	29	43	37	32	30	20	2	17	37	45	27	25	1	0	1	15	24	41	31	23	14	26	41	34	38	35
No. of waits for admission from DTA over 12 hours	0	0	1	2	14	20	13	4	3	1	0	0	0	16	0	0	0	0	0	0	6	16	11	0	1	14	7	2	22	11
No. of patients who do not meet the criteria to reside	48	49	56	57	55	47	56	48	46	46	44	44	44	45	49	47	54	55	54	62	59	60	61	61	62	64	57	51	45	44
No of beds open	447	444	444	440	445	445	446	449	445	445	445	445	445	446	440	440	440	440	439	444	445	442	442	440	439	436	442	431	429	426
% Beds Occupied	96.0%	93.0%	93.9%	97.7%	98.9%	98.0%	98.2%	97.6%	94.6%	97.3%	98.4%	98.9%	98.9%	96.9%	95.7%	91.8%	93.9%	96.4%	98.6%	99.3%	98.4%	98.4%	93.7%	95.7%	99.8%	98.9%	96.4%	95.8%	97.7%	95.1%

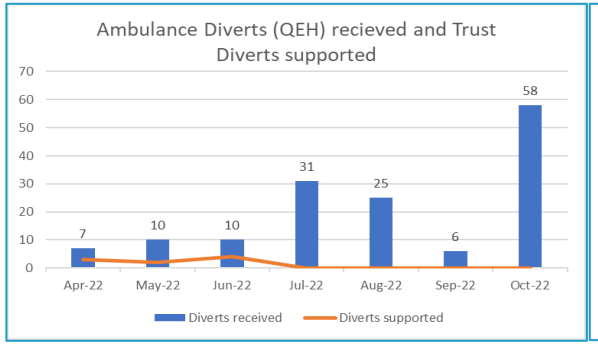
October

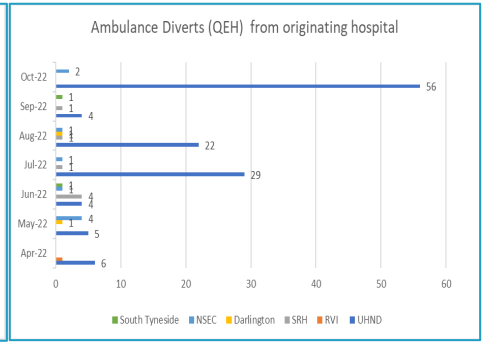
	Sat-01/10/2022	Sun-02/10/2022	Mon-03/10/2022	Tue-04/10/2022	Wed-05/10/2022	Thu-06/10/2022	Fri-07/10/2022	Sat-08/10/2022	Sun-09/10/2022	Mon-10/10/2022	Tue-11/10/2022	Wed-12/10/2022	Thu-13/10/2022	Fri-14/10/2022	Sat-15/10/2022	Sun-16/10/2022	Mon-17/10/2022	Tue-18/10/2022	Wed-19/10/2022	Thu-20/10/2022	Fri-21/10/2022	Sat-22/10/2022	Sun-23/10/2022	Mon-24/10/2022	Tue-25/10/2022	Wed-26/10/2022	Thu-27/10/2022	Fri-28/10/2022	Sat-29/10/2022	Sun-30/10/2022	Mon-31/10/2022
No. of A&E Attendances	318	307	374	334	297	289	255	288	304	324	321	340	324	287	312	284	360	326	291	275	278	303	317	345	284	279	229	310	284	293	356
No. of admissions	66	61	87	95	96	101	93	70	55	108	118	101	116	111	73	72	96	114	89	103	101	73	72	96	106	106	85	104	80	81	113
No. of discharges	61	32	83	101	103	100	105	58	39	103	116	108	105	110	71	54	97	120	105	88	115	65	63	93	113	83	95	130	70	61	106
No. of emergency admissions	65	50	78	80	86	88	83	68	53	94	93	84	97	97	72	69	78	92	82	83	94	72	70	83	97	98	70	95	80	81	94
No. of emergency admissions via A&E	47	50	49	56	58	59	47	49	44	65	55	53	58	63	55	50	53	70	50	49	59	51	53	54	62	65	46	56	53	66	62
No. of patients arriving by Ambulance	57	51	54	60	47	49	48	56	46	61	57	64	63	59	59	56	52	59	55	48	51	48	58	57	60	70	39	55	46	60	60
Ambulance handover delays of 30 to 60 minutes	3	5	3	3	3	5	4	5	0	5	2	3	3	5	4	1	4	4	1	1	2	2	1	5	16	3	2	6	7	2	2
Ambulance handover delays of over 60 minutes	3	3	0	10	2	1	0	0	3	4	7	8	1	2	8	3	2	0	0	0	2	7	5	6	5	9	0	0	7	0	12
No. of 4 Hour Wait Breaches	78	88	83	99	92	91	73	106	77	116	91	114	99	88	111	79	94	102	91	75	88	86	85	101	108	120	70	95	69	96	124
4 hour performance	75.4%	71.3%	77.6%	69.9%	68.6%	68.3%	71.3%	62.8%	74.7%	64.2%	71.7%	66.3%	69.3%	69.0%	63.7%	72.1%	73.9%	68.3%	68.5%	72.2%	68.0%	71.2%	73.1%	70.7%	61.4%	56.8%	69.2%	69.1%	75.5%	67.2%	65.2%
No. of waits for admission 4-12 hours from DTA	34	26	23	25	38	37	22	37	25	39	38	35	33	45	34	33	37	34	23	34	26	28	35	26	27	43	14	34	37	34	32
No. patients waiting over 12 hours in department	14	23	22	34	1	14	25	18	14	29	26	31	16	26	41	21	23	38	3	12	37	39	30	27	39	19	6	27	35	19	22
No. of waits for admission from DTA over 12 hours	1	12	6	17	1	0	10	0	0	1	0	1	0	0	5	0	5	7	0	0	17	16	5	8	17	0	0	0	5	0	0
No. of patients who do not meet the criteria to reside	42	40	39	41	41	35	37	40	41	40	42	44	42	41	45	47	47	43	40	41	41	43	39	38	37	37	38	40	38	35	32
No of beds open	426	435	430	439	438	430	427	435	439	442	441	467	450	447	451	458	449	443	446	444	440	448	448	459	462	460	458	458	450	464	465
% Beds Occupied	97.9%	99.3%	98.6%	96.6%	95.4%	96.7%	93.2%	93.6%	98.4%	96.4%	95.7%	91.6%	94.7%	99.1%	98.7%	99.3%	98.4%	98.6%	95.3%	97.7%	96.1%	96.0%	97.5%	97.6%	95.7%	97.4%	95.6%	94.1%	96.4%	97.6%	98.1%

Pressures

Operational Performance Pressures & Operational Supporting Standards

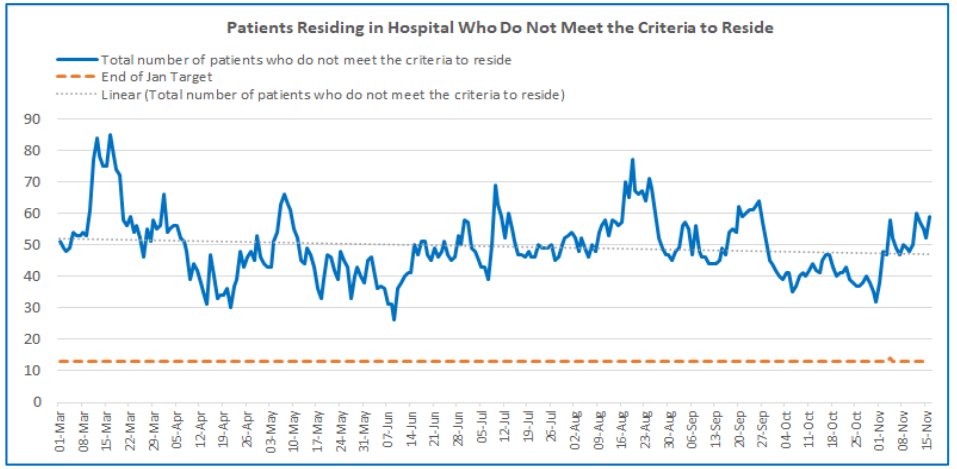
1. No. of ambulance diverts
2. No. of Beds Open over Planned Levels
3. No. of patients no longer meeting the Criteria to Reside
4. Patients discharged who no longer met the criteria to reside





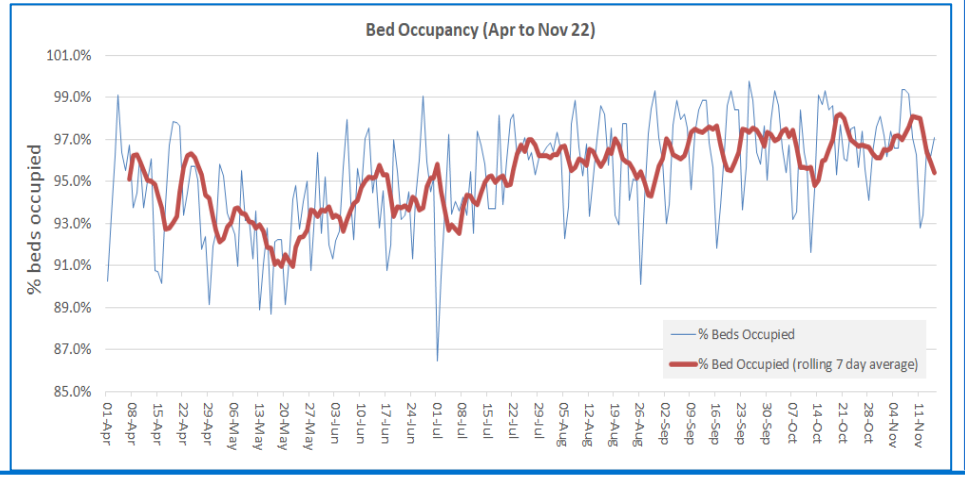
Handover Delays – 30-60 minutes

	2019/20																
Provider	Avge	Min	Max	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
Gateshead Health NHS Foundation Trust	40	5	99	87	46	43	87	47	55	72	26	40	63	45	106	112
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	93	65	109	116	97	66	102	83	123	90	84	90	107	93	114	137
Northumbria Healthcare NHS Foundation Trust	472	283	723	427	334	399	276	352	531	398	578	442	587	556	557	484
South Tees Hospitals NHS Foundation Trust	138	105	184	175	163	151	179	170	210	200	206	231	260	309	355	344
North Tees & Hartlepool NHS Foundation Trust	64	42	116	24	48	100	85	19	44	35	34	68	41	47	48	110
County Durham & Darlington NHS Foundation Trust	313	165	438	356	426	345	374	437	325	365	238	346	365	347	376	341
South Tyneside and Sunderland NHS Foundation Trust	313	208	471	419	463	501	464	373	292	363	354	493	446	461	402	520
North Cumbria University Hospitals NHS Trust	405	265	559	200	190	157	222	238	246	282	248	201	207	297	303	316
NENC	1836	1308	2612	1804	1767	1762	1789	1719	1826	1805	1768	1911	2076	2155	2261	2364



Handover Delays – 60 minutes +

	2019/20																
Provider	Avge	Min	Max	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
Gateshead Health NHS Foundation Trust	21	0	81	54	21	26	33	11	10	62	10	17	37	36	123	110
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	2	0	6	2	1	2	1	1	0	0	0	0	1	0	0	8
Northumbria Healthcare NHS Foundation Trust	79	24	206	189	76	120	52	93	183	84	122	87	110	102	125	171
South Tees Hospitals NHS Foundation Trust	47	10	117	120	129	133	156	172	178	183	208	278	419	291	320	565
North Tees & Hartlepool NHS Foundation Trust	6	1	18	11	32	47	13	7	3	8	4	15	6	24	12	29
County Durham & Darlington NHS Foundation Trust	178	32	404	401	269	271	253	254	161	265	127	286	340	359	420	401
South Tyneside and Sunderland NHS Foundation Trust	117	23	268	111	147	144	170	59	57	133	81	171	130	164	98	270
North Cumbria University Hospitals NHS Trust	72	26	117	65	39	35	75	95	71	85	90	71	100	184	228	209
NENC	522	227	1138	953	714	778	753	692	663	820	642	925	1143	1160	1326	1763



NHS Gateshead Health NHS Foundation Trust

Situation

- Even with the significant increases in handover delays, in October the Trust remained 2nd top performing Trust in the (ICS) region for 30-60m Ambulance hand-over times and improved to 4th for 60+ minute delays.
- Significant increase in Ambulance diverts in October, to 58, 56 of which were from Durham Hospital
- Patients who no longer meet the criteria to reside remain problematic, averaging daily 40 in October, an improvement from 52 September
- Out of area patients continue to account for notable numbers of patients and blocked beds (majority pathway 1)
- Additional beds are open over planned levels to accommodate patients who we are unable to discharge.

Context:

- Highest bed occupancy levels in ICS (Oct 22), Bed occupancy average 96.7% in October (peaking at 99.3%)
- Site pressures continue with beds blocked due to difficulties discharging patients
- Diverts increased in October - There were 58 conveyances supported by the Trust.

Community Teams and Rapid Response

NHS Gateshead Health NHS Foundation Trust

Community Teams

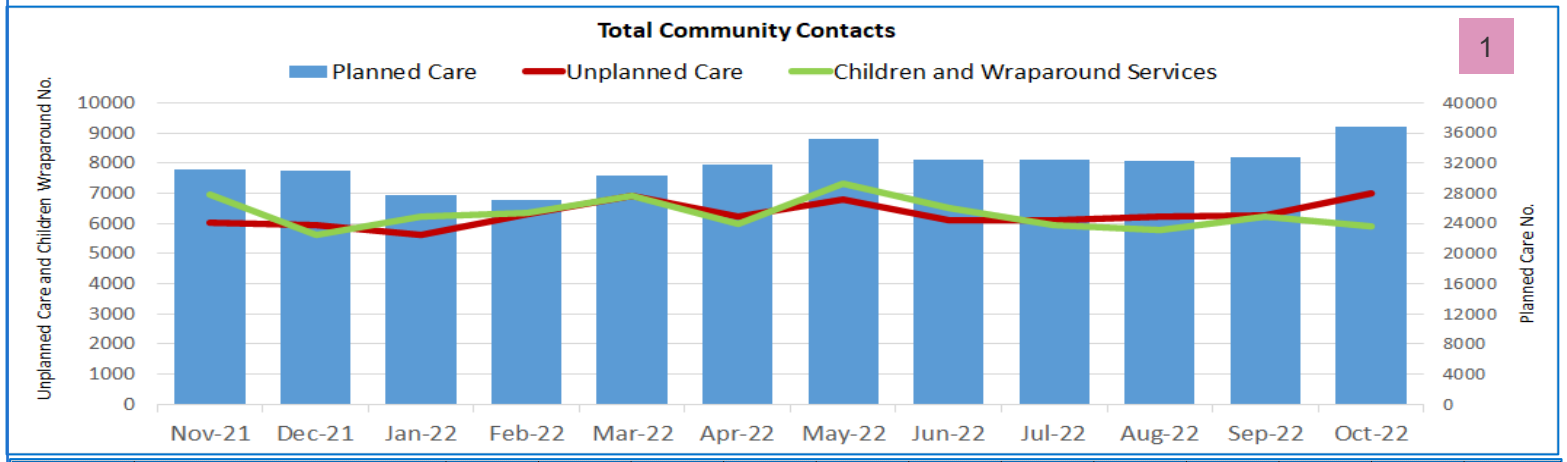
Community teams work with patients from birth to end of life to provide care to patients in their place of residence, clinic or education setting. The aim is to provide care close to home, avoiding admission, support early discharge and support patients to reach their maximum potential and independence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

The graphic (right) provides activity data for each of the areas above, for the past 12 months.



	Team	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
Total contacts	Planned care	31232	31055	27739	27134	30418	31804	35216	32543	32399	32369	32850	36775
	Unplanned care	6042	5932	5635	6316	6901	6238	6818	6114	6130	6216	6286	6990
	Children & Wraparound services	6962	5620	6239	6370	6907	5984	7333	6525	5932	5798	6219	5893

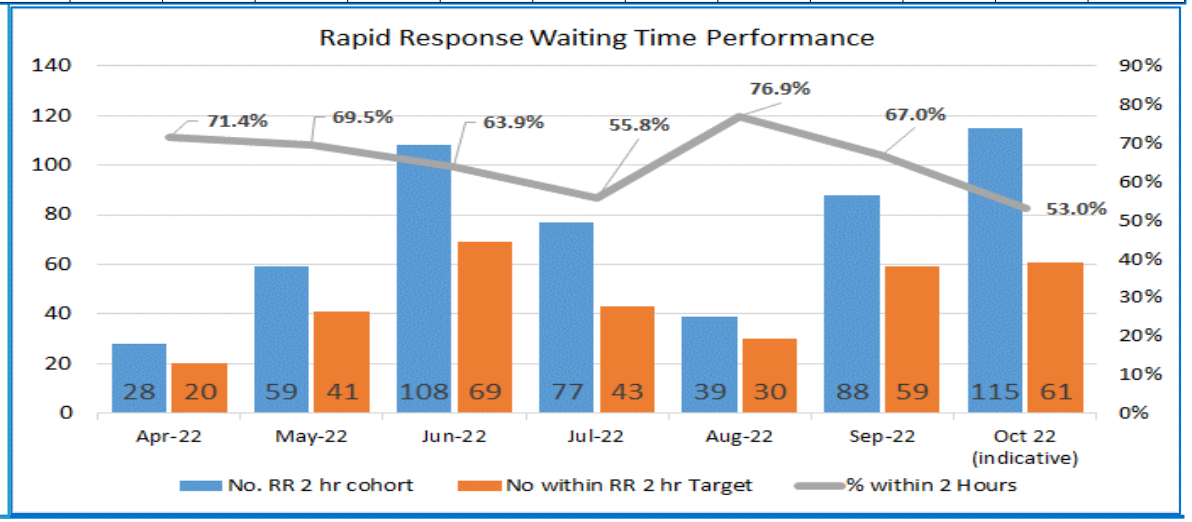
Rapid Response

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.

Monthly updates have been provided in the IOR since April. The Rapid Response team responded to 88 two-hour crisis response referrals in September and achieved a validated compliance rate of 67.0% for patients seen within 2 hours, slightly below the 70% compliance target. **Indicative** (currently being validated) performance for October is 115 referrals with a compliance rate of 53.0%. The requirement is to achieve this standard by Q3 2022.



Elective Care Activity & Recovery

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, 104% Day cases 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.

