MEETING OF THE BOARD OF DIRECTORS IN PUBLIC

Gateshead Health NHS Foundation Trust

Date: Wednesday 26th July 2023
Time: 9:30 am
Venue: Rooms 9&10, Education Centre/Teams

AGENDA

	TIME	ITEM	STATUS	PAPER
1.	9:30 am	**Welcome and Chair's Business**		
2.	9:33 am	**Declarations of Interest** To declare any pecuniary or non-pecuniary interests and receive the Declarations of Interest from new Board members *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	Enclosure 2
3.	9:34 am	**Apologies for Absence** *Quoracy check: (s3.3.31 SOs: No business shall be transacted at a meeting unless a minimum of **4** members of the Board (including at least **one** Non-Executive and **one** Executive Member of the Board are present)*	Agree	Verbal
4.	9:35 am	**Minutes of the meeting held on 24 May 2023** To be agreed as an accurate record	Agree	Enclosure 4
5.	9:40 am	**Matters Arising / Action Log**	Update	Enclosure 5
6.	9:45 am	**Patient & Staff Story** • Maternity patient story	Assurance	Enclosure 6
		ITEMS FOR DECISION		
7.	10:05 am	**Nursing Apprenticeships 4 Year Programme Proposal** To approve the recommendations presented by the Chief Nurse/Deputy Chief Executive and Interim Director of People & Organisational Development	Approval	Enclosure 7
		ITEMS FOR ASSURANCE		
8.	10:15 am	**Assurance from Board Committees** i. Finance and Performance Committee – 27 June 2023 and 25 July 2023 ii. Quality Governance Committee – 21 June 2023 iii. Digital Committee – 7 June 2023 iv. POD Committee – 11 July 2023 v. Audit Committee – 26 June 2023	Assurance	Enclosure 8
9.	10:30 am	**Chief Executive's Update Report** To receive a briefing report from the Chief Executive i. Mental health services overview	Assurance	Enclosure 9
10.	10:50 am	**Governance Reports** i. **Strategic Aims and Objectives update** ii. **Board Assurance Framework update** iii. **Organisational Risk Register** To receive the reports presented by the Director of Strategy, Planning & Partnerships, Company Secretary and Chief Nurse	Assurance	Enclosure 10
11.	11:05 am	**Finance Report (including capital and the Financial Sustainability overview)** To receive the report, presented by the Group Director of Finance and Digital	Assurance	Enclosure 11

12.	11:15 am	**Integrated Oversight Report** To receive the report, presented by the Chief Nurse, Medical Director and Interim Director of People and Organisational Development	Assurance	Enclosure 12
13.	11:30 pm	**Nurse Staffing Monthly Exception Report** To receive the report, presented by the Chief Nurse	Assurance	Enclosure 13
14.	11:40 pm	**Maternity Update** i. **Maternity Integrated Oversight Report** To receive the report, presented by the Head of Midwifery	Assurance	Enclosure 14
		ITEMS FOR INFORMATION		
15.	11:50 pm	**Quality Account 2022/23** To receive the report for information presented by the Chief Nurse	Information	Enclosure 15
16.	11:55 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 16
17.	12:00 pm	**Questions from Governors in Attendance** To receive any questions from governors in attendance		Verbal
18.	12:10 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 27th September 2023		Verbal
19.	12:10 pm	**Chair Declares the Meeting Closed**		Verbal
20.	12:10 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

Report Cover Sheet Agenda Item: 2

Report Title:	**Declaration of Board Members Interests, Gifts and Hospitality**			
Name of Meeting:	Board of Directors			
Date of Meeting:	Wednesday 26th July 2023			
Author:	Diane Waites, Corporate Services Assistant			
Executive Sponsor:	Alison Marshall, Chair of the Board of Directors Trudie Davies, Chief Executive			
Report presented by:	Jennifer Boyle, Company Secretary			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☒	**Discussion:** ☐	**Assurance:** ☐	**Information:** ☐
	In accordance with section 20 of Schedule 1 of the Health & Social Care (Community Health and Standards) Act 2003 NHS Foundation Trusts are required to maintain a register of Directors' and Governors' interests. This requirement is also enshrined in section 10 of the Trust's Constitution. The register for Gateshead Health NHS Foundation Trust is held at Trust Headquarters and is available to the public through the Company Secretary.			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☒ *No gaps in assurance*	**Partially assured** ☐ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	-			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	• The Register of Board Members interests has been updated to include new Board Members • Interests have been declared in accordance with the Trust's Managing Conflicts of Interest Policy. • This is aligned to the model policy issued by NHS England. • All Board Members must make an annual declaration and are required to make subsequent in-year declarations to record any changes in interests.			

<table>
<tr><td>Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper</td><td colspan="5">The Board is asked to:
Approve and record in the Board minutes the declared interests
Note that the next annual review of the declaration of Board members' interests will take place in March 2024.</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">Declarations of interests enable the early identification of any potential conflicts which may in turn impact upon the ability to achieve the strategic aims and objectives.</td></tr>
<tr><td>Links to CQC KLOE</td><td>Caring
☐</td><td>Responsive
☐</td><td>Well-led
☒</td><td>Effective
☐</td><td>Safe
☐</td></tr>
<tr><td colspan="6">Risks / implications from this report (positive or negative):</td></tr>
<tr><td>Links to risks (identify significant risks and DATIX reference)</td><td colspan="5">-</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>

Forename	Surname	Position	Interest	From	To	Comments
Andrew	Beeby	Medical Director	None			
Adam	Crampsie	Non-Executive Director	Chief Executive - Everyturn Mental Health	20/11/2021	present	Provider to Trust
			Chair - North East & North Cumbria VCSE Board	10/06/2023	present	
			Board Member - North East & North Cumbria MHLDA Board	10/06/2023	present	
Trudie	Davies	Chief Executive	None	01/03/2023	31/03/2023	Started in post on 1 March 2023
Gill	Findley	Chief Nurse	None			
Neil	Halford	Medical Director of Operations	None			
Steven	Harrison	Managing Director QE Facilities	None			
Martin	Hedley	Non-Executive Director	Non-Executive Director - Royal Surrey NHS Foundation Trust	01/03/2016	present	
			Chair & Non-Executive Director - RSCH Pharmacy Limited	01/11/2019	present	
			Governor - Gateshead College	01/03/2019	present	
			Managing Director/Recruiting/Coaching - Vision Achievement Limited	01/02/2013	present	
Kris	Mackenzie	Group Director of Finance and Digital	None			
Alison	Marshall	Chair	Non-Executive Director of Northern Powergrid plc (North East and Yorkshire)	2014		
			Ambassador for North Northumberland Hospice Care	2015		
			Spouse - NED of North East Ambulance Service NHSFT	2017		
			Spouse - NED of North East Ambulance Service Unified Solutions Ltd	2019		
			Spouse - Chair of Newcastle Gateshead Initiative	2016		
			Spouse - Chair of North East England Chamber of Commerce	2020		
			Spouse - Director of Newcastle United Foundation Projects Ltd			
			Spouse - NED of Believe Housing Ltd	2019		
			Spouse - Chair of Trustees for Newcastle United Foundation			
			Spouse - Ambassador of North Northumberland Hospice Care	2015		
			Spouse - Chair of Regional Development Committee, Prince's Trust			
Andrew	Moffat	Non-Executive Director	Non-Executive Director of Advanced Northumberland	24/04/2023		
Hilary	Parker	Non-Executive Director	Non-Executive Director of Kingston Properties Ltd (wholly owned subsidiary of Bernicia Housing)	2019		Registered housing association
			Trustee - Newcastle University Development Trust	2016		Charitable Trust
			Non-Executive Director of QE Facilities Ltd (wholly owned subsidiary of GHNHSFT	2020		
			Consultant - Sintons LLP Law Firm	2016	present	
Mike	Robson	Vice Chair/Non-Executive Director	None	01/04/2022	31/03/2023	
Anna	Stabler	Non-Executive Director	Position in Family Court in Co Durham Justice area	01/02/2023		Note - this will exclude any public law cases in relation to the Trust
Maggie	Pavlou	Non-Executive Director	Owner / Director - People Gauge (software business)	2011		
			Trustee - The People's Kitchen (charitable organisation)	2020		
			The Chronicle Sunshine Fund (charitable organisation)	2020		
			Trustee - York Theatre Royal (arts)	2022		
			Non-Executive Director of QE Facilities Ltd (wholly owned subsidiary of GHNHSFT	2022		
			Spouse - Harlow Printing (printing firm)	2022		
Amanda	Venner	Interim Director of People and Organisational Development	None			

Gateshead Health NHS Foundation Trust

Trust Board

Minutes of a meeting of the Board of Directors
held at 9.30 am on Wednesday 24th May 2023, in
Rooms 9&10, Education Centre, Queen Elizabeth Hospital and via MS Teams

Present:	
Mrs A Marshall	Chair
Mr A Beeby	Medical Director
Dr R Bonnington	Non-Executive Director
Mrs L Crichton-Jones	Executive Director of People & OD
Mrs T Davies	Chief Executive
Dr G Findley	Chief Nurse
Cllr M Gannon	Non-Executive Director
Mr S Harrison	Interim Managing Director for QE Facilities
Mrs K Mackenzie	Group Director of Finance and Digital
Mr A Moffat	Non-Executive Director
Mrs H Parker	Non-Executive Director
Mr M Robson	Vice Chair / Non-Executive Director
Mrs A Stabler	Non-Executive Director
In Attendance:	
Mrs J Boyle	Company Secretary
Mrs J Conroy	Interim Head of Midwifery (23/119)
Ms A Heads	Heart Failure Nurse (23/109)
Ms D Waites	Corporate Services Assistant
Governors and Members of the Public:	
Mrs H Adams	Staff Governor
Mr M Learmouth	Public Governor – Central
Mr G Riddell	Public Governor – Western
	2 members of the public
Apologies:	
Mrs J Baxter	Chief Operating Officer
Mr N Halford	Medical Director of Operations
Mrs M Pavlou	Non-Executive Director