Elective Activity	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Monthly Trend
Total - Comined Elective Activity	93%	98%	102%	88%	101%	95%	87%	
Daycase	90%	103%	113%	85%	105%	103%	92%	
Elective Overnights	71%	71%	78%	68%	76%	86%	73%	
Outpatient - New	92%	107%	104%	90%	106%	103%	90%	
Outpatient - Followup	94%	96%	100%	88%	99%	92%	86%	
Total Outpatient	93%	98%	102%	89%	102%	100%	87%	

Indicative

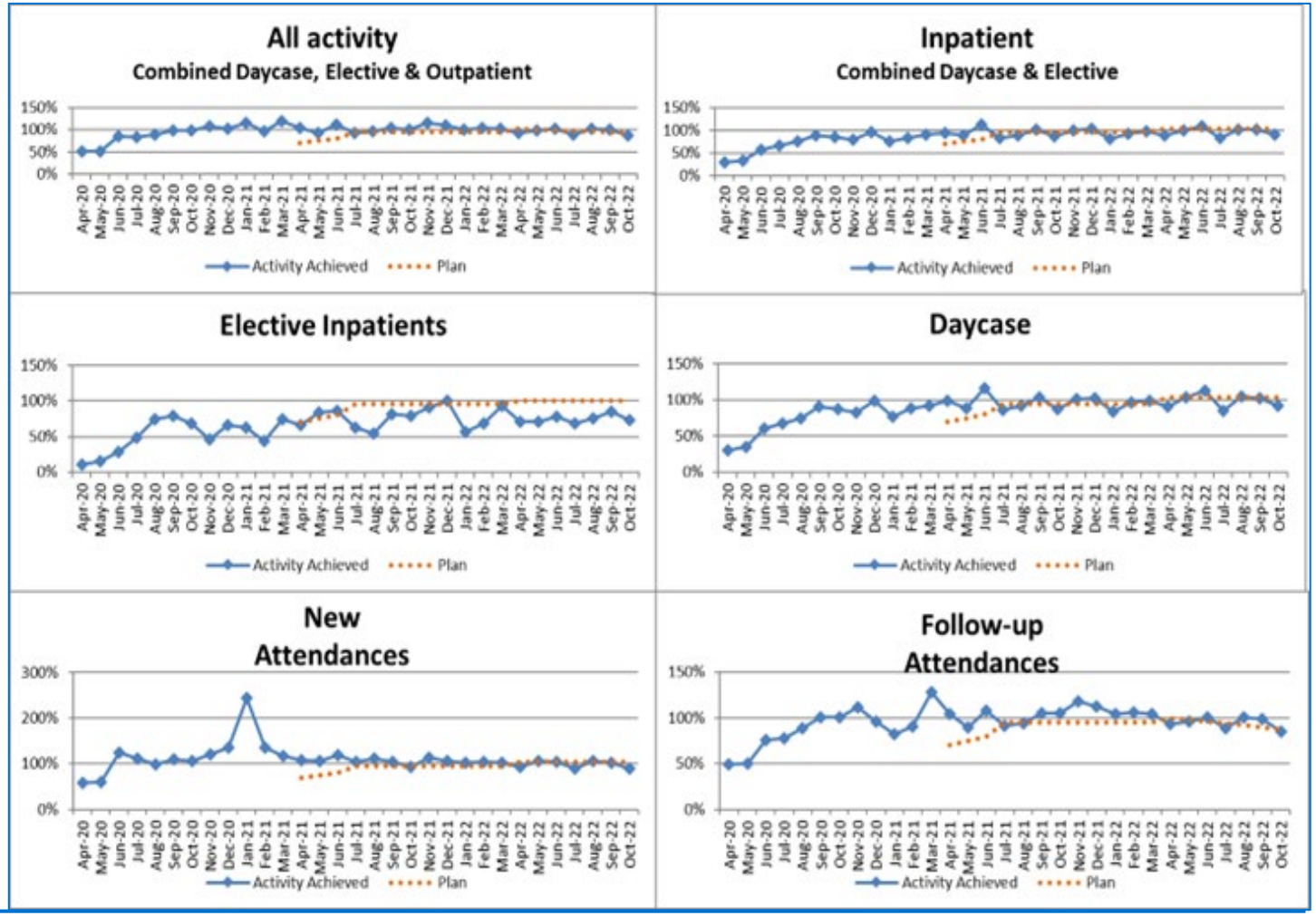
October Activity: (DRAFT) - Activity is below planed levels, and the lowest month overall of the year so far.

Combined elective activity 87%

- **Day cases 92%**
- **Elective inpatients 73%**
- **New Outpatients 90%**
- **FU Outpatients 86%**

Other key requirements:

- The Trust is reporting 18.8% of all outpatient attendances conducted remotely, which is below the 25% expectation.
- 2.59% of all OP recorded as Patient Initiated Follow-Up – which is below planned levels of 3.1%.



Activity & Recovery - Diagnostic

The expectation is to deliver 120% ICS diagnostic activity across the ICS. Trusts are expected to deliver as much as they can to support elective recovery. Overall October activity levels are at **111%** of activity in same period 19/20, **Endoscopy: 118%** of activity in same period 19/20, **Echocardiography: 89%** of activity in same period 19/20.

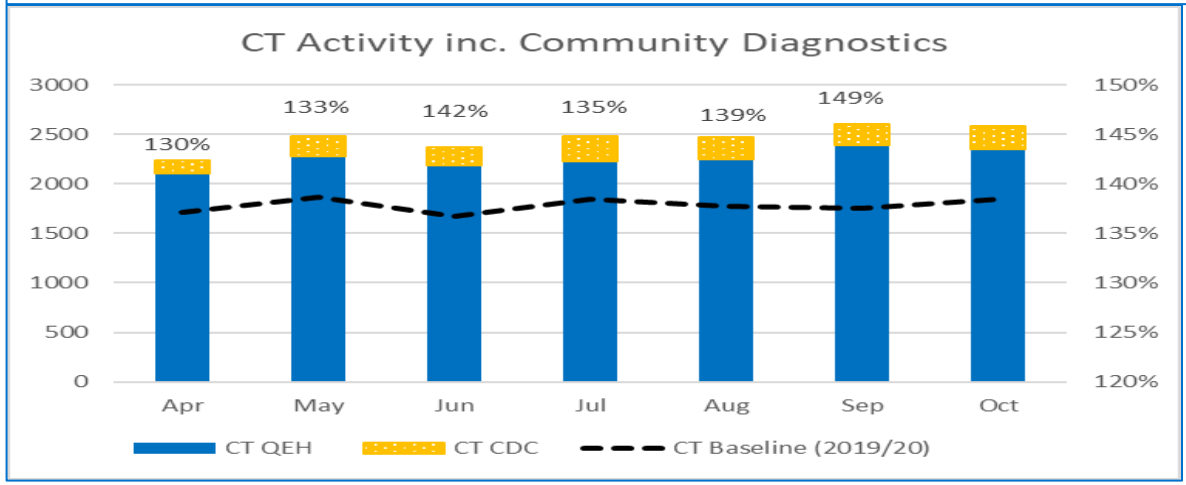
Diagnostic Activity Delivered	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Monthly Trend
Total - Total (100%)	100%	112%	110%	102%	111%	115%	111%	
MRI (120%)	91%	101%	100%	103%	105%	105%	94%	
CT (120%)	122%	122%	131%	121%	127%	136%	127%	
Colonoscopy (100%)	92%	106%	130%	90%	116%	120%	112%	
Non Obs Ultrasound (100%)	85%	100%	96%	83%	88%	93%	98%	
Flexi Sigmoidoscopy (100%)	66%	86%	73%	82%	124%	109%	76%	
Gastroscopy (100%)	86%	108%	109%	81%	125%	98%	98%	
Echo (100%)	73%	83%	76%	96%	90%	103%	89%	
Endoscopy (100%)	98%	127%	129%	105%	145%	128%	118%	

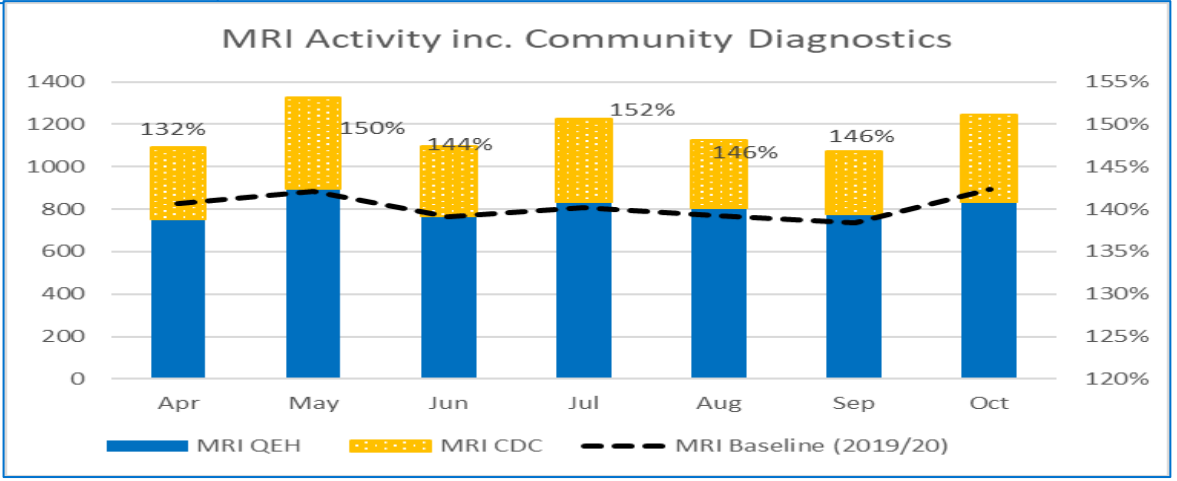
Indicative

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.

While MRI remains below the 120% target, data collated for October's IOR showed when Community Diagnostic Centre* modality activity is included – percentages are increased in excess of the required 120% activity levels for both MRI and CT.

Sept reports for CT would be 140% and MRI at 140% (see below).





Maximum 6-week wait for diagnostic procedures

Responsive

Gateshead Health NHS Foundation Trust

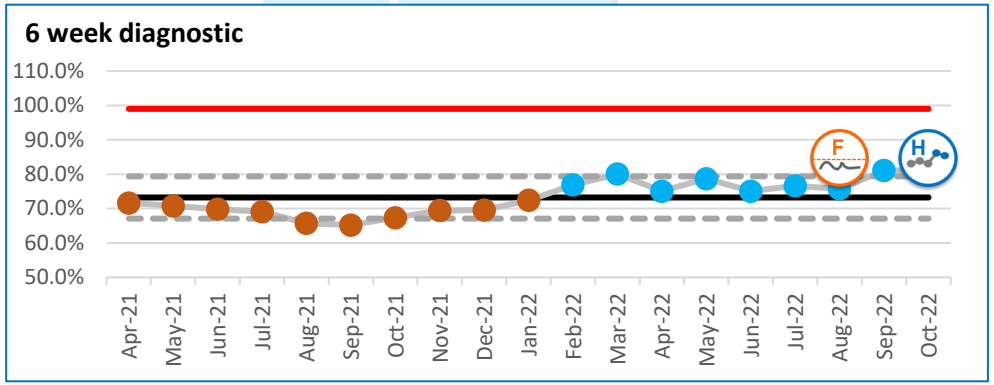
NHSI SOF Operational Performance & National Operational Standard

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

Trust's Diagnostic performance remained stable:

- Performance 81.2% in October, a slight increase from 81.2% in September.
- Overall Trust performance remains below both 99% and 95% targets
- Trust performance is in line with the latest NENC average of 81.3% and above national average of 70.2%
- In October 6 out of 12 specialities achieved the 99% target, and 9 the 2023 95% target
- Numbers waiting for a diagnostic test fell from 5681 in September to 5325 (356 reduction in month)
- Number of patients waiting >6 weeks fell from 1074 in September to 1003
- Echocardiography and Audiology continue to contribute to risk in achieving this standard, audiology performance falling to 48.9% in October, the lowest so far this year
- Echo noted a significant 9% increase in overall performance in September to 39.1%, increasing again to 42.7% in October
- Echocardiography recovery plan aims to recover the long waiters by February 2023, to date September and October target has been achieved.
- Audiology improvement trajectory plans for standards to be achieved in Summer 2023

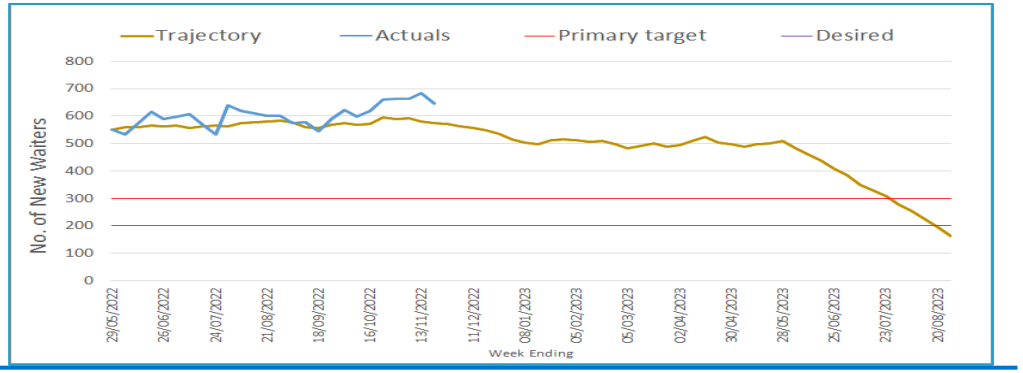
Diagnostic waiters <6 weeks	99% traditional standard							95 % Standard							Trend
	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	
Trust Total	75.1%	78.7%	75.1%	76.6%	75.8%	81.1%	81.2%	75.1%	78.7%	75.1%	76.6%	75.8%	81.1%	81.2%	
Barium Enema	98.3%	100.0%	98.4%	100.0%	96.6%	97.6%	100.0%	98.3%	100.0%	98.4%	100.0%	96.6%	97.6%	100.0%	
CT	99.4%	99.5%	99.0%	99.6%	99.5%	99.8%	99.5%	99.4%	99.5%	99.0%	99.6%	99.5%	99.8%	99.5%	
MRI	96.7%	97.6%	99.6%	99.2%	98.0%	98.9%	99.3%	96.7%	97.6%	99.6%	99.2%	98.0%	98.9%	99.3%	
Non-Obstetrc Ultrasound	89.9%	99.6%	99.0%	99.2%	98.5%	99.3%	99.3%	89.9%	99.6%	99.0%	99.2%	98.5%	99.3%	99.3%	
Audiology	56.7%	57.1%	55.5%	57.2%	57.6%	54.9%	48.9%	56.7%	57.1%	55.5%	57.2%	57.6%	54.9%	48.9%	
Urodynamics	86.7%	90.0%	88.2%	100.0%	100.0%	95.2%	96.0%	86.7%	90.0%	88.2%	100.0%	100.0%	95.2%	96.0%	
Colonoscopy	95.6%	97.7%	98.7%	94.8%	96.2%	96.2%	94.5%	95.6%	97.7%	98.7%	94.8%	96.2%	96.2%	94.5%	
Flexi-Sig	94.3%	93.5%	97.7%	100.0%	98.2%	97.5%	100.0%	94.3%	93.5%	97.7%	100.0%	98.2%	97.5%	100.0%	
Gastroscopy	95.0%	96.8%	98.1%	98.4%	98.2%	98.3%	96.9%	95.0%	96.8%	98.1%	98.4%	98.2%	98.3%	96.9%	
Dexa	97.2%	97.9%	98.8%	99.2%	98.3%	97.7%	98.0%	97.2%	97.9%	98.8%	99.2%	98.3%	97.7%	98.0%	
Echo Cardiology	32.6%	38.4%	30.0%	29.1%	30.1%	39.1%	42.7%	32.6%	38.4%	30.0%	29.1%	30.1%	39.1%	42.7%	
Cystoscopy	83.5%	85.7%	89.6%	94.2%	96.7%	97.8%	100.0%	83.5%	85.7%	89.6%	94.2%	96.7%	97.8%	100.0%	



Echocardiography 6 Week Performance Recovery Trajectory:

ECHO	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Total waiting List (projection)	1328	1294	1143	828	646	499	450
> 6 weeks	925	744	505	194	62	5	4
% within 6 weeks	30.3%	42.5%	55.8%	76.6%	90.4%	99.0%	99.1%
Total waiting List	1183	1028					
> 6 weeks	721	589					
% within 6 weeks	39.1%	42.7%					
Difference to projection (%)	8.7%	0.2%					
Met recovery trajectory	Yes	Yes					

Audiology Recovery Trajectory:



Referral to Treatment

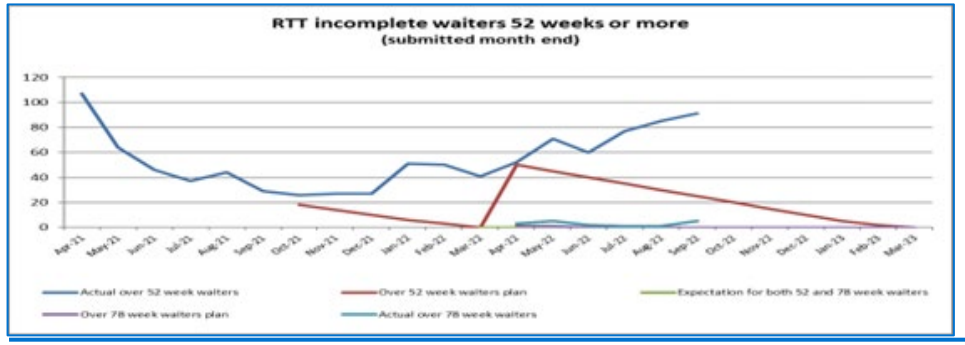
Responsive

Gateshead Health NHS Foundation Trust

RTT % Within 18 weeks (92%)	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Monthly Trend
Trust	74.2%	75.9%	76.3%	75.8%	75.1%	74.3%	73.4%	
General Surgery	79.5%	80.4%	79.0%	75.8%	78.0%	79.8%	79.0%	
Gynaecology	72.8%	77.3%	80.8%	80.2%	78.0%	81.7%	80.5%	
Trauma & Orthopaedics	64.2%	66.7%	67.0%	66.2%	64.0%	63.2%	62.6%	
Urology	77.7%	78.2%	73.3%	74.8%	75.5%	77.5%	76.2%	
Paediatrics	76.3%	74.6%	74.8%	73.3%	69.6%	68.5%	69.1%	
Cardiology	76.5%	78.7%	76.4%	74.5%	72.0%	69.6%	71.2%	
Gastroenterology	72.7%	78.1%	87.7%	90.0%	88.4%	80.8%	77.2%	
General Medicine	64.0%	78.1%	75.0%	86.2%	95.0%	76.9%	88.9%	
Geriatric Medicine	87.3%	91.2%	95.4%	89.7%	88.6%	89.1%	86.8%	
Respiratory Medicine	68.9%	69.1%	66.2%	65.2%	67.8%	64.4%	60.9%	
Rheumatology	83.5%	84.3%	80.1%	81.0%	83.6%	82.6%	83.2%	
Other	75.3%	73.3%	72.2%	71.9%	70.6%	69.2%	69.2%	

Number of 52 week waiters (at month end)

Waiters at month end		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Trend
Total Waiters	Actual	11336	11542	11604	11949	12244	12430	12837	
52w waiters	Plan	50	45	40	35	30	30	20	
	Actual	52	71	58	77	81	91	89	
General Surgery	Actual	13	12	8	12	10	17	10	
Gynaecology	Actual	7	2	1	2	1	2	0	
Trauma & Orthopaedics	Actual	16	21	25	31	28	31	17	
Urology	Actual	4	4	1	0	1	1	1	
Paediatrics	Actual	0	14	12	13	16	17	24	
Cardiology	Actual	1	0	0	3	5	2	3	
Gastroenterology	Actual	5	5	3	1	4	4	7	
Respiratory Medicine	Actual	3	4	4	7	3	9	13	
Other	Actual	3	9	4	8	13	8	14	
78w waiters	Plan	1	1	0	0	0	0	0	
	Actual	3	5	2	1	1	5	2	



NHSI SOF Operational Performance & National Operational Standard

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

Trust's RTT performance

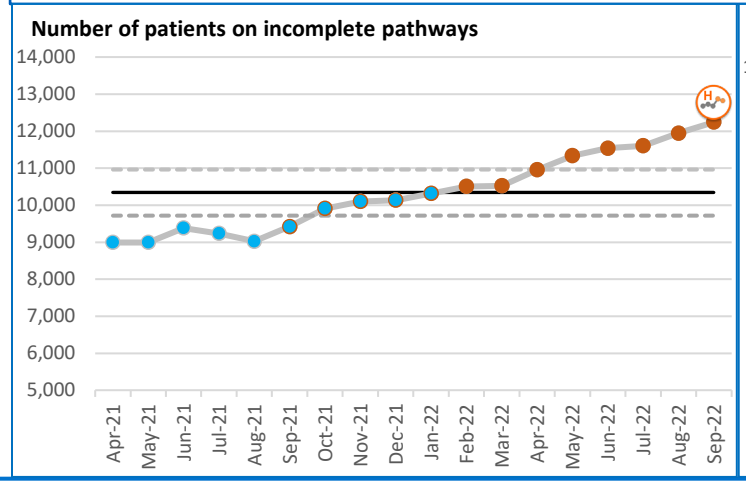
- October performance 73.4% (indictive) compared with 74.3% in September, below the 92% target
- At 73.4% Trust performance was above latest national average 59.4% (Sept 22), and ICB average of 71.1% (Sept 22)
- Total waiting list increased from 12,430 in September to 12,837 in October (indicative)
- The number of long waiters (52 weeks or more) remained above plan levels but slightly
- 52 week waiters reduced from 91 in September to 89 end of October (indicative)
- 2 patients were waiting over 78 weeks end of October (indicative), a fall from 5 in September under a General Surgery speciality

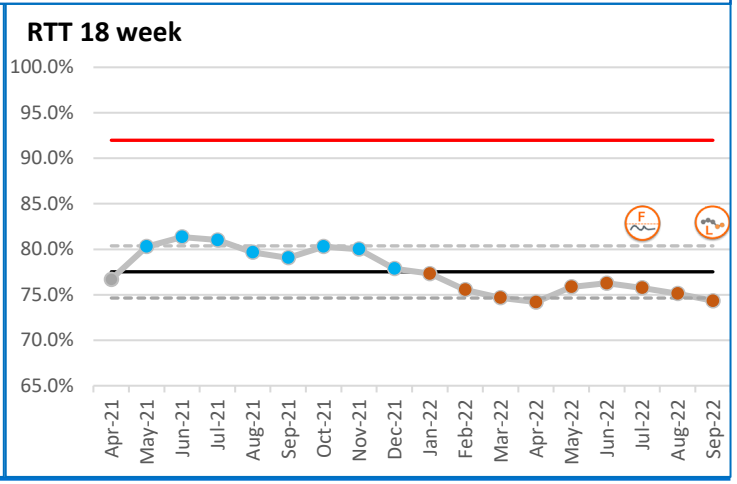
Risks: Continues Increases in > 52 weeks over planned levels in October (indicative):

- T&O 17 (-14), Paediatrics 24 (+7), General Surgery 10 (-7), Gastroenterology 7 (+3), Gynaecology 0 (-2), Cardiology 3 (+1), Respiratory medicine 13 (+4), Other 14 (+6)

Main Risks

- Outpatient capacity to review the backlog
- Theatre capacity / Theatre workforce
- Staffing pressures / bed capacity
- Capacity for autism assessments in Paediatric 52 week patients – proposal being drafted by the ICB supported by the Trust to support an increase capacity (paper currently out for comment, expected early December)





Cancer Standards - 2 Week Waits

Responsive

NHS Gateshead Health NHS Foundation Trust

NHSI SOF Operational Performance & National Operational Standard

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

2ww performance - target 93%	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Monthly Trend
Trust	84.8%	89.4%	88.8%	89.1%	84.7%	79.9%	84.2%	
Breast	92.4%	97.4%	94.9%	97.0%	96.8%	93.2%	92.8%	
Gynae	78.3%	95.5%	89.8%	82.4%	86.4%	73.6%	85.9%	
Lower GI	87.4%	80.0%	82.8%	67.6%	45.8%	36.4%	38.7%	
Testicular	70.0%	85.7%	100.0%	100.0%	100.0%	100.0%	100.0%	
Urology	84.2%	79.0%	71.2%	83.2%	84.4%	94.2%	91.4%	
Haematology	100.0%	100.0%	88.9%	100.0%	92.3%	86.7%	100.0%	
Lung	21.7%	43.1%	65.7%	77.4%	74.6%	47.2%	73.7%	
Upper GI	83.5%	82.1%	79.5%	86.5%	84.8%	74.6%	75.4%	
Symptomatic Breast	96.8%	97.8%	93.6%	94.5%	95.0%	90.3%	100.0%	

Indicative

Trust's 2 week wait Cancer performance

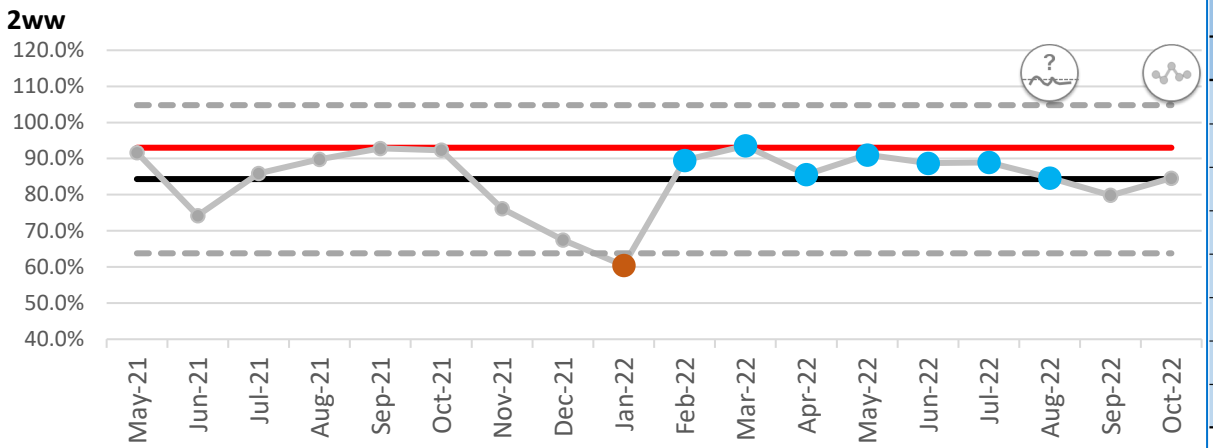
- Indicative performance for October is 84.2%, a 4.3 percentage point increase from 79.9% in September.
- 84.2% remains below the 93% target
- 84.2% is above the latest national average 72.6 (sept 22) and NENC average 72.6% (sept 22)

Tumour Update:

- Breast and Testicular tumour sites exceeding the 93% target since June, however Breast did not achieve the standard in October (indicative)
- Pressures in September and October for most other tumour sites
- Activity volumes for most tumour sites in September and October higher than 19/20 levels, with the exception of lower GI

Risks

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



Volumes as a % of 2019/20 Activity	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
Trust	99%	121%	125%	104%	140%	112%	115%
Breast	102%	122%	151%	126%	141%	122%	123%
Gynae	110%	141%	152%	129%	172%	164%	196%
Lower GI	108%	114%	89%	60%	120%	84%	65%
Testicular	200%	88%	38%	40%	138%	100%	100%
Urology	87%	132%	96%	117%	163%	132%	104%
Haematology	125%	144%	129%	100%	186%	136%	75%
Lung	98%	138%	108%	63%	158%	91%	116%
Upper GI	80%	101%	106%	84%	119%	78%	107%

Indicative

Cancer Standards – 28 day Faster Diagnosis

Responsive

Gateshead Health NHS Foundation Trust

Trust's 28 day Faster Diagnosis performance:
- Trust has achieved 75% target all months since June 22
- Indicative performance for October is 83.2%, a 8 percentage point increase from 75.2% in September
- 83.2% is above the latest national average 67.2% (sept 22) and NENC average 72.9% (sept 22)
- This measure will replace the 2 Week wait in future.

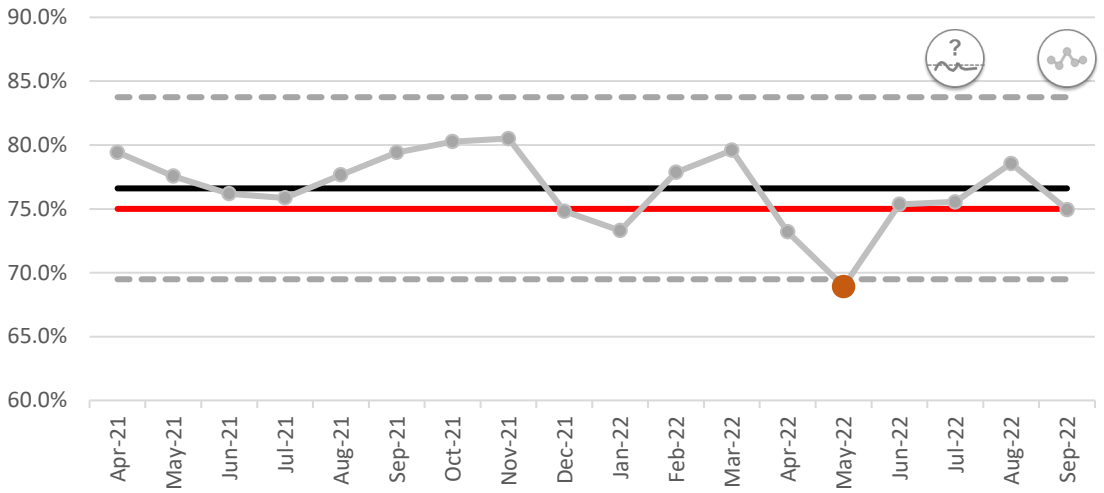
Tumour Update:
- Performance Risks across most specialties - Particular challenged specialties Lung, Gynae, Lower GI, Urology and Upper GI, Testicular
- Breast and Symptomatic Breast sites exceeding the 75% target in each of the last 7 months
- Lung are the first to go-live with Best Practice Timed Pathways
- Implementation of BPTP in the remaining tumour groups is underway

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

NHSI SOF Operational Performance & National Operational Standard

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

28 day



Faster Diagnosis Standard - target 75%	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Monthly Trend
Trust	73.2%	68.9%	75.4%	75.6%	78.5%	75.2%	83.2%	
Breast	96.8%	96.6%	96.9%	97.8%	98.5%	98.0%	98.2%	
Gynae	49.1%	46.0%	59.5%	64.7%	70.7%	69.6%	65.4%	
Lower GI	46.0%	36.1%	42.7%	44.4%	49.7%	52.0%	53.6%	
Testicular	100.0%	100.0%	66.7%	100.0%	100.0%	66.7%	50.0%	
Urology	28.1%	27.0%	30.4%	44.4%	50.6%	66.7%	65.8%	
Haematology	81.8%	100.0%	87.5%	57.1%	62.5%	64.3%	33.3%	
Lung	36.0%	38.1%	74.5%	62.1%	80.8%	53.8%	70.7%	
Upper GI	53.1%	50.8%	52.5%	51.7%	53.9%	41.5%	58.1%	
Symptomatic Breast	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	

Indicative

Cancer Standards - 31 Day Waits

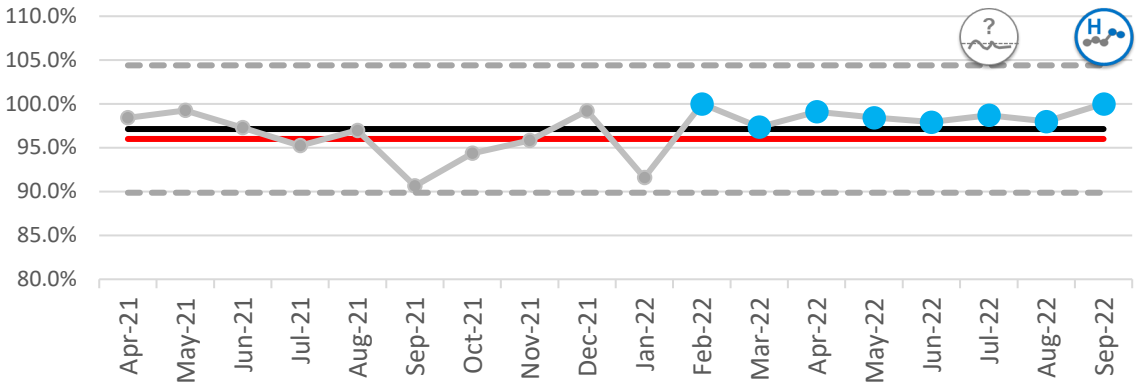
Responsive

Gateshead Health NHS Foundation Trust

NHSI SOF Operational Performance & National Operational Standard

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

31 day



Trust's 31 day cancer performance:

- Trust has exceeded the 31 day standard every month this year
- Trust's Cancer performance for October is 99.2% (indicative) against the 31 Day standard, with the Drug and Surgery subsequent treatment also achieved
- 99.2% is above the latest national average 91.1% (sept 22) and NENC average 89.1% (sept 22)
- **NOTE:** September and October data is indicative and is subject to change following sharing of information between Trusts and breach data being confirmed across pathways

Tumour Update:

- All tumour sites have achieved the target in the last 2 months

Risks

- Capacity / shared pathways
- Theatre workforce pressures
- Gynaecology – supporting ICS wide cancer treatments

31 day performance - target 96%	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Monthly Trend
Trust	99.1%	98.4%	97.9%	98.7%	98.0%	100.0%	99.2%	
Breast	97.7%	100.0%	100.0%	100.0%	98.6%	100.0%	100.0%	
Gynae	100.0%	92.6%	89.3%	94.1%	95.2%	100.0%	100.0%	
Lower GI	100.0%	100.0%	100.0%	100.0%	91.7%	100.0%	93.3%	
Urology	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Haematology	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Lung	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Sarcoma	100.0%	NA	100.0%	NA	NA	NA	NA	
Upper GI	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Other	NA	100.0%	NA	100.0%	100.0%	100.0%	NA	
						Indicative		
Susequent Treatments	**Apr-22**	**May-22**	**Jun-22**	**Jul-22**	**Aug-22**	**Sep-22**	**Oct-22**	**Monthly Trend**
Surgery	94.7%	100.0%	100.0%	93.8%	100.0%	96.0%	100.0%	
Drug	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.6%	

Volumes as a % of 2019/20 Activity	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
Trust	90.2%	99.2%	126.1%	106.3%	120.8%	97.7%	72.6%
Breast	85.7%	90.0%	129.3%	111.8%	147.9%	91.5%	63.8%
Gynae	68.0%	112.5%	116.7%	100.0%	75.0%	79.2%	85.2%
Lower GI	114.3%	55.6%	115.4%	114.3%	107.7%	100.0%	88.2%
Urology	100.0%	190.9%	158.3%	138.5%	175.0%	150.0%	144.4%
Haematology	128.6%	71.4%	83.3%	55.6%	80.0%	71.4%	85.7%
Lung	86.7%	140.0%	141.7%	87.5%	50.0%	91.7%	50.0%
Upper GI	122.2%	50.0%	166.7%	116.7%	333.3%	300.0%	40.0%

INDICATIVE

Cancer Standards - 62 Day Waits

Responsive

NHS Gateshead Health NHS Foundation Trust

Trust's 2 62 day cancer performance

- Performance improvement to 70.5% in September, the highest since April but reduction to 56.5% (indicative) in October
- Latest national average 60.5% (sept 22) and NENC average 63.1% (sept 22)
- **The Trust reported 57 patients waiting over 62 days on a 2ww classic pathway (7.9% of the total waiters on a 62 day 2ww classic pathway) (139 on all pathways (15.4% of total waiters)).**
- Within the operational guidance 'Systems are being asked to plan to restore >62-day backlogs to the relative backlog using urgent suspected cancer referral volumes seen in Q3 2019/20 compared to the overall national backlog for the w/e 16th February'; for Gateshead this was a position of 55 however due to the pressures supporting the ICS the Trust submitted a plan of 55 at October 2022, reporting 57 for the month, the plan has not been met.
- The number of long waits (>104 days) on a 62 day (2ww) pathway at the end of October had decreased to 11 patients (1.5% of total waiters on a 62 day 2ww classic pathway) (30 on all pathways (3.3% of total waiters).

Tumour Update:

- Performance Risks across all specialties to achieve 85%
- Monthly positions are variable but particularly challenged specialties continue to be Gynae, Lower GI, Upper GI and Urology

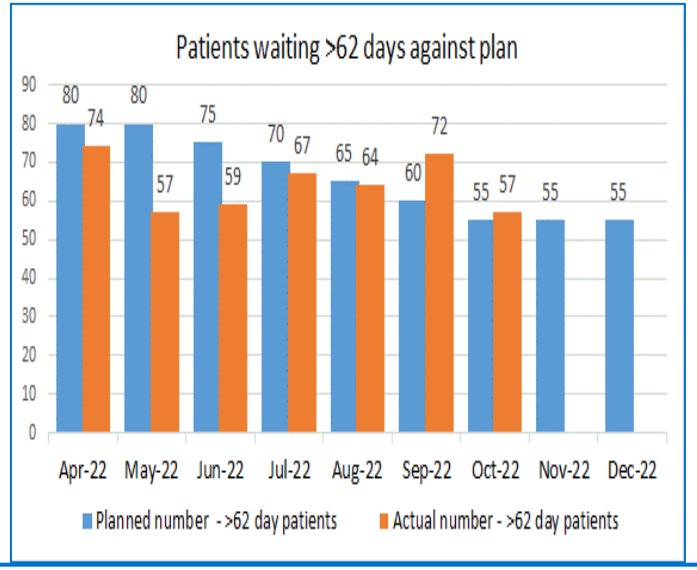
Risks

- Capacity / shared pathways (urology/lung)
- Theatre capacity
- Staffing

NHSI SOF Operational Performance & National Operational Standard

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

62 day performance - target 85%	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Monthly Trend
Trust	67.2%	34.5%	53.6%	63.2%	56.7%	70.5%	56.5%	
Breast	93.3%	91.7%	81.1%	96.6%	78.7%	85.7%	82.4%	
Gynae	44.4%	4.2%	20.0%	54.2%	50.0%	53.8%	38.9%	
Lower GI	NA	0.0%	53.3%	16.7%	50.0%	46.2%	40.0%	
Urology	13.6%	20.0%	22.2%	21.4%	32.6%	53.3%	38.1%	
Skin	NA	0.0%	NA	NA	NA	NA	NA	
Haematology	80.0%	66.7%	75.0%	NA	100.0%	0.0%	57.1%	
Lung	54.5%	30.0%	40.0%	42.9%	61.5%	88.2%	80.0%	
Sarcoma	100.0%	NA	100.0%	0.0%	NA	NA	0.0%	
Upper GI	100.0%	NA	100.0%	57.1%	0.0%	60.0%	50.0%	
Other	100.0%	NA	100.0%	100.0%	100.0%	100.0%	NA	
						Indicative		



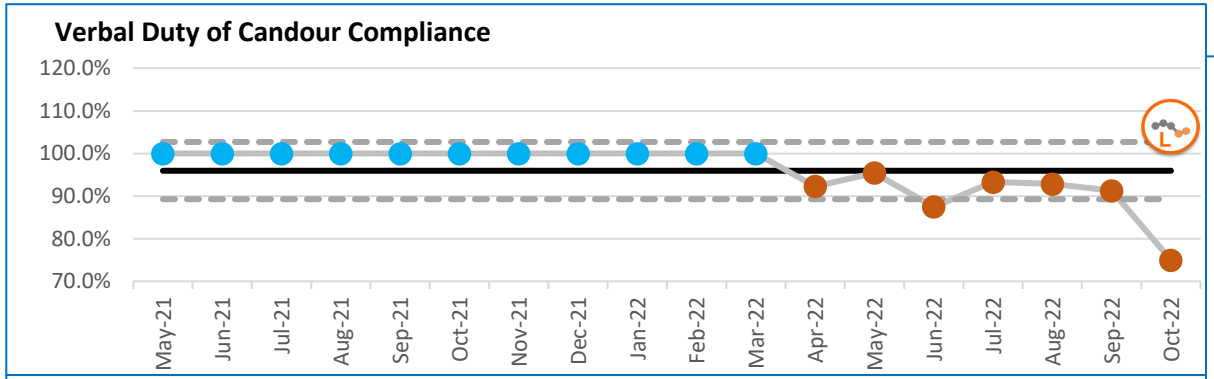
Cancer - Patients waiting more than 62 days							
63 to 104 days	April	May	June	July	Aug	Sept	Oct
Breast	4	2	1	7	4	2	4
Gynaecological	15	4	11	5	11	17	14
Haematological	8	4	1	3	0	2	2
Lower Gastrointestinal	5	3	6	6	8	12	3
Lung	4	6	1	3	4	2	8
Upper Gastrointestinal	7	8	6	11	16	12	9
Urological	14	17	26	15	12	11	6
Other	1	1	0	0	0	0	0
63 to 104 days total	58	45	52	50	55	58	46
Over 104 days	April	May	June	July	July	Sept	Oct
Breast	1	1	0	0	1	1	0
Gynaecological	7	3	1	3	1	4	3
Haematological	2	2	0	1	0	0	1
Lower Gastrointestinal	0	1	0	1	1	1	3
Lung	2	1	1	1	1	1	0
Upper Gastrointestinal	0	0	1	1	4	7	1
Urological	3	3	3	9	1	0	3
Other	1	1	1	1	0	0	0
Over 104 day total	16	12	7	17	9	14	11
Total No. Patients	74	57	59	67	64	72	57

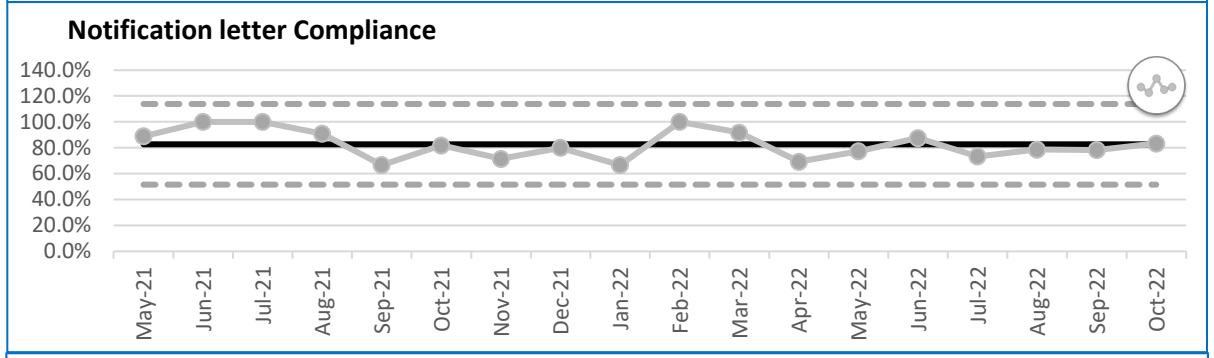
Report by exception: Responsive – Duty of Candour Compliance

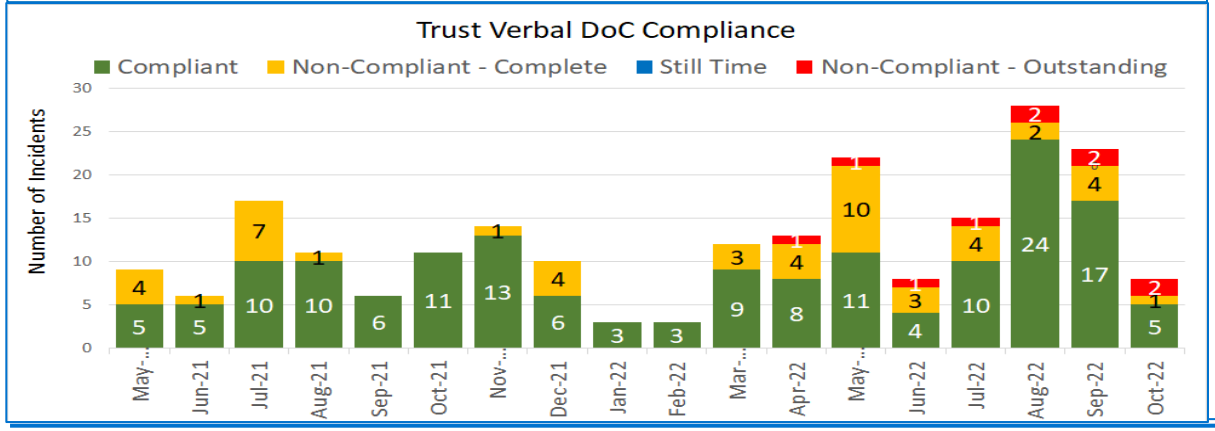
Detail on this measure is included as special cause variation (low) is identified from April 2022

Responsive

Gateshead Health NHS Foundation Trust







Situation

- Verbal Duty of Candour compliance is displaying special cause variation for concern since April.