Agenda Item	Discussion and Action Points	Action By
23/104	**CHAIR'S BUSINESS:** The meeting being quorate, Mrs A Marshall, Chair, declared the meeting open at 9.30 am and confirmed that the meeting had been convened in accordance with the Trust's Constitution and Standing Orders. She welcomed those present including the Trust's Governors and welcomed Mr Steven Harrison to his first meeting as Interim Managing Director for QE Facilities. She highlighted that this will be the last public Board meeting for Dr Ruth Bonnington and Cllr Martin Gannon as their terms of office as Non-Executive Directors comes to an end and Mrs Lisa Crichton-Jones, Executive Director for People and Organisational Development, who is leaving the Trust for a new role. She thanked them for their	

Agenda Item	Discussion and Action Points	Action By
	commitment, experience and advice during their time at the Trust and wished them well for the future.	
23/105	**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.	
23/106	**APOLOGIES FOR ABSENCE:** Apologies for absence were received from Mrs J Baxter, Mr N Halford and Mrs M Pavlou.	
23/107	**MINUTES OF THE PREVIOUS MEETING:** The minutes of the meeting of the Board of Directors held on Wednesday 25th January 2023 were approved as a correct record after the following minor amendments: • 23/64 Quality Governance Committee Assurance Report – the Committee received the Mental Health Act Compliance minutes and it was noted that there had been a significant reduction in restraints and a new policy has been implemented. • 23/69 Integrated Oversight Report – the Trust has a zero tolerance in relation to infections.	
23/108	**MATTERS ARISING FROM THE MINUTES:** The Board action log was updated accordingly.	
23/109	**PATIENT STORY – HEART FAILURE TEAM** The Board welcomed Ms Angela Heads, Heart Failure Nurse, who provided a presentation on the work of the Heart Failure Team. She provided some background on the aims of the service, the role of the Heart Failure Nurses working with other healthcare professionals and the Heart Failure Day Unit which provides timely review post discharge including a reduced risk of admission and length of stay. Dr R Bonnington, Non-Executive Director, provided some patient feedback from Lynn Reid on behalf of her mother, Constance Welsh, who wished to thank the team for the care provided and highlighted the support the team had provided.	

Agenda Item	Discussion and Action Points	Action By
	Following a query from Mrs L Crichton-Jones, Executive Director of People and Organisational Development, in relation to whether health inequalities had impacted on the age range of patients, Mrs Heads reported that most patients seen by the team were elderly. Mrs Marshall thanked Ms Heads and the rest of the team on behalf of the Board.	
23/110	**CONSTITUTIONAL AMENDMENT:** Mrs J Boyle, Company Secretary, presented the report which seeks Board approval for a constitutional amendment to remove the clause which prevents Board Members from serving on more than one NHS board. She reported that the current Trust Constitution prevents Board Members from serving as Board Members or Governors at any other NHS trust and that this legacy clause has been identified as a potential barrier to the recruitment of candidates to Board positions during the current Non-Executive Director recruitment. Benchmarking within the report demonstrates that the Trust is an outlier in this respect. The proposal was presented and approved by the Council of Governors at its meeting on 17th May 2023 however does not require to be presented at the Annual Members Meeting as it does not impact on the powers of Governors. After consideration, it was: **RESOLVED:** to approve the proposed change to remove the clause from the Constitution which prevents Board Members from serving on more than one NHS trust board.	
23/111	**TRUST STRATEGIC AIMS AND OBJECTIVES:** Mrs T Davies, Chief Executive, provided the Board with the final draft of the Trust Strategic Aims and Objectives for 2023/24. She reported that the Board Committees have considered the objectives which have been mapped to them and detailed discussions have also taken place at the Board Strategy Session in April 2023. Further clinical engagement work is taking place around the alignment of key indicators and it is expected that this will be completed in June 2023 and presented to the Board Committees in July 2023. Dr R Bonnington, Non-Executive Director, felt that it would useful to include baselines particularly around absence rates and Mrs A Stabler, Non-Executive Director highlighted that the Head of Maternity should be updated and an Executive Lead and Committee was required in relation to digital.	TD / JB

Agenda Item	Discussion and Action Points	Action By
	Mr M Robson, Vice Chair, reported that the objectives were discussed at the Finance and Performance Committee meeting yesterday and it was felt that the strategy work should be incorporated including some focus around the commercial strategy and QE Facilities strategy to strengthen the objectives in relation to financial sustainability and utilising skills and expertise beyond Gateshead. Following discussion, it was: **RESOLVED:** to agree the Strategic Objectives for 2023/24 subject to highlighted amendments.	
23/112	**ENABLING STRATEGIES:** Mrs L Crichton-Jones, Executive Director for People and Organisational Development, Mr A Beeby, Medical Director, and Mrs K Mackenzie, Group Director of Finance presented the Equality, Diversity and Inclusion (EDI) Strategy, Clinical and Finance strategies. The Communications, Quality and People strategies were approved by the Board at the March meeting. Mrs Crichton-Jones presented the EDI Strategy and highlighted the Trust's pledge to being an inclusive health care provider and employer which is central to achieving the ICORE ambitions and is at the heart of NHS and Trust values. She reported that the strategy outlines the rationale for action, and areas of focus as well as highlighting the actions required to implement and deliver progress. A high level action plan has been written and actions are being monitored by the Human Rights Equality Diversity and Inclusion Board however Mrs Crichton-Jones suggested that this may be beneficial for the Board to consider at a future development session. Responsibility for EDI has recently moved into the People and OD directorate and the team will be working closely with the EDI manager, with the monitoring of delivery and key performance indicators being reported into the People and OD Committee. Mrs Marshall felt that it would be beneficial to include Governors within this work and Mrs Crichton-Jones will update. Mr Beeby presented the Clinical strategy which incorporates research, estates, acute care, making services sustainable and Business Unit priorities and highlighted that this has been shared with the Clinical Strategy Group and has received good engagement and buy-in. Mr M Robson, Vice Chair, queried whether research targets had been set within the Business Units and Mr Beeby reported that this will be undertaken soon however investment within the team is required and is being worked on. Mrs Marshall highlighted that the Research Team is keen to provide a presentation to the Board or Council of Governors and this is being scheduled.	LCJ

Agenda Item	Discussion and Action Points	Action By
	Mrs Mackenzie presented the financial strategy and reported that this is a 3-year strategy to ensure optimum use of resources to provide the best care to our patients with yearly targets being set within the Business Units. Mr S Harrison, Interim Managing Director of QE Facilities, reported that the Estates Strategy is still being developed however an update can be provided at the next Board. Mr A Moffat, Non-Executive Director, felt that this strategy was an overarching strategy to demonstrate opportunities and investments. Mr Robson suggested that the strategies should be linked to the Board Committees to ensure focussed work is undertaken and Mrs A Stabler, Non-Executive Director, felt that it may be beneficial to reference the relevant strategies on the report cover sheets and Mrs T Davies, Chief Executive, highlighted that the new Interim Director of Strategy, Planning and Performance will ensure that the strategies are embedded within the organisation and will report regularly to the Executive Team. Following consideration, it was: **RESOLVED:** to accept the changes to the strategies presented and approve with agreement that these can be launched.	
23/113	**ASSURANCE FROM BOARD COMMITTEES** **Finance and Performance Committee (F&P):** Mr M Robson, Chair of the F&P Committee, provided a verbal update of the meeting yesterday (23 May 2023) and reported that there were no items to escalate. The meeting focussed on the following areas: • QE Facilities Report – a gap was identified in performance reporting and it was agreed that jointly developed key performance indicators were required. • Integrated Oversight Report (IOR) – the Committee noted a backlog in relation to RTT (referral to treatment) therefore a waiting list validation exercise will be undertaken in relation to long waiters and the Trust's planned response to the national Out-Patient Plan. • New Operating Model – following a query from Mrs A Stabler, Non-Executive Director, in relation to the expected benefits realisation report, Mr Robson explained that further work is required around reporting metrics however the discussion was deferred as the Chief Operating Officer was unable to be present. • Audit One Report on Accounts Payable was received with substantial assurance provided. There are also no outstanding actions • HFMA Sustainability Checklist – the Committee discussed two areas of focus in relation to training and culture, and financial management delegation and these have been escalated.	

Agenda Item	Discussion and Action Points	Action By
	• Organisational Risk Register – finance risks were reviewed and updates agreed. **Quality Governance Committee (QGC):** Mrs A Stabler, Chair of QGC, provided a brief verbal overview to accompany the narrative report following the April 2023 meeting. She reported that there were no items for escalation however highlighted that discussions had taken place in relation to the c.difficile trajectories which have been reduced from the previous year and some concerns had been raised in relation to the overdue complaints. Mrs T Davies, Chief Executive, reported that some work is being undertaken to improve the process. **Digital Committee** Mr A Moffat, Chair of the Digital Committee, provided a brief verbal overview to accompany the narrative report following the April 2023 meeting and reported that there were no items for escalation. He highlighted the following key points: • Strategic Objectives for Digital – it was noted that 3 of the objectives were not delivered and continue to be monitored by the Committee • Electronic Patient Record (EPR) update – concerns were raised by the Committee around the lack of progress and further information was requested in relation to critical timelines therefore an update was requested to be brought back at the next meeting. Mrs K Mackenzie, Group Director of Finance and Digital, reported that a re-evaluation of options has been requested and Mr A Beeby, Medical Director, highlighted that supplier demonstrations are being arranged. Following a query from Mrs Stabler in relation to funding, Mrs Mackenzie reported that regional offers are being considered and Mrs Davies reminded the Board of the work behind the enabling strategies to consider innovative digital solutions to ensure patient centred care. • Digital Key Performance Indicators – it was noted that there are some KPIs which remain below target in particular Information Asset Management • Digital Sub Committees – Mr Moffat wished to raise concerns in relation to some of the sub-groups not taking place and had asked the Executive team to review the assurance process. **People and Organisational Development (POD) Committee** Dr R Bonnington, Chair of the POD Committee, provided a brief verbal overview to accompany the narrative report following the May 2023 meeting and reported that there were no items for escalation. She wished to highlight the work that has been undertaken in relation to reducing sickness absence rates and increasing appraisal rates and the Board thanked the teams for their work around this. Mrs Marshall thanked the Committee Chairs for their reports and after consideration, it was:	