Background

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

Assessment

- Duty of Candour depicted here show compliance with the actions being completed and not the whether this was done within the Trust timescales for notification letter. Verbal DOC is currently recorded from the date of the incident being reported and not when the organisation agrees a notifiable patient safety incident has occurred, and to some extent this means they are often not completed within the ten day requirement set in the system.
- For October there are ten incidents (one completed since report run) that currently require DOC to be enacted verbally that are out of time and remain incomplete. Reminders and offers of support have been made from the legal and patient safety team.

Actions

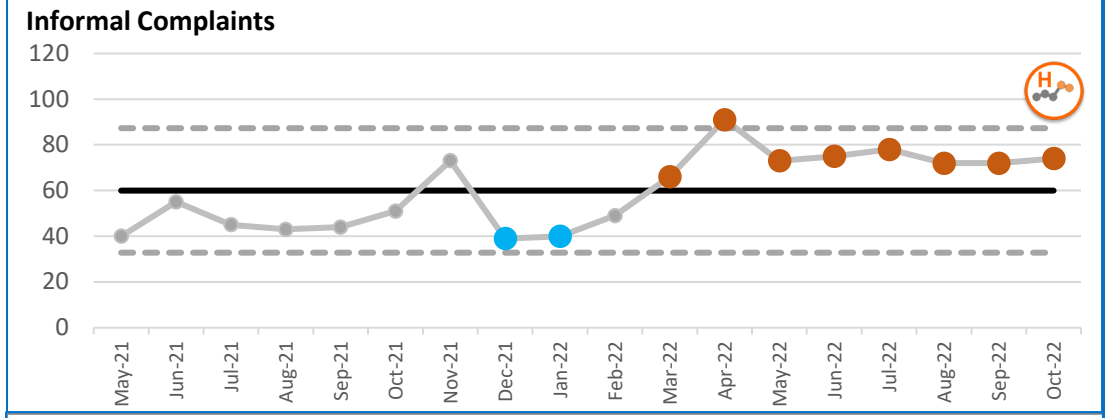
- The Datix system add complexity to recording DOC and it inflexibility further hampers recording from when a notifiable patient safety incident is identified and agreed
- The DOC allocation responsibility within the DATIX system often sits with matrons and SLM's and not the attending clinicians
- There are some identified themes in relation to the overdue notifications which are being addressed

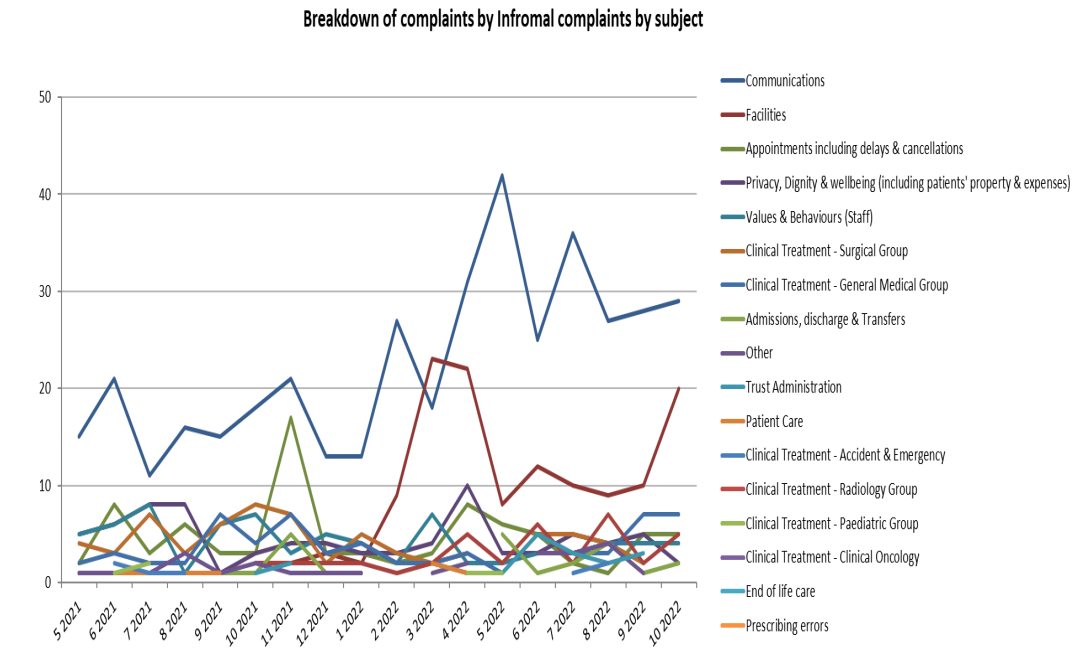
Report by exception: Responsive – Informal Complaints

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

Responsive

Gateshead Health NHS Foundation Trust





Situation

The number of Informal complaints (PALS) is triggering special cause variation for concern. The figures have exceeded the 18 month average for 8 consecutive months

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 shift in the number of informal complaints has been observed from March 2022, which coincides with increased family members visiting patients on site as Covid-19 restrictions lifted. The themes noted in October are:

- Communications (29)
- Facilities (20)
- Clinical treatment (Medicine) (7)
- Appointments including delays & cancellations (5)
- Values & Behaviours (Staff) (5)

Concerns raised by patients about Parking Eye issues continues and this is one of the reasons for the increase in PALS. In November, a meeting was scheduled with QEF to discuss the processes and management of Parking Eye concerns and for a decision on the most appropriate place for these concerns to be received. The requested individuals did not attend the meeting.

The PALS teams are also receiving large numbers of requests from switchboard, when they have been unable to transfer calls to the appropriate areas. This could be to discuss an appointment, or queries about relatives care on wards. As such, these concerns are being logged on the system as required, and tis is further increasing the number of concerns raised on a monthly basis.

Actions

A further meeting will be scheduled with QEF to discuss the process and management of Parking Eye concerns, and with the switchboard team. We welcome all feedback, whether positive or negative and will continue to monitor the number of informal concerns received. Where it is identified that wards require additional support, particularly to enhance communication, 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.

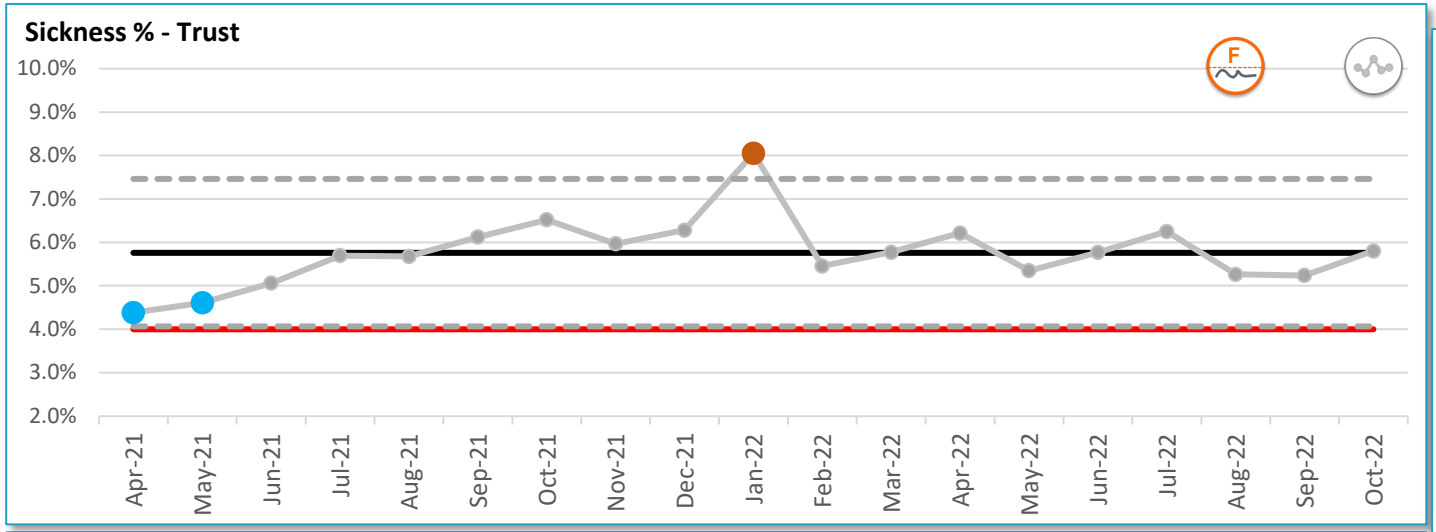
Recommendation

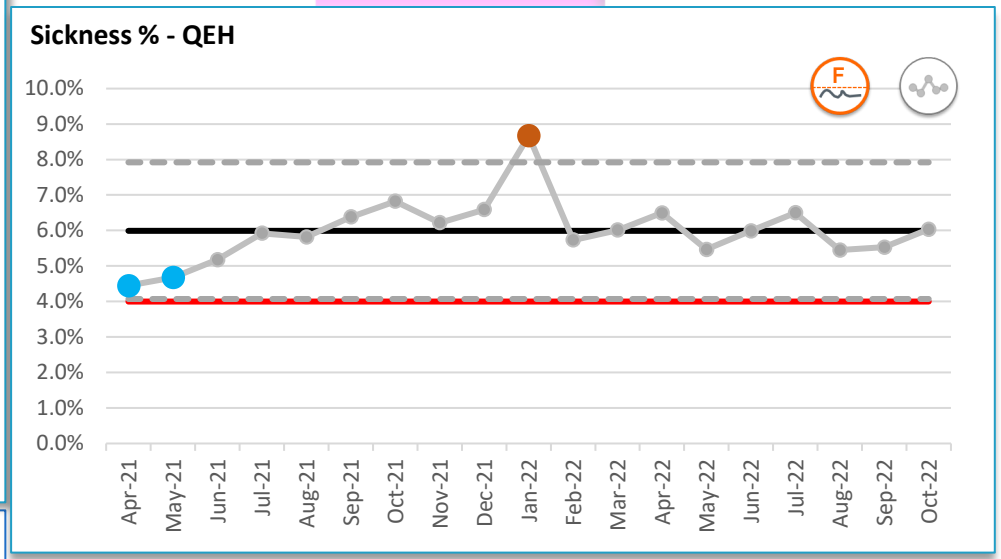
To be reviewed and discussed at the Quality Governance Committee.

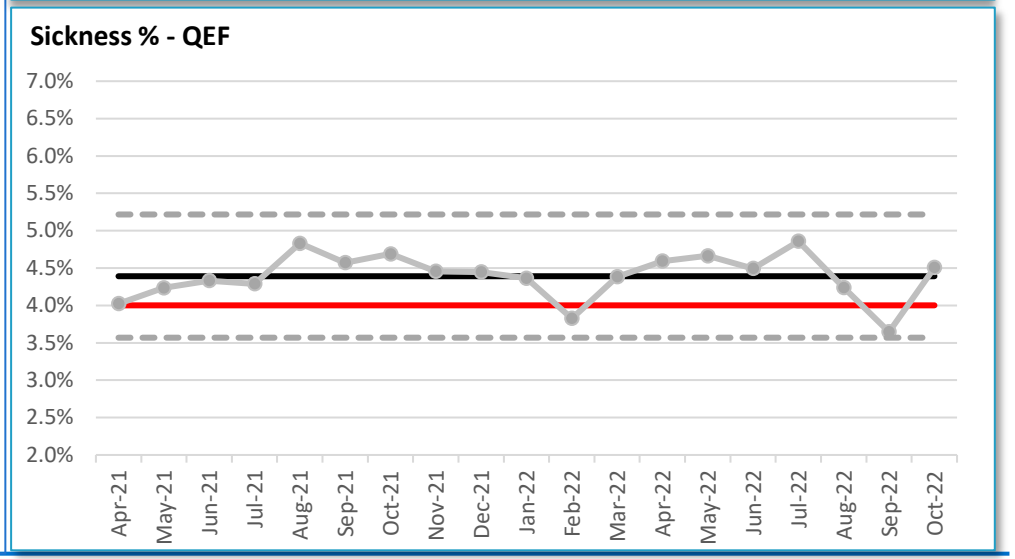
Sickness Absence

Well Led

Gateshead Health NHS Foundation Trust







What is the data telling us?

- Absence rates dropped to 5.1% in August on trend, however we saw an increase in absence levels overall in September and October to 5.8%.

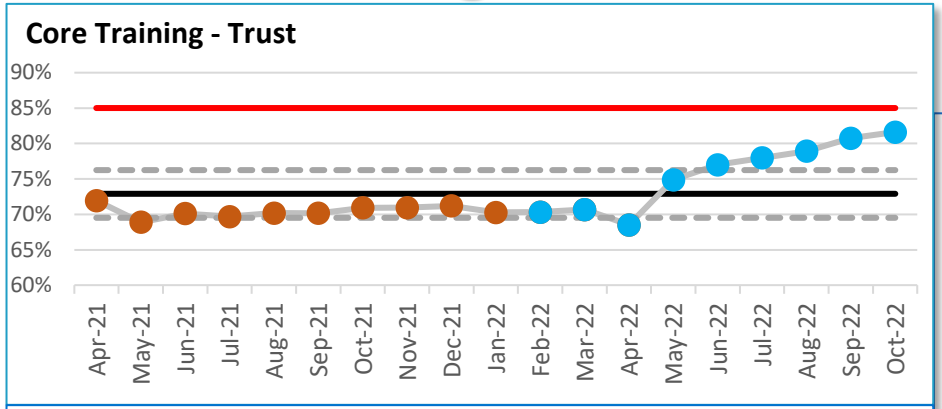
What is our plan and expected impact?

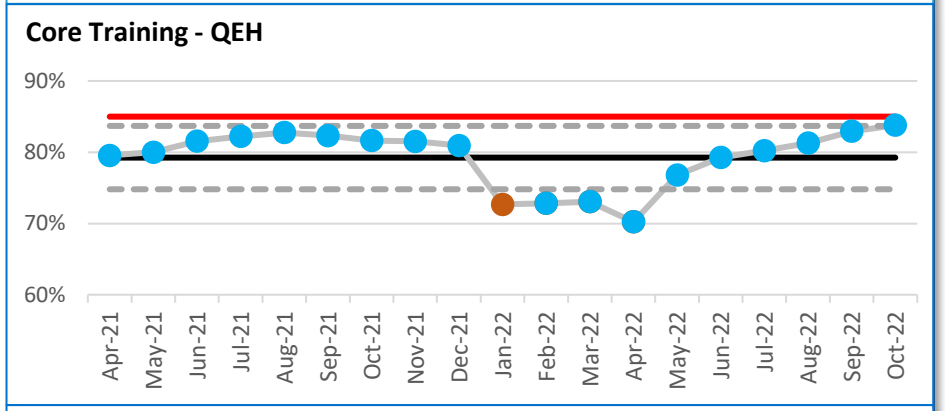
- All Business Units and corporate directorates have received a presentation highlighting key areas of focus for their Business Unit/directorate in respect of reducing sickness absence.
- The new Promoting and Supporting Attendance Policy was agreed at JCC and LNC and launched on the 01st June 2022. There has been a further refresh to the policy in July/Aug 2022 signed off by JCC and LNC. The updates aim to achieve a more streamlined and robust management of cases, earlier identification of support to maintain attendance and prevent absence occurring and ultimately a reduction in sickness absence.
- As we now have sign off there is a refocused and collective leadership approach to the management of sickness absence. We commence a targeted piece of work planned with Short Term Absence from 1st November 2022 through to 31st January 2023. Work is ongoing within POD Advisory to shape this direction.
- Monthly sickness absence reporting continues and is shared with the Business Units. POD are continuing to support managers to engage with the refocused collective leadership approach.
- Professional absence management training is being provided by Capsticks following the policy launch in June, we have training sessions commissioned up to Christmas. Our external facilitators have some cultural observations and will be sharing these with our Head of Service, Senior POD Leads, and Operational Directors on 2nd November.
- The Managing Well programme compliments this work and assists with building capability and capacity for our line managers. The program is about to commence its 17th cohort in November and so far 220 managers from across the Trust have attended.

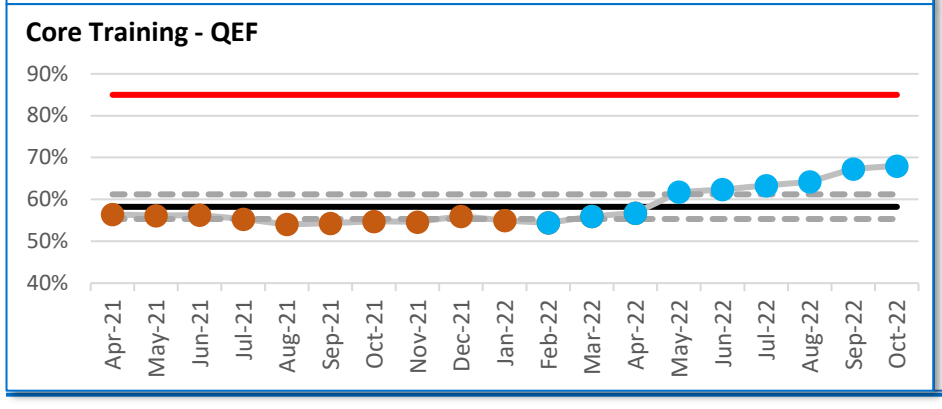
Core Training

Well Led

NHS Gateshead Health NHS Foundation Trust







What is the data telling us?

- A further overall increase of 2% in compliance with a whole group compliance figure of 80.8% against an 85% target.
- QEF currently have a compliance level of 67.4% against the 85% target, which is a further 3% increase on the last metrics report. Managers are aware that significant work is required to improve that position, however this is a positive improvement since the last report. There is a plan in place for additional space for QEF staff to increase compliance.
- The trust only has increased to 84.2% which is a further 4% increase on the last report, which is positive. We are starting to see sustained positive changes in compliance and will continue to work with business units to increase compliance and provide support around ESR.
- The topics that remain under compliance targets and provide a level of risk are-Moving and handling level 2, Level 2 and 3 PMVA, Safeguarding level 3 topics and Information Governance.
- PMVA training will remain a risk until further staff have completed the training. Dates have now been made available and staff are booking on to attend so there should continue to be sustained increases in compliance with this topic. Level 2 training has seen a sustained increase to compliance to over 27% and whilst that is still significantly under target, this is an increase of 10% since September 2022 and remains on an upward trajectory. Level 3 training has increased compliance to over 10% and although again considerably under target, this is a 6% increase on last month.
- Moving and Handling level 2 compliance is approximately 55% which is 30% under target. Information below details the work on-going to support an increase in compliance. The areas with lowest compliance are Medicine and Elderly, followed by Surgery.
- Safeguarding children level 3 has two competencies to ensure alignment with the Intercollegiate document. One remains just under the 85% target which is positive, however one remains under at just over 67%. The areas with the lowest compliance (and highest numbers of staff to complete) are Medicine and Elderly, and CSS.
- Safeguarding Adults level 3 is under compliance at 64% with Medicine and Elderly, and Surgery having the lowest compliance.
- Information governance is at 80% and has a target from the ICO of 95%. Medicine and QEF are currently the lowest compliance, however all areas are amber or green currently. This is an annual training and compliance can fluctuate significantly if areas become non-compliant at the same time so this remains a risk.

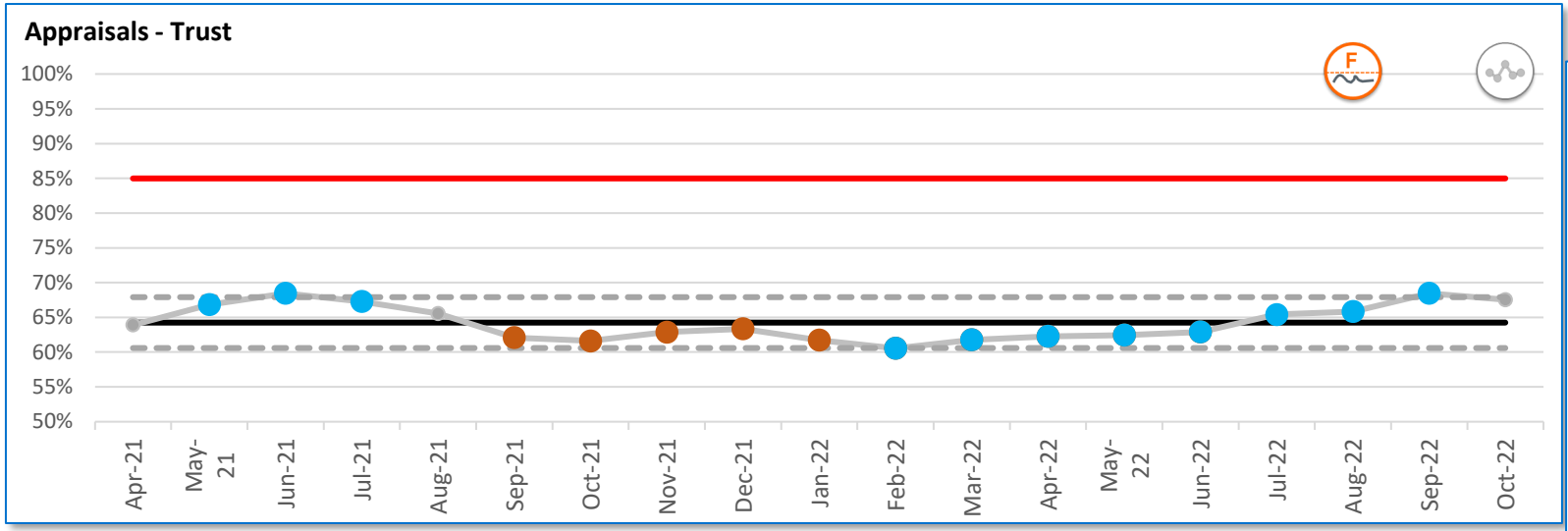
What is our plan and expected impact?

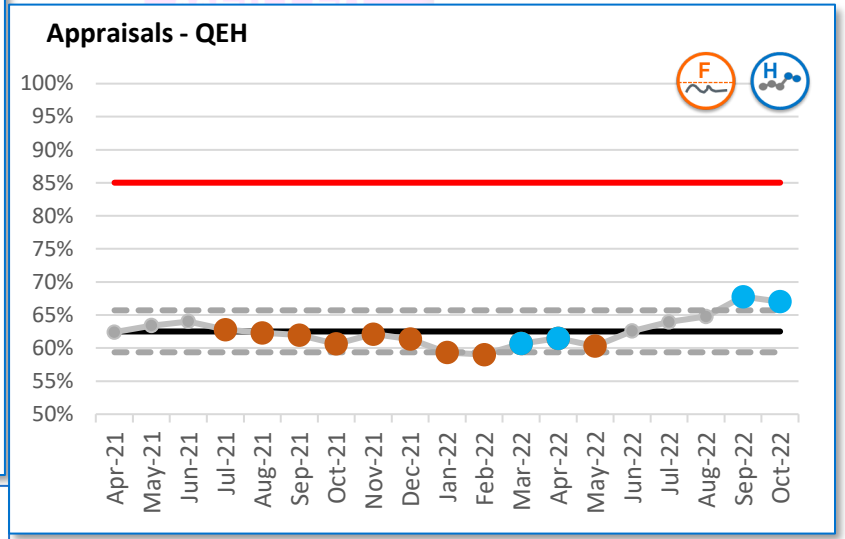
- Core skills compliance has been discussed at SMT, escalated to Executive Team and discussed at recent oversight meetings with business units. The Core Skills review, plans and recommendations have been discussed through SMT and will implemented as agreed. The addition of a couple of the topics will see an initial reduction in overall compliance, until the staff complete the training. The recommendations are all available as e-learning therefore not relying on a further face to face session which can cause a slower increase in compliance.
- e continue to promote on-line learning with support (as some staff need assistance logging on and using the system).
- Face-to-face learning will continue to take place. Providing a variety of options for staff to complete training should lead to an increase in compliance.
- The compliance noted below demonstrates QEH only and most are at target. The graphs below demonstrate the overall compliance for both Core and Position training, which is why the overall figure is lower.
- Reporting has altered to ensure business units receive detailed information about their areas of concern, with all core and position topics being reported by business unit and SLM. This will also flow through SMT on a monthly basis to ensure visibility of the topics at risk.
- If Information Governance training does not meet the required standard, there is a risk the Trust will fail the Information Governance Toolkit. The Information Governance team provide regular training sessions, and reminders for staff with regards to completing their training.
- The Ergonomics training team are continuing to provide flexibility within their training in terms of providing training in evenings and within the wards to encourage up take in the training. Challenge remains around estate for delivery of the sessions, and work is on-going to scope options for a dedicated training space for the team.
- Discussions on-going re statutory training and reporting of those figures. More information will be included in the months to come following review and recommendations to SMT.

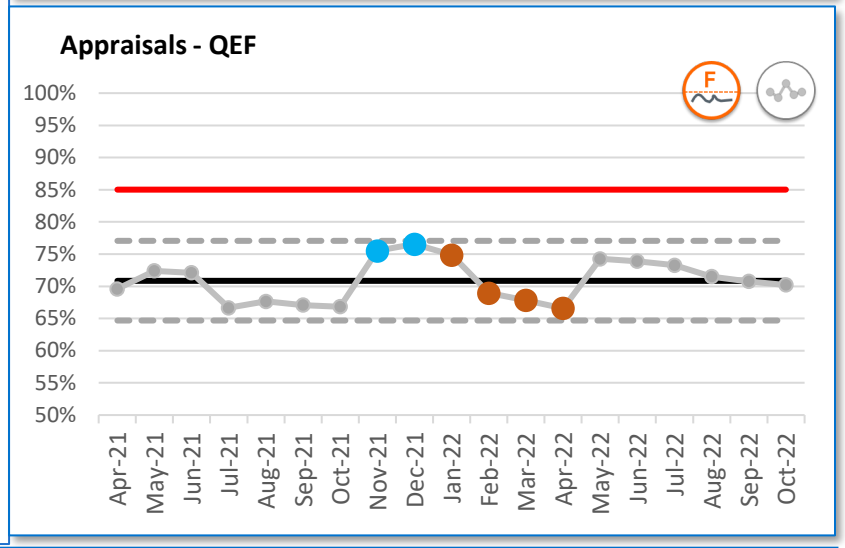
Appraisals

Well Led

NHS Gateshead Health NHS Foundation Trust







What is the data telling us?

- The target of 85% is consistently not being achieved. The data shows that there has been a slight decrease to 65.5% for the whole trust, which is a 0.3% decrease since last reported. There has been a sustained improvement since May 2022 prior to this slight decrease.
- There remain a number of areas of concern, with varying numbers of staff requiring an appraisal. Currently all business units are red or amber, with none green in terms of compliance, with the lowest areas of compliance being Nursing and Midwifery, Medicine SLM 3 and Surgery SLM 1 and 2, however the numbers vary for completions

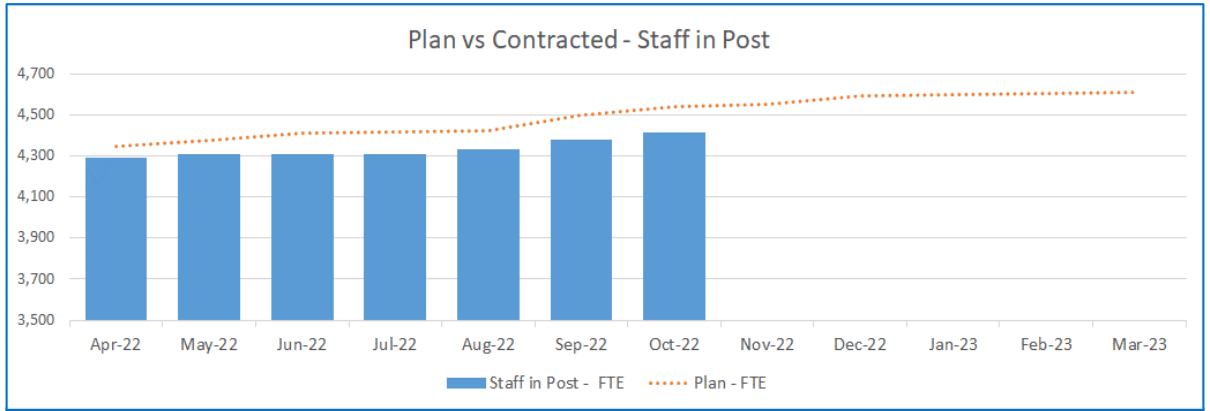
What is our plan and expected impact?

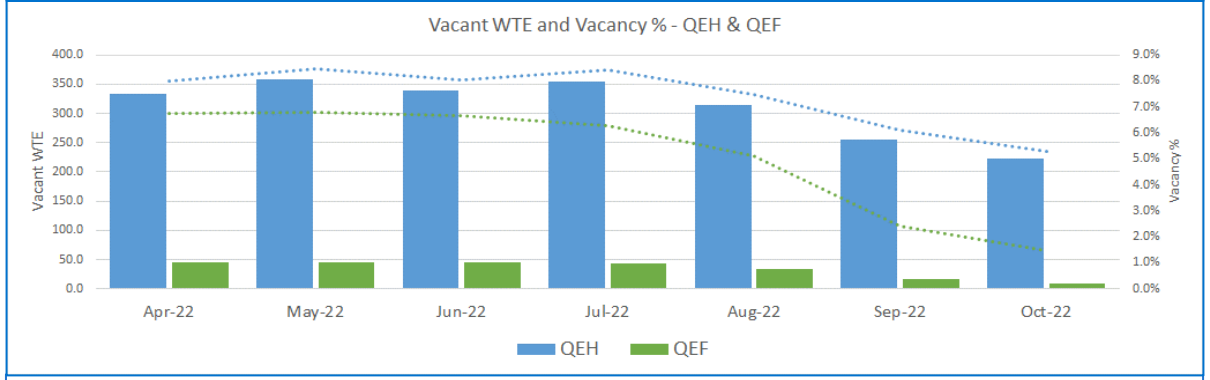
- The People and OD (POD) Leads are working with each business unit, directorates and teams to identify actions required to reach the required compliance levels. Additional training is being provided in areas as requested, for new appraisers and refresher training to ensure people are comfortable with the current process. The quarterly oversight reviews are making sure that appraisal compliance remains high on the agenda, and our colleagues in POD are supporting in any way possible.
- SMT are sighted on the challenge, and action plans have been requested to understand how the business units plan to get back on track. All business units have supplied plans to ensure increases in compliance. A monthly report by business unit and SLM will flow through SMT along with Core skills to ensure they are sighted on the high risk areas.
- The teams in POD have supported with inputting appraisals in areas requesting support to ensure we have the most accurate data possible. The matrix teams are working with the business units to ensure all appraisals are booked in.
- The renewed policy has been ratified, with the new appraisal form drafted and due for release shortly. A simple ESR logging process will be introduced alongside this to ensure we have the most up to date information possible within the system. Additional training re appraisal has been offered and delivered to multiple business units, simple how to guides have been developed and will be rolled out again when the new ESR process is ready to be launched.

SIP, Vacancies, Agency Spend

Well Led

Gateshead Health NHS Foundation Trust



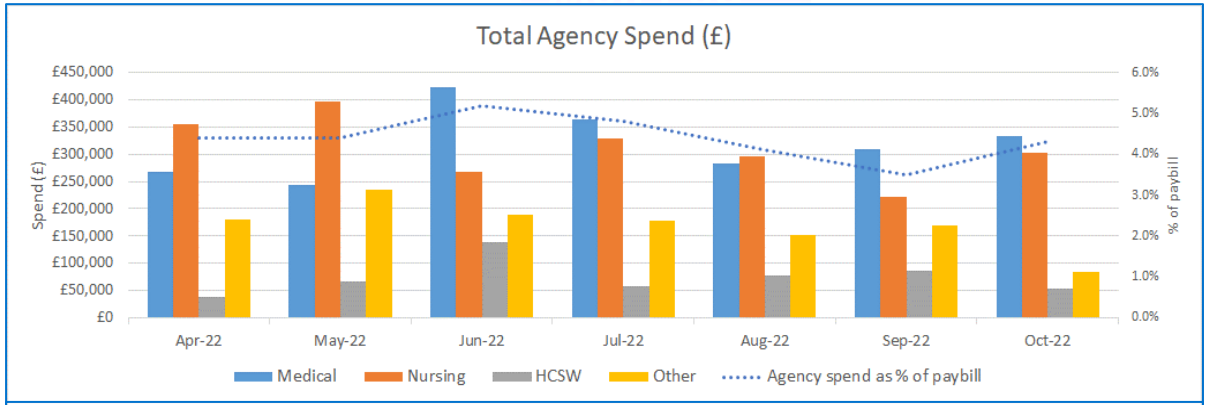


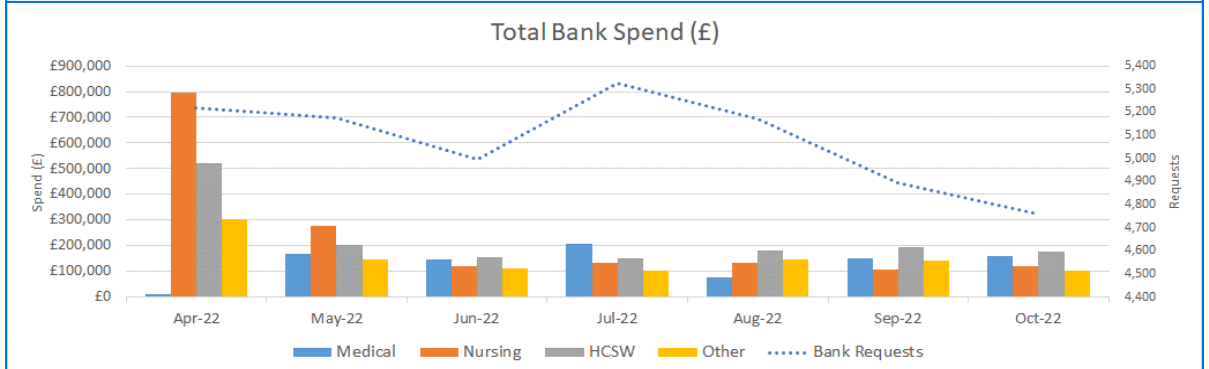
What is the data telling us?

- FTE has continued to increase, increasing by 66.88 in the last 3 months.

What is our plan and expected impact?

- Supply continues to be our core priority and we continue to both actively recruit whilst also focus on a range of retention initiatives.
- Domestic and international recruitment have been identified as a workstream within The Nursing Workforce Group. Medical Workforce vacancies are to be discussed/actions identified at the monthly Medical Workforce Group.
- 4 cohorts of international nurse recruits have arrived at the trust and a further bid has been submitted to NHSE/i to bring additional numbers in early 2023.
- The People Analyst continues to lead on analysing people data, identifying patterns and trends. Meetings with Medicine and Surgery Business units have been held with POD, Ops and Nursing Colleagues to discuss recruitment and retention strategies and understand if additional support is required.





What is the data telling us?

- Since March 2022 bank spend continued to decrease however, a slight increase has been seen for the month of July and October. Agency spend has seen a slight decrease from July 2022 which reflects the withdrawal of HCSW agency.

What is our plan and expected impact?

- Continue to reduce agency spend by utilising effective rostering planning, use of bank staff to fill gaps across areas that are experiencing vacancies and staff sickness. These practices will provide a reduction on the financial impact of agency spend.
- Preparation for the re-instating of Organisational agency controls in line with NHSE guidance to reduce off framework agency use and reduce overall agency spend is underway with clinical teams, finance and P&OD.

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 14

Report Title:	**Nursing Staffing Exception Report**			
Name of Meeting:	Board of Directors – Part 1			
Date of Meeting:	30 November 2022			
Author:	Janet Thompson, head of Nursing Laura Edgar, People Data and Information Lead			
Executive Sponsor:	Gillian Findley, Chief Nurse and Professional Lead for Midwifery and AHP's			
Report presented by:	Gillian Findley, Chief Nurse and Professional Lead for Midwifery and AHP's			
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. October has demonstrated a reduction in staffing challenges compared to September. There are still ongoing staffing challenges as we experience the continuation of managing COVID-19 activity within the organisation, periods of increased patient activity with surge pressure resulting in escalation areas alongside managing delays in transfers of care. This has affected staffing resource and the clinical operating model, which is supportive of maintaining elective recovery. Staffing challenges remain due to vacancies; however, we continue focused work around the recruitment and retention of staff and managing staff attendance. Wards where staffing fell below 75% of the funded establishment are shown within the paper. Detailed context and actions taken to mitigate risk are documented. A staffing escalation protocol is now in operation across all areas within the organisation and			

<table>
<tr><td></td><td colspan="5">assurance of this operating as expected, is provided by the number of staffing incident reports raised through the Datix system.

Ongoing concentrated work continues within the safe staffing Task and Finish Group to review staffing data, bank and agency usage and retire and return practice. Regular updates are shared with the executive team from this work.</td></tr>
<tr><td>Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper</td><td colspan="5">The Board are asked to:
receive the report for assurance
note the work being undertaken to address the shortfalls in staffing</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:</td><td>Aim 1
☒</td><td colspan="4">We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>Aim 2
☒</td><td colspan="4">We will be a great organisation with a highly engaged workforce</td></tr>
<tr><td>Aim 3
☒</td><td colspan="4">We will enhance our productivity and efficiency to make the best use of resources</td></tr>
<tr><td>Aim 4
☐</td><td colspan="4">We will be an effective partner and be ambitious in our commitment to improving health outcomes</td></tr>
<tr><td>Aim 5
☐</td><td colspan="4">We will develop and expand our services within and beyond Gateshead</td></tr>
<tr><td>Trust corporate objectives that the report relates to:</td><td colspan="5"></td></tr>
<tr><td>Links to CQC KLOE</td><td>Caring
☒</td><td>Responsive
☒</td><td>Well-led
☐</td><td>Effective
☒</td><td>Safe
☒</td></tr>
<tr><td colspan="6">Risks / implications from this report (positive or negative):</td></tr>
<tr><td>Links to risks (identify significant risks and DATIX reference)</td><td colspan="5">There were 4 staffing incidences raised via datix throughout the month of October 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>

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

1. Introduction

This report details the staffing exceptions for Gateshead Health NHS Foundation Trust during the month of October 2022. The staffing establishments are set by use of the Safer Nursing Care staffing tool (SNCT). This is a recognised, nationally used tool that matches the acuity of patients with the staffing requirements for acute medical and surgical wards. Maternity use the Birth Rate Plus tool and this has been reported to Quality Governance Committee and the Trust Board separately.