Agenda Item	Discussion and Action Points	Action By
	RESOLVED: to receive the reports for assurance	
23/114	**CHIEF EXECUTIVE'S UPDATE REPORT** Mrs T Davies, Chief Executive, gave an update to the Board on current issues which have aligned to the Trust's Strategic Aims. She highlighted that Dr G Findley has recently been appointed to the Deputy Chief Executive role and drew attention to the following updates: • Strategic Aim 1 – significant focus on length of stay with key improvements being seen including closure of escalation beds, reduction in non-elective length of stay and improvements in A&E-related metrics. Mrs Davies thanked teams within the organisation for the work taking place which will benefit patients. • Strategic Aim 2 – Mrs L Crichton-Jones, Executive Director for People & Organisational Development drew attention to the work which has been undertaken in relation to industrial action and reported that there has been 12 periods of action and wished to thank teams for their hard work and support. Mr A Beeby, Medical Director, reminded the Board of further plans for junior doctor strike action and resilience plans are being developed. • Strategic Aim 3 – an estates mapping exercise has been commenced following requests for increased visibility, openness and transparency. • Strategic Aim 4 – demonstrates some of the partnership working and Mrs Davies reported that a lot of engagement work is being undertaken. The first Gateshead Committee at Place recently took place and leads have been invited to attend an interactive session with the senior managers to develop the Trust's collaborative approach to place-based working. • Strategic Aim 5 – a shared strategy event has been held with colleagues from QE Facilities to discuss opportunities to continue to work together. Nicola Bruce has also recently been appointed as Interim Director of Strategy, Planning and Partnerships which will provide a proactive approach to the development of the Trust's strategic intent and ambition. **Thematic Review** Mrs Davies provided the Board with visibility on the outcome of the thematic review which includes a delivery plan and emerging key indicators. She explained that the report highlights the Trust's commitment to learning from feedback and a number of different sources have been used to identify the themes, trends and actions. The delivery plan will support the organisation to achieve the key principles outlined within the report and deliver high quality and efficient services for our patients. She highlighted that the findings have already been shared at a number of forums including the Council of Governors meeting on 17th May 2023 and has been well received.	

Agenda Item	Discussion and Action Points	Action By
	Following a query from Mrs Marshall in relation to the delivery of the key actions, Mrs Davies explained that it is expected that these will form the basis of the Trust's core actions for the next 12-18 months and key indicators are also currently in development. A consultation process is currently being undertaken with colleagues across the Trust including clinical colleagues to ensure views and input is included and following this process, the key indicators will be shared with the Board and will be used to underpin Board business. Mrs A Stabler, Non-Executive Director, welcomed the review and acknowledged the role of the Board and Non-Executive Directors. She queried whether updates would be provided to the Board and Mrs Davies highlighted that updates will be provided via the People & Organisational Development Committee. Mrs Crichton-Jones felt that it was important to ensure that the actions were reviewed as a whole however further development would be required around the culture and leadership within the organisation and the leading indicators will provide a comprehensive plan for delivering priority areas. Mrs Davies explained that the key indicators will also be reviewed on a regular basis by the Executive Team, Senior Management Team and Clinical Strategy Group however can also be considered by the Board during the Executive walkabouts. Mr Beeby highlighted that the response from clinical colleagues has been good and they are keen to be involved therefore it is important to ensure this is recognised and lessons around communications will be taken forward. Mrs Marshall acknowledged the Board's support around the plans for delivery and Mrs Davies highlighted that if further investment is required, business cases will be progressed through normal processes however will reference the overall plan for transparency. It is expected that an update will be provided to the Board in six months time. **RESOLVED:** to receive the report for assurance.	TD JB
23/115	**GOVERNANCE REPORTS** **Organisational Risk Register (ORR)** Dr G Findley, Deputy Chief Executive and Chief Nurse, presented the updated ORR to the Board, noting that it is now received at the weekly Executive Team Meeting and monthly Executive Risk Management Group (ERMG). This report covers the period 15th March 2023 to 15th May 2023. She reported that there are currently 18 risks on the ORR, 2 of which have a high score of 20, relating to the risk of failing to meet the CQC Fundamental Standards and the risk of being unable to release staff for mandatory training and medical devices training due to operational pressures and current vacancies, both of which have detailed action plans are in place. Dr Findley highlighted that a risk relating to the	

Agenda Item	Discussion and Action Points	Action By
	Disclosure and Barring Service (DBS) checks has now been escalated however will show on the ORR going forward. Mr A Moffat, Non-Executive Director, raised a risk in relation to the completion of actions from the QE Facilities review and Mrs K Mackenzie, Group Director of Finance and Digital, reported that this had been discussed at the Finance and Performance Committee therefore will be raised at the next ERMG meeting. Following a query from Mrs Marshall in relation to linking risks to Strategic Aim 5, Beyond Gateshead, Dr Findley explained that this will be looked at. **RESOLVED:** to receive the report for assurance. **Risk Management Strategy:** Dr Findley presented the proposed draft Group Risk Management Strategy for the Trust and QE Facilities. She explained that the strategy has been reviewed by the Audit Committee and QE Facilities Board however feedback from the QE Facilities Board needs to be incorporated due to the timing of the meeting therefore delegated authority is requested from the Board to ensure the changes are completed. **RESOLVED:** to approve the Risk Management Strategy and provide delegated authority to make the changes recommended by the QE Facilities Board.	
23/116	**ANNUAL PLANNING UPDATE:** Mrs K Mackenzie, Group Director of Finance and Digital, provided the Board with an update on the final submission of the 2023/24 revenue and capital financial plan. Mrs Mackenzie confirmed that the final plan was submitted ahead of the deadline of noon on 4th May 2023 and reminded the Board that the financial plan projected a revenue deficit of £12.588m and a capital spend of £27.345m. She drew attention to the highlighted risks within the report and explained that the risks have been considered by Executive Team, and once fully assessed and risk scored will be presented to the Executive Risk Management Group at the next meeting in June 2023. Mrs Mackenzie explained that there is no formal financial reporting for Month 1 however highlighted that early indications show that the Trust is slightly ahead of plan. Following consideration, it was:	

Agenda Item	Discussion and Action Points	Action By
	RESOLVED: to receive the final version of the financial plan for 2023/24 noting the figures for the planned revenue deficit and capital plan.	
23/117	**INTEGRATED OVERSIGHT REPORT:** Mrs K Mackenzie, Group Director of Finance and Digital, Dr G Findley, Deputy Chief Executive & Chief Nurse, Mr A Beeby, Medical Director, and Mrs L Crichton-Jones, Executive Director of People and Organisational Development, introduced the Integrated Oversight Report (IOR) for March and April 2023. The paper has been discussed and received in-depth scrutiny by the various Board Committees. Mrs Mackenzie provided an update in relation to Responsive performance targets. She highlighted that there have been no 12-hour trolley waits for a bed due to a reduced number of escalation beds which has also shown an improvement in length of stay and ambulance handover times. There are signs of increased waiting times however a Trust-wide validation exercise is currently underway to review this in line with the national out-patient delivery plan and there are plans to roll this out across the organisation beginning in June 2023. Mrs Crichton-Jones provided an update in relation to Well Led performance targets. She highlighted that the Trust's quarterly Pulse workforce survey response rate has improved and the Organisation Development team continue to work on this to improve scores across all categories. Following a query from Mr A Moffat, Non-Executive Director, in relation to how the survey is received by the workforce, Mrs Crichton-Jones explained that this is a nationally mandated survey which provides valuable feedback however work continues around staff engagement. Mr Beeby provided an update in relation to Effective performance targets and reported that the Hospital Standardised Mortality Ratio (HSMR) is showing deaths 'as expected' and the Summary Hospital-level Mortality Indicator (SHMI) is showing lower than expected deaths. Further discussion will take place as part of the Learning from Deaths Report later in the agenda. He also highlighted that there have been significant improvements in patients in beds who no longer meet the criteria to reside as well as improvements within the discharge process measurement. Dr Findley provided an update in relation to Safe performance targets and reported that there were six reported serious incidents (SIs) during April 2023. She explained that two incidents caused moderate harm to patients, one as a result of a medical devices or equipment error and the other because of an incorrect diagnosis. Four of the SIs caused severe harm, two related to a non-controlled drug incident, two related to falls from a height. One of the SIs occurred on a ward which is flagged as an exception in the Safer Staffing report (Agenda Item 15). Dr Findley reported that weekly meetings take place to discuss the incidents and	