2. Staffing

The actual ward staffing against the budgeted establishments from October 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 October 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 (%)**
87.1%	**112.6%**	**91.0%**	**99.5%**

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 removed covid 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 again in July (collected on bi-annual basis). Data was triangulated with key performance indicators and professional judgement templates in line with the Developing Workforce safeguards and safe staffing recommendations (NHSi 2018). The outcome and recommendations from the January review were presented at Trust Board in May 2022.

The Community Business Unit received training on the Mental Health Optimal Staffing Tool (MHOST) in July. The first data collection for a staffing establishment review was conducted throughout October.

Contextual information and actions taken

Ward 12 has 7.99 wte registered nurse vacancies. Seven registered nurses have been appointed into post and will be due to start over the course of the next six months.

Ward 24 currently has 3.68 wte registered nurse vacancies and a 4.7% sickness absence. Ward 25 currently has 1.52 wte registered nurse vacancies, sickness absence for registered staff was under the trust target at 1.8%.

EAU report reduced Registered Nurse fill rates for nights. They report sickness absence rates of 5.6% for October and have supported areas across the Trust with staff redeployments.

There was a sickness absence rate of 10.9% for Healthcare Support workers within Critical Care Department, contributing to the reduced fill rates.

The exceptions to report for October are as below:

October 2022	
Qualified Nurse Days	**%**
Ward 12	74.9%
Ward 24	72.6%
Ward 25	72.5%
Qualified Nurse Nights	**%**
EAU	72.0%
Sunniside	71.7%
Healthcare Assistant Days	**%**
N/A	
Healthcare Assistant Nights	**%**
Critical care Dept	72.8%

In October, 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 October, 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 October, 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 thresholds that trigger when a staffing related DATIX should be submitted to provide reporting consistency. In addition to this the ongoing work to triangulate fill rates and care hours against reported staffing and patient safety incidents, has highlighted that the subcategories available to the reporter within 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.

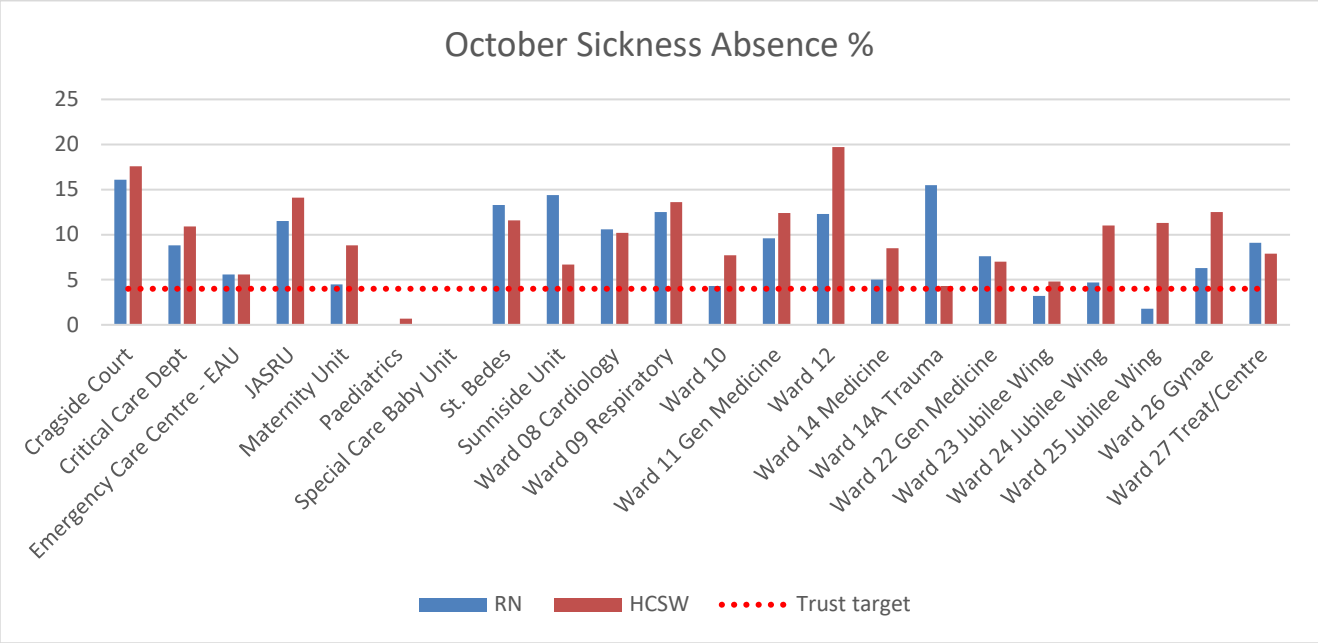
A task and finish group to streamline data capture and explore these potential emerging themes is being set up, alongside reviewing the potential to triangulate this data against a number of potential care quality measures to truly explore any impacts of staffing challenges on patient care, and to enable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

A report of staffing concern related incidents is generated monthly and discussed at the Nursing Professional Forum.

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 fourth wave of COVID 19. The number of Registered Nurse vacancies also contribute to this.

5. Attendance of Nursing workforce

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



6. Governance

Actual staff on duty on a shift-to-shift basis compared to planned staffing is demonstrated within the Safe care Live system. Staff are required to enter twice-daily acuity and dependency levels for actual patients within their areas/department, to support a robust risk assessment of staff redeployment.

7. Conclusion

This paper provides an exception report for nursing and midwifery staffing in October 2022 and provides assurance of ongoing work to triangulate workforce metrics against staffing and care hours.

8. Recommendations

The Board is asked to receive this report for assurance.

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

Appendix 1- Table 3: Ward by Ward staffing October 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**
Cragside Court	82.8%	119.5%	83.3%	238.8%	283	6.0	11.0	17.0
Critical Care Dept	88.3%	129.8%	95.7%	72.8%	261	30.0	5.8	35.8
Emergency Care Centre - Ward 01 & 02	85.4%	119.0%	72.0%	107.3%	1408	5.5	4.0	9.5
JASRU	77.9%	94.2%	98.8%	108.8%	608	3.0	4.3	7.3
Maternity Unit	146.1%	150.1%	98.7%	88.3%	544	15.5	5.4	20.9
Paediatrics	139.1%	126.6%	105.8%		51	51.4	14.5	65.9
Special Care Baby Unit	98.2%	104.3%	100.0%	90.5%	84	21.4	7.1	28.5
St. Bedes	90.0%	121.9%	97.0%	132.5%	297	4.9	5.0	9.9
Sunniside Unit	98.8%	103.1%	71.7%	154.1%	283	5.6	4.6	10.2
Ward 08 Cardiology	107.8%	118.0%	101.6%	92.6%	606	3.8	3.3	7.1
Ward 09 Respiratory	80.5%	149.8%	135.5%	101.7%	807	2.6	3.0	5.6
Ward 10	84.4%	141.6%	102.4%	117.8%	758	2.6	3.2	5.8

	Day		Night		Care Hours Per Patient Per Day (CHPPD)			
Ward	**Average fill rate - nurses/midwives (%)**	**Average fill rate - care staff (%)**	**Average fill rate - nurses/midwives (%)**	**Average fill rate - care staff (%)**	**Cumulative patient count over the month**	**Registered midwives / nurses**	**Care Staff**	**Overall**
Ward 11 Gen Medicine	79.9%	130.1%	105.1%	103.5%	810	2.3	3.1	5.5
Ward 12	74.9%	112.7%	125.9%	95.9%	684	2.9	3.3	6.1
Ward 14 Medicine	83.1%	122.5%	135.4%	109.5%	629	3.4	3.6	7.0
Ward 14A Trauma	99.7%	153.3%	111.6%	106.0%	859	2.7	3.7	6.3
Ward 22 Gen Medicine	0.0%	0.0%	0.0%	0.0%				
Ward 23 Jubilee Wing	76.7%	120.9%	101.5%	84.1%	905	2.2	3.3	5.5
Ward 24 Jubilee Wing	80.3%	136.5%	102.8%	98.5%	729	2.4	3.9	6.3
Ward 25 Jubilee Wing	72.6%	102.4%	102.3%	87.5%	893	2.1	3.0	5.2
Ward 26 Gynae	72.5%	102.3%	98.0%	79.3%	1002	1.9	2.6	4.5
Ward 27 Treat/Centre	82.8%	115.1%	108.2%	110.0%	882	2.5	3.1	5.5
QUEEN ELIZABETH HOSPITAL - RR7EN	76.7%	99.8%	107.0%	93.8%	876	2.4	2.7	5.0

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 15i

Report Title:	**Maternity and neonatal services in East Kent – the Report of the Independent Investigation**			
Name of Meeting:	Trust board meeting			
Date of Meeting:	30th November 2022			
Author:	Lesley Heelbeck			
Executive Sponsor:	Gillian Findley			
Report presented by:	Lesley Heelbeck			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☒	**Assurance:** ☒	**Information:** ☒
	All Provider trusts were sent a letter on the 20th of October outlining the next steps for maternity services. The expectation is that every Trust and ICB to review the findings of the report at its next public board meeting, and for boards to be clear about the action they will take, and how effective assurance mechanisms are at 'reading the signals'			
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*	New Report			
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 East Kent report outlines four areas for action: • To get better at identifying poorly performing units • Giving care with compassion and kindness • Teamworking with common purpose • Responding to challenge with Honesty This paper is a summary of the recommendations for the report and will be combined with the Ockenden IEA's for form our Maternity and Neonatal services strategy.			
Recommended actions for this meeting:	The independent review has identified 5 key recommendations for the wider system and to review at provider and operational levels.			

Outline what the meeting is expected to do with this paper	Maternity and Neonatal services with England are now to have a full review of how they are provided and commissioned. NHSE are working with partner organisations including regulators to publish a single delivery plan in 2023 for maternity and neonatal care which will bring together action required following this report, the report into maternity services at Shrewsbury and Telford NHS Foundation Trust, and the NHS Long-Term Plan and Maternity Transformation Programme deliverables. Maternity services will maintain current Ockenden action plan until the single national delivery plan for maternity and neonatal services is published.				
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:	We will continuously improve the quality and safety of our services for our patients				
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. Executive Summary

Purpose

This report reconfirms the requirement for all Trust boards to remain focused on delivering personalised and safe maternity and neonatal care. Trust boards and maternity services must ensure that the experience of women, babies and families who use our services are listened to, understood, and responded to with respect, compassion, and kindness.
All Provider trusts were sent a letter on the 20th of October outlining the next steps for maternity services. The expectation is that every Trust and ICB to review the findings of the report at its next public board meeting, and for boards to be clear about the action they will take, and how effective assurance mechanisms are at 'reading the signals'.

2. Introduction

The National focus is upon the improvement of safety within Maternity services. The Ockenden report was published in December 2020. The anticipated report into the independent investigation into East Kent Maternity Services 'Reading the Signals' was published on the 19th of October 2022. Sadly, the report contains similar themes and findings of avoidable harm and failing to learn from incidents, that Donna Ockenden found within Telford and Shrewsbury Maternity services investigation. This paper is a summary of the recommendations for the report and will be combined with the Ockenden IEA's for form our Maternity and Neonatal services strategy.

3. Key issues / findings

The East Kent Report is different from previous independent reviews as it does not recommend detailed changes of policy directed at specific areas of either practice or management. Dr Kirkup has commented that making policy based on extreme examples is not necessarily the best approach; nor are those who carry out investigations necessarily the best to do it. He also identifies that this approach has been tried by almost every investigation in the five decades however we can see that this is not working, or it does not work in preventing the recurrence of similar sets of problems in other places.

Key findings

The East Kent report outlines four areas for action:

- To get better at identifying poorly performing units
- Giving care with compassion and kindness
- Teamworking with common purpose
- Responding to challenge with Honesty

Themes from investigating team:

- ***Failures of teamworking***
- ***Failures of professionalism***
- ***Failures of compassion***
- ***Failures to listen***
- ***Failures after safety incidents***
- **Failure in the Trust's response, including at Trust Board level**

Findings were that repeated problems were systemic, particularly reflecting problems of attitude, behaviour and teamworking, and they reflect a persistent failure to look and learn. They concerned both hospitals within the Trust and continued throughout the period we have investigated. They included poor professional behaviour among clinicians, particularly a failure to work as a cohesive team with a common purpose.

4. Solutions / recommendations

The independent review has identified 5 key recommendations for the wider system and to review at provider and operational levels.

Key Action Area 1: Monitoring safety performance – finding signals among noise

Key Action Area 2: Standards of clinical behaviour – technical care is not enough

Key Action Area 3: Flawed teamworking – pulling in different directions

Key Action Area 4: Organisational behaviour – looking good while doing badly

The Board are asked to note that NHSE are working with partner organisations to publish a single delivery plan in 2023 for maternity and neonatal care which will bring together action required following this report, the report into maternity services at Shrewsbury and Telford NHS Foundation Trust, and the NHS Long-Term Plan and Maternity Transformation Programme deliverables.

In the interim Gateshead Trust board is asked to review the East Kent Report and focus upon the safe delivery of Maternity and Neonatal services within their organisation utilising the IEA's from Ockenden and integrating the key actions from the East Kent report to support the development of their safety and quality strategies.

NHS
Gateshead Health
NHS Foundation Trust

Reading the signals

Maternity and neonatal services in East Kent – the Report of the Independent Investigation

October 2022

1. Executive summary

The National focus is upon the improvement of safety within Maternity services. The Ockenden report was published in December 2020.

The anticipated report into the independent investigation into East Kent Maternity Services 'Reading the Signals' was published on the 19th of October 2022. Sadly, the report contains similar themes and findings of avoidable harm and failing to learn from incidents, that Donna Ockenden found within Telford and Shrewsbury Maternity services investigation.

This report reconfirms the requirement for all Trust boards to remain focused on delivering personalised and safe maternity and neonatal care. Trust boards and maternity services must ensure that the experience of women, babies and families who use our services are listened to, understood, and responded to with respect, compassion, and kindness.

All Provider trusts were sent a letter on the 20th of October outlining the next steps for maternity services. The expectation is that every Trust and ICB to review the findings of the report at its next public board meeting, and for boards to be clear about the action they will take, and how effective assurance mechanisms are at 'reading the signals'.

The East Kent report outlines four areas for action:

- To get better at identifying poorly performing units
- Giving care with compassion and kindness
- Teamworking with common purpose
- Responding to challenge with Honesty

This paper is a summary of the recommendations for the report and will be combined with the Ockenden IEA's for form our Maternity and Neonatal services strategy.

Gateshead Health NHS Foundation Trust

2. Introduction

The first Ockenden report is one year on, and all Maternity units have undergone a process of review and self-assessment. The second and final iteration of the report was published on the 30th of March 2022. Gateshead Maternity service has made significant improvements to work towards full compliance with the 7 IEAs and have the KLOE action plan from the Regional Perinatal oversight group. There is a working action plan, completed assessment and assurance document which the service will be working to. 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.

This identified 4 key pillars upon which to robustly plan operational change for safety which must be aligned to the report's four key pillars of:

- **Safe staffing levels**
- **A well-trained workforce**
- **Learning from incidents**
- **Listening to families**

The Board are asked to note that NHSE are working with partner organisations to publish a single delivery plan in 2023 for maternity and neonatal care which will bring together action required following this report, the report into maternity services at Shrewsbury and Telford NHS Foundation Trust, and the NHS Long-Term Plan and Maternity Transformation Programme deliverables.

3. Background

The East Kent investigation highlights as with the Ockenden investigation that after listening to families and staff they identified problems at every level of the services. Running through each one of these layers has been a failure to recognise and acknowledge the scale and nature of the problem.
The Trust took comfort from the fact that the great majority of births in East Kent ended with no damage to either mother or baby as an outcome indicator of safety and quality.

The East Kent Report is different from previous independent reviews as it does not recommend detailed changes of policy directed at specific areas of either practice or management. Dr Kirkup has commented that making policy based on extreme

examples is not necessarily the best approach; nor are those who carry out investigations necessarily the best to do it. He also identifies that this approach has been tried by almost every investigation in the five decades however we can see that this is not working, or it does not work in preventing the recurrence of similar sets of problems in other places.

4. **Key themes/findings within the East Kent Report**

This Report identifies four areas for action aimed at providers, system leaders which reflect the findings in the Ockenden report:

- **identifying poorly performing units,**
- **giving care with compassion and kindness,**
- **teamworking with a common purpose**
- **responding to challenge with honesty.**

'There is a crucial truth about maternity and neonatal services which distinguishes them from other services provided at hospitals. It is childbirth that most mothers are healthy, and, thankfully, their babies will be too. But so much hangs on what happens in the minority of cases where things start to go wrong because problems can very rapidly escalate to a devastatingly bad outcome.'

1.11 We listened carefully to the families who have participated.'

Themes from investigating team:

- ***Failures of teamworking***
- ***Failures of professionalism***
- ***Failures of compassion***
- ***Failures to listen***
- ***Failures after safety incidents***
- **Failure in the Trust's response, including at Trust Board level**

In specific instances where things had gone wrong, the Trust has found it easier to attribute the causes to individual clinical error, usually on the part of more junior staff,

or to difficulties with locum medical staff. The investigating team found that these were symptoms of the problems, not the root causes.

Findings were that repeated problems were systemic, particularly reflecting problems of attitude, behaviour and teamworking, and they reflect a persistent failure to look and learn. They concerned both hospitals within the Trust and continued throughout the period we have investigated. They included poor professional behaviour among clinicians, particularly a failure to work as a cohesive team with a common purpose.

5. Key areas for action

Key Action Area 1: Monitoring safety performance – finding signals among noise

The aim must be for every trust to have the right mechanism in place to monitor the safety of its maternity and neonatal services, in real time; for the NHS to monitor the safety performance of every trust; and for neither the NHS nor trusts to be dependent on families themselves identifying the problems only after significant harm has been done over a period of years.

Maternity and Neonatal services require:

- Better outcome measures that are meaningful, reliable, risk adjusted and timely.
- Trends and comparators, both for individual units and for national overview
- Identification of significant signals amongst the dearth of dashboards (noise), using techniques that account properly for variation while avoiding spurious ranking into “league tables”.

As a Trust we recognise that there are huge benefits to the effective monitoring of outcomes, and we are in the process of developing a meaningful Maternity Integrated oversight report. There is also national work going on currently to support a standardised and rational approach to ensure:

Key Action Area 2: Standards of clinical behaviour – technical care is not enough

Technical competence is not enough. In any clinical situation, not least the stressful circumstances of giving birth, there is an equal need for staff to behave professionally and to show empathy and compassion. The report found a worrying recurring tendency among midwives and doctors to disregard the views of women and other family members.

Key Action Area 3: Flawed teamworking – pulling in different directions

Fundamentally, there were poor relationships both within and between professional groups. There were factions and divisions within midwifery. There was poor working in obstetrics, with a division between consultants and junior staff that left unsupported staff to deal with complex situations beyond their experience.

Key Action Area 4: Organisational behaviour – looking good while doing badly

East Kent Trust prioritised reputation management to the detriment of being open and straightforward with families, with regulators and with others.

With families, this was evident in the way in which their concerns were dismissed. Where there were complaints, too often the Trust's instinct was to manage those complaints rather than to consider what was being said as feedback and learning.

Regulators such as CQC, HSIB and professional bodies were challenged and findings denied.

6. Grading of outcomes

The review team objectively reviewed and graded incidents and cases and found:

- Had care been given to nationally recognised standards, the outcome could have been different in 97 of the 202 cases reviewed (48%).
- In 69 of these 97 cases, the outcome would have reasonably been expected to be different.
- In 28 of these 97 cases, it might have been different.

Baby deaths

- Had care been given to nationally recognised standards, the outcome could have been different in 45 of the 65 cases of baby deaths (69.2%).
- In 33 of these 45 cases, the outcome would have reasonably been expected to be different.
- In 12 of these 45 cases, it might have been different.

Baby injury

- Had care been given to nationally recognised standards, the outcome could have been different in 12 of the 17 cases of brain damage (70.6%), including HIE and/or cerebral palsy attributable to perinatal hypoxia.

- In 9 of these 12 cases, the outcome would have reasonably been expected to be different.
- In three cases, it might have been different.

Maternal injuries and death

- Had care been given to nationally recognised standards, the outcome could have been different in 23 of 32 such cases (71.9%).
- In 15 of these 23 cases, the outcome would have reasonably been expected to be different.
- In eight cases, it might have been different

7. Recommendations

The independent review has identified 5 key recommendations for the wider system and to review at provider and operational levels.