Agenda Item	Discussion and Action Points	Action By
	Mrs A Stabler, Non-Executive Director, highlighted that the Board should receive a summary if any SIs are reported and Dr Findley will ensure that this is being distributed. Mrs Stabler raised concerns in relation to the rising trajectory for 52 week waiters and Mrs T Davies, Chief Executive, highlighted that this was being driven by paediatric autism referrals. She explained that the Executive Team have requested a briefing report to determine what support is required and an update will be included in the next report. Mr Beeby highlighted that alternative agency involvement was being offered in the meantime. Following discussion in relation to the waiting list validation exercise and dedicated resources, Mrs Davies reported that this should be included within the Annual Audit Plan and Mrs Mackenzie explained that the Deputy Director of Planning and Performance was reviewing this. Mr Moffat queried whether there had been any impact from industrial action and Mrs Davies reported that quality risk assessments were taking place. After consideration, it was: **RESOLVED:** to receive the report for assurance acknowledging the improvements in key areas and impact in elective recovery and waiting times.	GF
23/118	**NURSE STAFFING EXCEPTION REPORT:** Dr G Findley, Deputy Chief Executive & Chief Nurse, presented the report for April 2023 which provides an exception report for nursing and midwifery staffing, including healthcare support workers, and provides information relating to ward staffing levels (funded against actual) and details of the actions taken to address any shortfalls. She reported that during April, the Trust worked to the agreed clinical operational model, which meant at times some wards had lower patient occupancy and staff were redeployed appropriately to areas with the greatest clinical need. 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. **Bi-Annual Safe Staffing Review Report:** Dr Findley reported that the review took place using the Safer Nursing Care Tool (SNCT) which is a recognised, evidence-based tool approved by the National Institute of Health and Care Excellence for calculating staffing establishments. This bi-annual approach supports workforce planning and ensures effective utilisation of staff to ensure the Trust continues to have the right person in the right place with the right skills. This includes in-patient wards and emergency areas however does not yet include community services.	

Agenda Item	Discussion and Action Points	Action By
	Dr Findley highlighted that since the last review, a greater number of health care assistants has been required against fewer registered nurses however there continues to be a high level of temporary staff usage to cover vacancies and absences and a high reliance on international recruitment. The Trust also has a high turnover rate however following a deep dive exercise, it was highlighted that this is predominantly due to retirement. Discussions have taken place with matrons and ward managers around skill mix and there is a recommendation to move more staff onto overnight duties. There is also a recommendation to support the uplift of registered nurses to supervisory roles which will strengthen improvement rates of appraisals, sickness absence and training. Mrs L Crichton-Jones, Executive Director of People and Organisational Development, felt that this was a useful report and will support the People and Organisational Development Committee in the review of supply and income. She felt it would be useful to receive the audit documents embedded within the report separately and Dr Findley will ensure these are forwarded to the Board. Mrs A Stabler, Non-Executive Director, supported the recommendations however felt that it was important to receive any "red flags" within the monthly assurance report. Following previous concerns received from staff in relation to moving posts to different areas, Dr Findley highlighted that the review of night shifts would reduce further movements and this will be monitored via Health Roster however can be included in the monthly report going forward. Following further discussion on turnover rates and funding establishments, Dr Findley advised that review work will continue to be undertaken and will be highlighted within the monthly report. Mrs T Davies, Chief Executive, report that this work will link with the thematic review and ensure staff are being supported to ensure patients receive the best service. Following discussion, it was: **RESOLVED:** to receive the report for assurance and support the recommendations of the Bi-Annual Safe Staffing Review.	GF GF
23/119	**MATERNITY UPDATE:** **Maternity Integrated Oversight Report:** Mrs J Conroy, Interim Head of Midwifery, presented a summary of the maternity indicators for the Trust. Mrs Conroy reminded the Board that the Maternity Dashboard is being aligned to the regional North East and North Cumbria Local Maternity and Neonatal Systems dashboards therefore a review is being made of the current dashboard with the Performance team to ensure the same	

Agenda Item	Discussion and Action Points	Action By
	data is being collected. It is expected that the new dashboard will be included in reports going forward. She reported that in April 2023, the Trust had 145 births with no serious incidents however there has been an increase in post-partum haemorrhage (PPH) rates therefore a deep dive exercise is being undertaken and protocols have been updated. Exception reporting around acuity data is also being reviewed and will be strengthened within the report going forward. Mrs Conroy informed the Board that the National Maternity Delivery Plan has recently been published which brings together the recommendations from Ockenden and East Kent reports and will provide a strategic oversight improvement plan for maternity services. Mrs T Davies, Chief Executive, thanked Mrs Conroy for the report however queried the use of the graphs within the report and Dr Findley, Deputy Chief Executive and Chief Nurse, highlighted that these will be reviewed as part of the updated report. After consideration, it was: **RESOLVED:** to receive the report for assurance. Mrs Conroy left the meeting.	GF/JC
23/120	**LEARNING FROM DEATHS SIX MONTHLY REPORT:** Mr A Beeby, Medical Director, provided an update on Mortality and Learning from Deaths over the last six months. He reported that the Trust's latest publications of national mortality indicators, places the Trust with bandings of 'lower than expected' and 'as expected' for the SHMI and HSMR respectively. He reminded the Board that all deaths are scrutinised by the Medical Examiner's office. Mrs T Davies, Chief Executive, felt that it was important to provide triangulation of assurances and supportive information to Board Committees and Mrs A Stabler, Non-Executive Director, felt that it would be beneficial to link these with SafeCare litigations and Getting It Right First Time standards to provide additional assurances to the Board. After further consideration, it was: **RESOLVED:** to receive the report for assurance	AB
23/121	**SIRO REPORT AND DIGITAL UPDATE:** Mrs K Mackenzie, Group Director of Finance and Digital informed the Board that this report had been removed from the agenda whilst the	