Recommendation 1

The prompt establishment of a Task Force with appropriate membership to drive the introduction of valid maternity and neonatal outcome measures capable of differentiating signals among noise to display significant trends and outliers, for mandatory national use.

Recommendation 2

- **Those responsible for undergraduate, postgraduate and continuing clinical education be commissioned to report on how compassionate care can best be embedded into practice and sustained through lifelong learning.**
- **Relevant bodies, including Royal Colleges, professional regulators and employers, be commissioned to report on how the oversight and direction of clinicians can be improved, with nationally agreed standards of professional behaviour and appropriate sanctions for non-compliance.**

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Recommendation 3

- **Relevant bodies, including the Royal College of Obstetricians and Gynaecologists, the Royal College of Midwives and the Royal College of Paediatrics and Child Health, be charged with reporting on how teamworking in maternity and neonatal care can be improved, with particular reference to establishing common purpose, objectives and training from the outset.**
- **Relevant bodies, including Health Education England, Royal Colleges and employers, be commissioned to report on the employment and training of junior doctors to improve support, teamworking and development.**

Recommendation 4

- **The Government reconsider bringing forward a bill placing a duty on public bodies not to deny, deflect and conceal information from families and other bodies.**
- **Trusts be required to review their approach to reputation management and to ensuring there is proper representation of maternity care on their boards.**
- **NHSE reconsider its approach to poorly performing trusts, with particular reference to leadership.**

Recommendation 5

The Trust accept the reality of these findings; acknowledge in full the unnecessary harm that has been caused; and embark on a restorative process addressing the problems identified, in partnership with families, publicly and with external input.

8. Summary and actions for the Trust

Maternity and Neonatal services with England are now to have a full review of how they are provided and commissioned. NHSE are working with partner organisations including regulators to publish a single delivery plan in 2023 for maternity and neonatal care which will bring together action required following this report, the report into maternity services at Shrewsbury and Telford NHS Foundation Trust, and the NHS Long-Term Plan and Maternity Transformation Programme deliverables.

Gateshead Health NHS Foundation Trust

This will form the blueprint for the delivery of maternity and Neonatal care for the future with the aim of having clear standards of safety and quality of care for all Trusts to demonstrate.

In the interim Gateshead Trust board is asked to review the East Kent Report and focus upon the safe delivery of Maternity and Neonatal services within their organisation utilising the IEA's from Ockenden and integrating the key actions from the East Kent report to support the development of their safety and quality strategies.

Lesley Heelbeck

Head of Midwifery/SCBU

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 15ii

Report Title:	**Maternity Oversight Report**			
Name of Meeting:	Trust Board			
Date of Meeting:	30 November 2022			
Author:	A Ward/K Hooper/I Aird/K Hewitson/L Heelbeck			
Executive Sponsor:	Gillian Findley, Chief Nurse			
Report presented by:	Gillian Findley, Chief Nurse			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☒	**Discussion:** ☒	**Assurance:** ☐	**Information:** ☒
	Aim from the Ockenden Report: *The aim must be for every Trust to have the right mechanism in place to monitor the safety of its maternity and neonatal services, in real time; for the NHS to monitor the safety performance of every Trust; and for neither the NHS nor Trusts to be dependent on families themselves identifying the problems only after significant harm has been done over a period of years*. This is the first example of the bespoke Maternity Integrated Oversight Report (IOR) for Gateshead Health NHS Trust. The Board is asked to discuss the content of the maternity IOR and decide whether it meets the needs of the Board. The Board is also asked to note the content of the maternity IOR and the risks identified within the 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*	The maternity IOR has been discussed at Quality Governance Committee on 19 October 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.*	As a Trust we recognise that there are huge benefits to the effective monitoring of outcomes, and we are in the process of developing a meaningful Maternity Integrated Oversight Report which is attached for review and decide whether this meets the need of the Trust Board. There is			

<table>
<tr><td>

- *Finance*
- *Patient outcomes / experience*
- *Quality and safety*
- *People and organisational development*
- *Governance and legal*
- *Equality, diversity, and inclusion*

</td><td colspan="5">also national work underway currently to support a standardised and rational approach to ensure clear outcome measures and standards. This may result in changes being required for this report in the future.

This report shows the position for November 2022. Key points from the November position are:

• The Trust is compliant with 8 out of 10 safety actions from the Maternity Incentive Scheme Year 4
• One serious incident has been reported this month. This was a full term still birth.
• There were 3 moderate harm incidents identified, but no themes within the incidents
• There has been an improvement in the staffing position this month</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 Trust Board is asked to:

• Note the content of the report
• Agree that the maternity IOR provides assurance for the Board in relation to the quality of maternity services</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:</td><td>Aim 1
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☐</td><td colspan="2">No
☐</td><td>Not applicable
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</table>

Gateshead Health NHS Foundation Trust

Maternity Oversight Report

November 2022

IOR Summary/contents

Maternity

NHS

Gateshead Health
NHS Foundation Trust

- Maternity dashboard
- Exception reports
  - Maternity Incentive Scheme (6-monthly & exception reporting)
  - Ockenden
  - East Kent – separate summary paper to be presented 30.11.2022
- Serious Incidents
- Moderate harm incidents
- Risk update (bi-monthly following maternity operational board)
- Quarterly exception report schedule
  - PMRT (Aug/Nov/Feb/May)
  - Transitional care & term admissions (Sept/Nov/March/June)
  - Saving Babies Lives Care Bundle (July/Oct/Jan/Apr)

Maternity Dashboard

Maternity

NHS Gateshead Health NHS Foundation Trust

		Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2022/23	Spark chart
Births - Live			126	152	138	139	155	132	144						**986**	
Births - Still			0	1	1	0	1	1	0						**4**	
Total Births			126	153	139	139	156	133	144						**990**	
Spontaneous vaginal deliveries			71	76	84	73	77	75	87						**543**	
Assisted births			55	77	55	66	79	58	57						**447**	
Induction of Labour			62	76	63	71	85	67	67						**491**	
Maternity Readmissions		<42 Days	2	2	2	2	4	1	3						**16**	
Neonatal Readmissions		<42 Days	3	3	2	4	3	5	4						**24**	
Smoking in Pregnancy	Smoking at time of booking	15%	12.13%	11.67%	12.05%	10.38%	11.62%	11.63%	10.42%							
	Smoking at time of delivery	6%	10.40%	12.00%	14.39%	12.23%	12.50%	7.58%	9.03%							
	In area CO at booking (*MIS)	>80%	80.2%	67.02%	71.43%	79.01%	80.37%	80.0%	87.76%						**77.96%**	
	In area CO at 36 weeks (*MIS)	>80%	72.48%	67.79%	65.35%	76.71%	80.99%	78.07%	81.21%						**74.79%**	
Neonatal morbidity	Admitted directly to NNU (SCBU) (>37 weeks)	<4	6	4	2	1	5	2	2						**22**	
	Percentage Admitted directly to NNU (SCBU) (>37 weeks)	<6%	5.17%	2.86%	1.48%	0.74%	3.40%	1.59%	1.52%						**2.43%**	
	Neonatal Deaths		0	0	0	0	0	0	0						**0**	
Preterm birth rate	<=32 Weeks at birth															
	<=36+6 Weeks at birth	<6%	7.94%	7.89%	2.90%	2.16%	3.23%	4.55%	6.25%							
Continuity of Carer	Percentage placed on Pathway (29 weeks)		21.4%	18.1%	23.2%	19.4%	21.9%	22.1%	21.8%							
	Percentage from BAME background/areas of deprivation		31.6%	33.3%	42.9%	29.7%	43.5%	36.0%	27.3%							
Risk Management	SGA (<10th centile) detection rate quarterly				40.0%			45.8%								
	FGR (<3rd centile) detection rate quarterly				61.1%			47.6%								
	Number of SUIs		0	0	1	0	1	0	0						**2**	
	Moderate and above harm orange incidents		1	1	1	0	3	0	1						**7**	
	HSIB Cases		0	0	0	0	0	0	0						**0**	
Patient experience	Total Complaints/PALS		0	1	1	2	2	0	2						**8**	
	Total compliments		1	0	0	1	0	0	1							
	Friends & family feedback		100%	100%	83.3%	100%	50%	100%	50%							
	Birth reflections															

Maternity Incentive Scheme update

Maternity NHS Gateshead Health NHS Foundation Trust

Relaunch of year 4 scheme with extended submission date & amended standards in May 2022– further amendments to technical guidance & submission date extended to ***2 February 2023*** in October 2022

Fully complaint with safety actions 1, 2, 3, 4, 5, 7, 9, 10

Working towards full compliance with safety actions 6 & 8

At risk of non-compliance with safety action 6 – due to altered standard to include pregnant people declining CO monitoring in the fail data –wording challenged with national midwifery safety group as it does not replicate the Saving Babies Lives care bundle requirements and does not support the principle of informed choice. Our decline levels are potentially higher in our Jewish population – to work with the local population leads to educate & understand service user voices.

At risk of non-compliance with safety action 8 – due to altered standard to allow 12 month period only for training (not whole of MIS year 4 reporting period) – additional targeted training sessions arranged – projected compliance >90%

Maternity Key Risks update

Maternity

NHS

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Increased acuity of service users

- Rising intervention rates & patient co-morbidities including Induction of Labour & operative deliveries impact on staffing required (in all disciplines)
- Increased theatre usage time
- Increased antenatal clinic capacity

Maternity estate

- Increasing leaks, pest infestations, requirements for partial unit shutdowns for maintenance works
- Additional risks identified in recent infant abduction drill – isolation of unit with multiple exit points
- 2nd theatre now operational, work on-going on development of Birthing pool suite and refurbishment of bereavement room beginning 14.11.2022

Infant abduction drill

- Drill completed and report to go to Safecare, Risk and Safety Council with follow up work with EPRR team

Midwifery Staffing

- Recruited to 17 WTE midwifery posts. 13 WTE Newly Qualified midwives to be supported
- Staff listening events x 3 commenced in October/November to discuss current recommendations around MCOC models of care and staffing requirements around this.
- 6 monthly staffing paper to be received by Chief Nurse November 2022

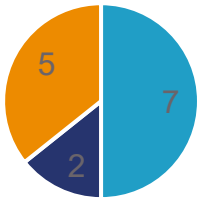
ATAIN- Avoiding term admissions to SCBU

There is overwhelming evidence that separation of mother and baby so soon after birth interrupts the normal bonding process.

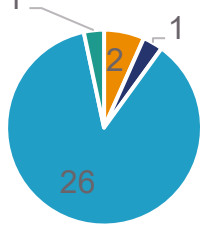
A robust transitional care pathway supports care of babies requiring additional care, alongside their mothers, reducing separation.

Q2 2022/23 Term admissions	Total births	Births >37 weeks	Total term admissions	Reason for admission	Avoidable term admissions*
July - Sept 2022	426	409	8	Respiratory distress/sepsis	No
Q2 2022/23 TC		**TC days**	**Babies receiving TC**	**Reason for TC**	**Number of babies avoiding SCBU**
July- Sept 2022	426	125	58	Low birth weight, Preterm, jaundice, sepsis	13

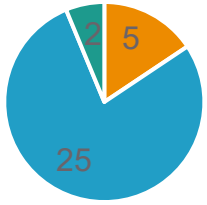
July 2022



Sept 2022



Aug 2022



Q2 2022/23

Summary:

- 20 babies avoided SCBU admission through TC
- 13 term infants admitted to SCBU

Themes:

- C/S - no steroids
- Raised maternal BMI
- GDM (Gestational Diabetes)
- **Nb. All themes identified follow local & national guidance – unavoidable & appropriate admissions**

Learning/actions:

- Prompt treatment; recognising the deteriorating baby
- Datix reporting & review
- ANNP presence
- Ensure infants have early feeds when in obstetric theatre
- Audit and MSW support will focus on the golden hour

Perinatal Mortality – Quarterly
Maternity Deaths / Morbidity - Annual

Maternity

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NHS Foundation Trust

Perinatal mortality Q1 & Q2 2022-23

MBRRACE ID	Gestation & Outcome	DOB	Date added to MBRRACE	Date PMRT started	Reported to MBRRACE within 7 working days	Info complete within 1 month of death	PMRT review started within 2 months of death	External clinician
Case 1 81002	Late miscarriage at 22+2	6/4/2022	7/4/2022	7/4/2022	Yes	Yes	Yes	Yes
Case 2 81545	Antepartum stillbirth at 29+1	12/5/2022	11/5/2022	11/5/2022	Yes	Yes	Yes	Yes
Case 3 82049	Unknown gestation & details	10/6/2022	17/6/2022	17/6/2022	Yes	n/a	n/a	n/a
Case 4 82091	Antepartum stillbirth at 25+5	19/6/2022	20/6/2022	20/6/2022	Yes	Yes* 23/7/2022	Yes	Yes
Case 1 82793	38+3 Intrapartum /antenatal stillbirth	1/8/2022	2/8/2022	15/8/2022	Yes	Yes	Yes	Yes
Case 2 83659	25+3 IUD	21/9/2022	23/9/2022	23/9/2022	Yes	Yes	Yes	Yes

Situation
Reduction in perinatal mortality seen year on year – small case numbers mean unable to SPS
Exception reporting of cases

Background
Safety action 1 of year 4 Maternity Incentive Scheme is compliance with the national perinatal mortality review tool

Assessment
Full compliance reported for year 3 MIS
Full compliance to be reported for year 4 MIS
Case 4 Q1 – 3 days outwith timescale for full information input onto portal due to manual error saving data – did not impact review of case

Actions
Quarterly reports to Mortality & Morbidity steering group
Manual diary note & additional individuals identified to ensure no further lapses in reporting timescales

Recommendation
Declare full compliance with MIS year 4 safety action 1

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 16

Report Title:	Learning from Deaths Report – six monthly update			
Name of Meeting:	Trust Board			
Date of Meeting:	Wednesday 30th November 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*	NA			
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 publications of national mortality indicators places the Trust with bandings of 'Deaths as expected' for both indicators. • SHMI May 2021 to April 2022 = 0.99 • HSMR August 2021 to July 2022 = 106.7 • All Deaths scrutinised by the Medical Examiners office. • 98.3% of cases reviewed are identified as being definitely not preventable; 87.7% of cases reviewed were identified as good practice; No potentially preventable deaths were identified during the period. • Revised Learning from deaths policy and new process incorporating Medical Examiners review as first level now live • Revised process for identifying and reviewing deaths where the patient had a diagnosis of Severe Mental Illness implemented and backlog of 20 cases reviewed. The majority of cases			

<table>
<tr><td></td><td colspan="5">demonstrated good collaborative working to ensure both physical and mental health was considered.</td></tr>
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Mortality Report

Executive Summary

The Trust's latest published SHMI (Summary Hospital-level Mortality Indicator) for May 2021 to April 2022 is 0.99 placing the Trust with the banding of deaths 'as expected'.

The HSMR (Hospital Standardised Mortality Ratio) for Gateshead for the latest period August 2021 to July 2022 21 is 106.7 placing the Trust with 'Deaths as expected' as calculated by the model.

The Trust continues trigger for the diagnosis group Congestive heart failure, additional reviews previously undertaken highlighted some learning and the alert continue to be monitored.

All deaths are initially scrutinised by the Trusts Medical Examiner office.
37.8% (439 of 1,162) of inpatient deaths have been reviewed by the ward-based team providing care at the time of death for deaths occurring between September 2021 and August 2022.

98.3% of cases are identified as being definitely not preventable.
87.7% of cases reviewed were identified as good practice.
No potentially preventable deaths were identified during the period.

Where mortality alerts have been triggered, case note review demonstrates that in the main cases are identified as 'definitely not preventable'. Those cases that demonstrate evidence of preventability continue to be reviewed by the Trust's Mortality Council where learning and actions are identified.

The Lead Medical examiner and Medical Examiner team continue to provide scrutiny of deaths within the Trust, supporting learning from deaths within the trust and development of the Trusts mortality review process. The Medical examiner pathway includes feedback mechanisms to clinicians and/or nursing staff whilst ensuring any escalation of concerns or areas for quality improvement and patient safety are shared with the correct teams.

1. Introduction:

The purpose of this paper is to update the Board upon on going work in relation to mortality within Gateshead Health NHS Foundation Trust. Within the paper is an update on the Summary Hospital-level Mortality Indicator (SHMI) which is the national mortality ratio score developed for use across the NHS, a summary of the Hospital Mortality Standardised Ratio (HSMR) provided by Healthcare Evaluation Data (HED) and learning from mortality review.

2. The National Picture: Summary Hospital-level Mortality Indicator (SHMI)

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

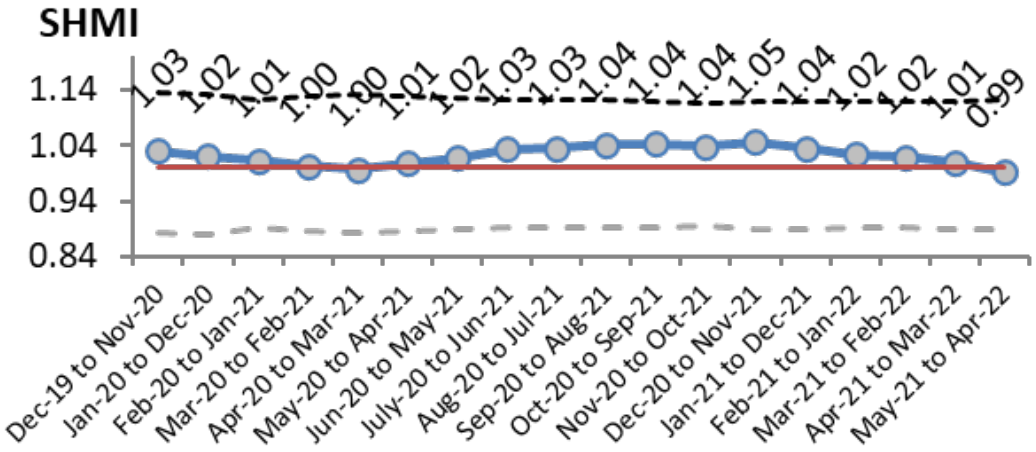
The SHMI compares the actual number of patients who die following hospitalisation (both in- hospital deaths and deaths within 30 days of discharge) at a trust with the number that would be expected to die based on average England figures, given the characteristics of the patients treated there.

For any given number of expected deaths, an upper and lower bound of observed deaths is considered to be 'as expected'. If the observed number of deaths falls outside of this range, the trust in question is considered to have a higher or lower SHMI than expected.

COVID-19 activity excluded from the SHMI. The SHMI is not designed for this type of pandemic activity and the statistical modelling used to calculate the SHMI may not be as robust if such activity were included.

SHMI Trust Position May 2021 to April 2022

The latest SHMI was published on 8th September 2022 covering the period from May 2021 to April 2022. The Trust has a SHMI Banding of 'As Expected' with a score of 0.99, below the national baseline of 1.00



There are currently reforms being made to the SHMI. This is likely to lead to the removal of some hospice and community sites. The impact of this will mean the confidence intervals are likely to narrow somewhat in the data, however it is not anticipated that this will lead to a change in the Trust banding.

3. Trust based data analysis:

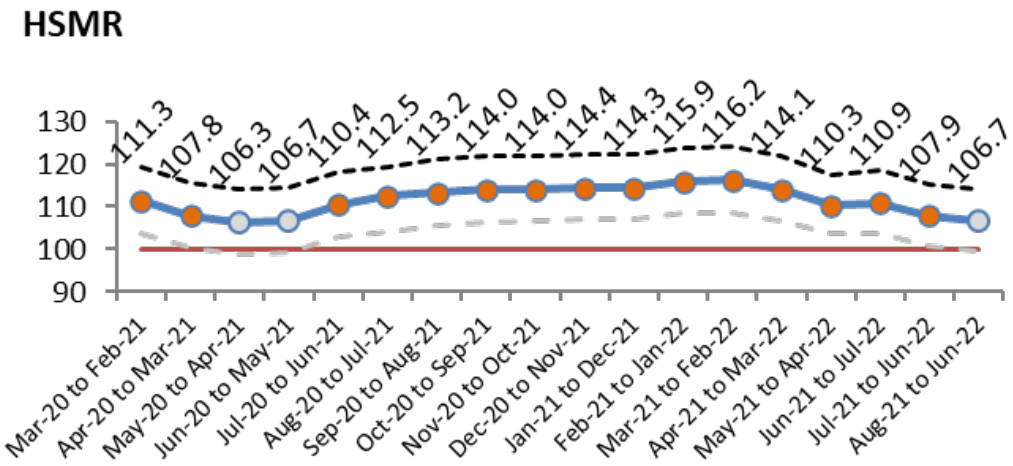
The Hospital Standardised Mortality Ratio (HSMR) is a risk-based assessment using a basket of 56 primary diagnosis groups which account for approximately 80% of hospital mortality.

The HSMR is the ratio between the number of patients who die in hospital compared to the expected number of patient deaths based on average England figures given the characteristics e.g., presenting and underlying conditions, age, sex, admission method, palliative coding.

COVID 19 activity is excluded from the HSMR based on the clinical coding of patient spells placing these deaths outside of the 56 diagnosis groups considered by the model. However, a patient may be still included if their primary diagnosis does not include COVID-19 but a subsequent diagnosis does.

HSMR Trust Position August 2021 to July 2022

The HSMR for the period August 2021 to July 2022 is 106.7 showing 'Deaths as Expected'. The recent trend has been encouraging with five consecutive falls.



Mortality Alerts from HED (Healthcare Evaluation Data)

Below are details of the recent mortality alerts identified in HED, the system used to monitor and analyse mortality indicators by the Trust.

Alert	CCS Diagnostic Group	Period	Expected Deaths	Observed Deaths	Obs -Exp	HSMR / CUSUM Score	% Reviewed (where death within Trust)	% Definitely not preventable	% NCEPOD Good Practice
HSMR	Congestive heart failure; non hypertensive	Jul-21 to Jun-22	42	68	26	161	29.4%	85.0%	70.0%
HSMR	Cancer of the Oesophagus	Jul-21 to Jun-22	6	19	13	310	63.2%	100%	81.8%
HSMR CUSUM*	Cancer of bronchus; lung	May-22	9	15	6	4.1	20.0%	100%	66.7%
HSMR CUSUM*	Cancer of colon	May-22	2	5	3	4.0	20.0%	100%	100%
HSMR CUSUM*	Intracranial injury	Apr-22	3	3	0	4.4	33.3%	100%	10.0%

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

Congestive Heart Failure

Congestive Heart failure continues to alert for the Trust. Case specific Mortality council meetings took place earlier in the year and learning was included in the April report a summary is provided below.

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.

Cancer of the Oesophagus

Several Oesophageal cancer deaths have been reviewed and all cases reviewed were deemed to be definitely not preventable.

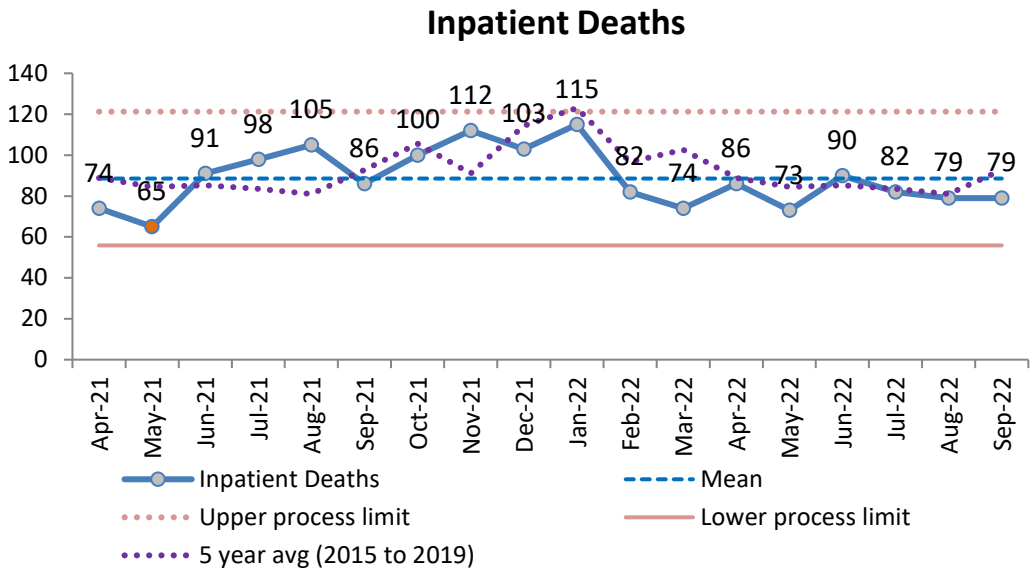
CUSUM Alerts

CUSUM alerts flag any diagnosis groups with consecutive months where the observed deaths are higher than the expected deaths. For the CUSUM alerts listed, none have re-alerted in the most recent month and where cases have been reviewed, they were deemed to be definitely not preventable.

Alerts continue to be presented and discussed at each Mortality and Morbidity Steering Group where any further actions or investigation can be discussed and agreed.

Inpatient mortality

The chart below provides the figures for the Trust inpatient deaths.



4. Learning from Deaths and Mortality Review

Mortality Review Compliance and Results September 2021 to August 2022

Deaths 01/09/2021 to 31/08/2022

Deaths in scope	Deaths reviewed by Medical Examiner	Deaths reviewed by Ward Team	Learning Disability Deaths reviewed at Mortality Council	Severe Mental Illness deaths reviewed at Mortality Council	Patients reviewed at Mortality Council Review
1162	99.9%	37.8%	42.9%	13.0%	3.9%

The scores below relate to reviews undertaken by either the Ward Based Team and /or Mortality Council.
Mortality Council review score supercedes Ward Based Team review score where both have taken place.

Hogan 1 - Definitely Not Preventable	Hogan 2 - Slight Evidence of Preventability	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
98.3%	1.5%	0.2%	0.0%	0.0%	0.0%	0.0%

NCEPOD Score 1 Good Practice	NCEPOD Score 2 Room for Improvement - Clinical Care	NCEPOD Score 3 Room for Improvement - Organisational Care	NCEPOD Score 4 Room for Improvement Clinical and Organisational Care	NCEPOD Score 5 Less Than Satisfactory	NCEPOD score 6 Insufficient data	No Score Allocated
87.7%	0.9%	9.4%	1.8%	0.0%	0.2%	0.0%

13 Learning disability and 3 severe mental illness cases were reviewed between September 2021 and August 2022 by the Mortality Council. This is irrrespective of when the death occurred.

A process was recently finalised for the review of Severe Mental Illness (SMI) deaths using the NHSE criteria. Two extraordinary meetings of the Mortality Council have taken place (29th September and 4th October) to review the backlog of 20 cases.

The majority of cases demonstrated good collaborative working and care hadn't been compromised as a result of their diagnosis, although learning was identified in a small number of cases and actions will be taken forward.

All deaths are now overseen and initially scrutinised by the Trust Medical Examiners.

37.8% (585 of 1,188) deaths have been reviewed by the ward-based teams between September and 2021 and August 2022.

- 98.3% of cases are identified as being definitely not preventable.
- 87.7% of cases reviewed were identified as good practice.
- 12.1% of cases identified room for improvement.
- 0 deaths identified as potentially avoidable (Hogan score >=4)

The review of the Mortality Review process is now complete, and the Learning from Deaths policy amended accordingly. The required changes to the mortality database to incorporate the changes to the process are also complete. Communications have been shared with via the Business Unit SafeCare Meetings.

In summary, the new process now contains three key stages:

First level review
The Medical Examiner team will conduct the first stage, they will determine whether there is evidence of any preventability of the death and whether where is evidence of any good practice/room for improvement in the care. They will also consider whether a clinical or staff incident or relative enquiry, an element of preventability or any combination of all these are the reason for a more in depth ward level case record review should be undertaken by the ward team. This will be notified to the ward team via email and should be carried out within 6 weeks of notification.

Ward level case record review
A structured review of case notes carried out by clinicians to determine whether there were any problems in care provided to the patient. Case record review is undertaken routinely to learn and improve in the absence of any particular concerns about care. This is because it can help find problems where there is no initial suggestion anything has gone wrong. It can also be done where concerns exist, such as when bereaved families or staff raise concerns about care.

This will relieve some burden on ward teams and allow them to focus on the cases where there may be greater learning. Regardless of whether they are notified of a case by the ME team, the ward can still undertake a review if they choose to.

Mortality Council Structured Judgement Review
The Mortality Council will continue to undertake a structured judgement review of the deaths that are mandated within the National Quality Board guidance:

- Deaths of people with a learning disability – was autistic and was over 18 years old or learning a learning disability and was over 4 years old
- Deaths of people with a severe mental illness (SMI) – all inpatient, outpatient and community patient deaths of people with SMI
- Infant or child deaths – come to Mortality Council for oversight
- Still births – are reviewed via the Perinatal Mortality Review Tool
- Concerns for bereaved families/carers – formal complaints/PALS/concerns via ME
- Service specialty, particular diagnosis or treatment group where an ‘alarm’ has been raised (e.g. national indicators, CQC, audit work etc)
- Elective procedures

As well as random sample of 5% for quality assurance purposes.

5. Learning from Mortality Council

For the period April to September 2022, 75 cases had a level 2 review undertaken by the Mortality Council. The scores of the review are detailed in the table below:

Hogan 1 – Definitely not preventable	47
Hogan 2 – Slight evidence of prevention	9
Hogan 3 – Possibly preventable, less than 50:50	4

NCEPOD 1 – Good practice	33
NCEPOD 2 – Room for improvement clinical care	0
NCEPOD 3 – Room to improve organisation of care	15
NCEPOD 4 – Room to improve clinical and organisational	11
NCEPOD 5 – Less than satisfactory	1

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

Good practice identified:
Good practice was identified around obtaining a second opinion from a colleague in complex cases which highlighted effective team working.
Good evidence of family involvement in decision making
Evidence of collaboration between teams in terms of patients with both physical and mental conditions.

Learning themes identified:

- **Sharing investigation results with patients:**
- Results from investigations should be shared fully with patients and/or their families in an appropriate manner, this should be carried out in a face to face consultation when the results are significant. Radiology team to ensure that any results that require urgent review are flagged to the requesting consultant.
- **Discharge / handover of frail elderly patients:**
- Theme emerged around patients being discharged home late in the day and concerns around the handover of discharge information to care homes. This theme has also been identified through the Safeguarding Team, a Rapid Process Improvement Workshop (RPIW) has been planned to review these processes.
- **Caring for patients with a learning disability:**
- In order to support patients with a Learning disability, alerts on Medway will be reviewed to explore the option of adding extra info in terms of how to best support them during the admission or appointment.
- Severity of learning disability and how this affected the deceased patient to be added to learning disability mortality review proforma, to assist with whether reasonable adjustments made where required and also to determine whether the care given was appropriate for their needs and was not hindered by the learning disability.
- Issues with MCA 1 & 2 and DoLS not being completed correctly continue to be a theme.
- When patients struggle to communicate their symptoms due to a cognitive impairment, it can be difficult to perform an assessment, consider consultant review for these patients to prevent any misdiagnosis.
- **Caring for end of life patients in inpatient mental health units:**
- In order to ensure the appropriate support for staff and patients is in place, involve the specialist palliative care team for those patients at the end of life on the inpatient mental health units.
- **Communication:**
- Being able to contact staff on busy wards via the telephone can be very challenging. Explore the possibility of having a dedicated telephone line for the ward clerks for internal calls.
- Ensure that all documentation and terminology is grammatically correct as this sets the tone for the care provided including replacing ‘patient refuses treatment’ with ‘patient declines treatment’.
- **Care/treatment:**
- Consider when tranquilisation and sedation of patients with life threatening illness is appropriate when they do not want to take their prescribed medications
- Chest x-ray checklist

- Telemetry – alarm fatigue, equipment
- Enhanced care tool/ afloat tool
- Potential for full review of patients with a long admission

Actions identified/taken:

- A RPIW has taken place to review the discharge processes and design a new way of working across the system.
- The Lead Nurse for Learning Disabilities has an ongoing programme of work to promote best practice for patients with a learning disability. A basic level training will be added into the core skills for all staff. A more in-depth level will be developed and added to core skills for the relevant groups of staff – this is a work in progress.
- The annual DNACPR review for patients with a learning disability is being carried and will be presented to the Mortality & Morbidity Steering Group and SafeCare Council in October 2022.
- Learning in relation to documenting decisions and communication with patients has been shared widely through the organisation via Business Unit meetings.

6. Recommendation

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

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 17

Report Title:	**Well-led Action Plan**			
Name of Meeting:	Board of Directors – Part 1			
Date of Meeting:	30 November 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 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*	-			
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 (93% now completed). • There are three overdue (red-rated) 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. • A closure report will be presented to Board in March 2023.			
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 increase in completed actions. Assurance is provided that there will be a continued focus on addressing off-track and in progress actions and the commitment to complete all actions prior to the presentation of a closure report to Board in March 2023.			

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)					
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒		

Well-Led Action Plan Update – November 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 an increase in the number of complete actions, which now account for 93% of the total actions, compared to 81% when the plan was last presented to the Board.

1.4. The off-track category accounts for 7% of the total although the composition of this has changed slightly. 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. The three open actions will be closely monitored with the aim of completing the action plan fully by March 2023 and presenting a closure report to Board.

2. Introduction

2.1. The Well-Led action plan was last formally reviewed at the Board of Directors in May 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 previously reported Board positions, can be summarised as follows:

Key	Description	Nov 22	Nov 22 as a % of total actions	May 22	May 22 as a % of total actions	Jan 22	Sept 21
	Not yet started	**0**	**0%**	0	0%	3	6
	Started and on track no risks to delivery	**0**	**0%**	3	7%	3	18
	Plan in place with some risks to delivery	**0**	**0%**	1	3%	2	7
	Off track, risks to delivery and or no plan/timescales and or objective not achievable	**3**	**7%**	4	9%	7	-
	Complete	**40**	**93%**	35	81%	28	12
	TOTAL ACTIONS	**43**	**100%**	**43**	**100%**	**43**	**43**

3.2. Assurance can be taken from the improvement in the proportion of completed actions, which now account for 93% of the total number of actions.

3.3. Off-track actions have reduced from 4 to 3, although this includes one action which was previously on-track (information asset management plan) and 2 previous off-track actions has been closed (business unit representation at the Finance and Performance Committee and business unit capacity review). There remains a clear commitment to complete these actions, which have been impacted by operational pressures and other capacity constraints. A plan is in place to seek external support to review and update key governance documents such as the Standing Financial Instructions and Scheme of Delegation following a recent review. In addition, the findings of the desktop review of business unit governance are currently being drafted and should be completed in a matter of weeks.

4. Solutions / recommendations

4.1. The Board of Directors is requested to review the latest action plan, noting the increase in completed actions. Assurance is provided that there will be a continued focus on addressing off-track and in progress actions and the commitment to complete all actions prior to the presentation of a closure report to Board in March 2023.

REC REF	RECOMMENDATION	ACTIONS	LEAD	DELEGATED SENIOR MANAGER	DUE DATE	PROGRESS UPDATE	RAG SEPT 21	RAG JAN 22	PROPOSED RAG MAY 22	NOV 22
R4	Feedback from ICS /ICP	Develop a communication plan for sharing feedback from ICS/ICP across senior management – 2 way process	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 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. Nov 22 – this now features in the cycle of business for SMT. Recommended for closure.				
R5	Capacity concerns raised by some	Carry out a deep dive into	Joanne Baxter	N/a	Dec 21	New structures now in place and all gaps to management structures filled.				

REC REF	RECOMMENDATION	ACTIONS	LEAD	DELEGATED SENIOR MANAGER	DUE DATE	PROGRESS UPDATE	RAG SEPT 21	RAG JAN 22	PROPOSED RAG MAY 22	NOV 22
	Operational Business Units (OBU) management	capacity within OBUs and identify an action plan that includes capacity and staff wellbeing				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 Nov 22- a number of changes have taken place to strengthen operational business unit capacity. This includes embedding the new structure and strengthening the support through aligning business unit business partners from corporate partners. Leadership development work continues with a commitment to continue to strengthen triumvirate working. Action recommended for closure.				
R6	Visibility	Develop programme of activity to include: Corporate – develop a back to floor and 15	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				

REC REF	RECOMMENDATION	ACTIONS	LEAD	DELEGATED SENIOR MANAGER	DUE DATE	PROGRESS UPDATE	RAG SEPT 21	RAG JAN 22	PROPOSED RAG MAY 22	NOV 22
		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				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 and a plan to restart them safely will be considered. Retain as ongoing but with some element of risk.				

REC REF	RECOMMENDATION	ACTIONS	LEAD	DELEGATED SENIOR MANAGER	DUE DATE	PROGRESS UPDATE	RAG SEPT 21	RAG JAN 22	PROPOSED RAG MAY 22	NOV 22
						Nov 22 – Governor engagement has now restarted with visits to theatres and intensive care. Plans in place for Governors to join PLACE visits when they recommence. Recommended for closure as we move to business as usual.				
R10	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. Nov 22 – terms of reference recently reviewed. Business units now attend when required as part of the accountability framework reporting.				
	Scheme of delegation	Ensure the scheme of delegation and Standing Financial Instructions	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				

REC REF	RECOMMENDATION	ACTIONS	LEAD	DELEGATED SENIOR MANAGER	DUE DATE	PROGRESS UPDATE	RAG SEPT 21	RAG JAN 22	PROPOSED RAG MAY 22	NOV 22
		(SFIs) reflect the decision-making authority of the 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.				Delegation and Standing Orders has been rescheduled to March 22 Board. May 22 – note that due to capacity constraints this action has been further delayed until after the year end processes have been completed. Nov 22 – external review to be commissioned to undertake wider review of Scheme of Delegation, SFIs etc following recent QEF governance review. Action remains ongoing.				
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.	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				

REC REF	RECOMMENDATION	ACTIONS	LEAD	DELEGATED SENIOR MANAGER	DUE DATE	PROGRESS UPDATE	RAG SEPT 21	RAG JAN 22	PROPOSED RAG MAY 22	NOV 22
		This should include comparing and contrasting the meeting structures. This will enable a more accurate assessment of Business Unit governance to be made.				to commence review, but given operational pressures and reprioritisation of resource, this has been postponed. May 22 – due to capacity constraints this action has not been able to be progressed and is retained as off track. Nov 22 – desktop review completed and in the process of being documented. Anticipated to be completed imminently.				
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	Kris Mackenzie	N/a	~~Sept 21~~ 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. Nov 22 – forecasting now included in the finance report. Action recommended for closure.				

REC REF	RECOMMENDATION	ACTIONS	LEAD	DELEGATED SENIOR MANAGER	DUE DATE	PROGRESS UPDATE	RAG SEPT 21	RAG JAN 22	PROPOSED RAG MAY 22	NOV 22
		Part 2 of the finance report.								
R18	Data Quality	Identify ways in which the accountability and responsibility for data entry can be re-emphasised to staff, including education on the implications of entering inaccurate data.	Nick Black	N/a	~~Sept 21~~ 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 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. Nov 22 – there has been further slippage against this plan with regular escalation to SMT in August, October and November. Overdue returns continue to be highlighted with the IG team supporting teams to reach full compliance.				

Meeting:	Trust Board
Chair:	Alison Marshall
Financial year:	2021/22 and 2022/23

	Lead	Type of item	Public/Private	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	√	√
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		
Well Led Review Action Plan Update / Closure report	Company Secretary	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 (now via POD Committee)	Exec Director of People & OD	Item for Assurance	Part 1	√	
WRES and WDES Report (6 monthly report March 23 and Sept 23)	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		
Maternity Integrated Oversight Report	Chief Nurse	Item for Assurance	Part 1	√	√
Items for Information			Part 1 & Part 2		
Register of Official Seal	Company Secretary	Item for Information	Part 1		
Ad Hoc Items (i.e. items emerging during the year)			Part 1 & Part 2		
Trust Green Plan 2022-2025 annual updates	QEF Managing Director	Item for Assurance	Part 1		√
Ockenden Next Steps and Assurance Visit	Chief Nurse	Item for Assurance	Part 1		
Communications Strategy	Deputy Director of Corporate Services	Item for Decision	Part 1		
Digital Strategy	Deputy Director of Corporate Services	Item for Decision	Part 1		
Estates Strategy	Deputy Director of Corporate Services	Item for Decision	Part 1		
Commercial Strategy	Deputy Director of Corporate Services	Item for Decision	Part 1	√	
Equality Diversity and Inclusion Strategy	Deputy Director of Corporate Services	Item for Decision	Part 1	√	
Finance Strategy	Deputy Director of Corporate Services	Item for Decision	Part 1	√	
People Strategy	Deputy Director of Corporate Services	Item for Decision	Part 1	√	
East Kent Maternity and Neonatal Services Investigation Report	Chief Nurse	Item for Assurance	Part 1		
Maternity Incentive Scheme	Chief Nurse	Item for Assurance	Part 1	√	