Agenda Item	Discussion and Action Points	Action By
	Good Governance Institute review of Committee governance structures is taking place.	
23/122	**CYCLE OF BUSINESS:** Mrs J Boyle presented the cycle of business which outlines forthcoming items for consideration by the Board. This provides advanced notice and greater visibility in relation to forward planning. The Board are therefore encouraged to review the cycle of business ahead of the next meeting in July 2023 and it was: **RESOLVED:** to receive the cycle of business for 2023/24.	
23/123	**QUESTIONS FROM GOVERNORS IN ATTENDANCE:** There were no questions from Governors received.	
23/124	**DATE AND TIME OF THE NEXT MEETING:** The next meeting of the Board of Directors will be held at 9:30am on Wednesday 26th July 2023.	
23/125	**CLOSURE OF THE MEETING:** Mrs Marshall declared the meeting closed.	
23/126	**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

	Not yet started
	Started and on track no risks to delivery
	Plan in place with some risks to delivery
	Off track, risks to delivery and or no plan/timescales and or objective not achievable
	Complete

Agenda Item Number	Date of Meeting	Agenda Item Name	Action	Deadline	Lead	Progress	RAG-rating
22/139	27/09/2022	Risk Management Strategy	To come back to Board for approval at future meeting	31/12/2022	GF	To be reviewed with enabling strategies in February. It was felt that the risk management policy should sit above this and will be discussed at Audit Committee. March 23 – a draft risk management strategy has been developed and is currently being consulted on. This included being shared with Audit Committee. This will be presented to Board following the consultation process – expected at May Board May 23 – on agenda **Action recommended for closure**	
23/12	25/01/2023	Integrated Oversight Report	Duty of candour compliance – proposed new recording method being considered with focussed work taking place. To discuss outside of meeting	29/03/2023	GF/AS	March 23 – this is in progress and will be changing with the implementation of the new incident reporting system to replace our current provider. May 23 – new process in place and review taking place via QGC **Action recommended for closure**	
23/59	29/03/2023	Constitutional Amendment	To be presented at the AMM	20/09/2023	JB	Action not yet due	
23/64	29/03/2023	Board Committee Assurance Report	Discussion around proposed rescheduling of committee meetings	24/05/2023	Exec	May 23 – outcome to be provided	

Agenda Item Number	Date of Meeting	Agenda Item Name	Action	Deadline	Lead	Progress	RAG-rating
			required – to be discussed at Exec Team				
23/67	29/03/2023	Annual NHS Staff Survey Results	Progress on action plan to come back to Board for review	27/09/2023	LCJ/AV	Action not yet due but included on cycle of business for September. **Action recommended for closure**	
23/111	24/05/2023	Trust Strategic Aims and Objectives	To make minor adjustments to the strategic aims and objectives document to ensure appropriate leads and assurance committees are identified	31/07/2023	TD/JB	Requested updates have been made. **Action recommended for closure.**	
23/112	24/05/2023	Enabling Strategies	EDI strategy – to include Governors within this work and update document	26/07/2023	LCJ / AV		
23/114	24/05/2023	Thematic Review	Consultation process taking place and following this key indicators to be shared with Board	26/07/2023	TD/JB	Leading indicators feature on the July Board agenda **Action recommended for closure.**	
			6 month update to be provided to Board – to add to cycle of business	26/07/2023	JB	Added to the cycle of business. **Action recommended for closure.**	
23/117	24/05/2023	Integrated Oversight Report	To ensure Non-Executive Directors receive summary of reported SIs	31/05/2023	GF	Process now in place. **Action recommended for closure.**	
23/118	24/05/2023	Safe Staffing Review Report	To ensure embedded documents are distributed to the Board separately	31/05/2023	GF	Sent separately via email **Action recommended for closure.**	
			Recommendation to receive “red flags” within monthly assurance report going forward	26/07/2023	GF	Included in the next report **Action recommended for closure.**	
23/119	24/05/2023	Maternity IOR	To review the use of graphs within the report	26/07/2023	GF/JC	New style maternity IOR being presented this month. **Action recommended for closure.**	
23/120	24/05/2023	Learning from Deaths	To include suggested links to litigations and Getting It Right First Time in next iteration of the report	29/11/2023	AB	Action not yet due.	

Closed Actions from last meeting

Agenda Item Number	Date of Meeting	Agenda Item Name	Action	Deadline	Lead	Progress	RAG-rating
23/60	29/03/2023	Annual Declarations of Interest	To include declaration of board members of QE Facilities	24/05/2023	DW	Completed **Action recommended for closure.**	
23/61	29/03/2023	Trust Strategic Aims and Objectives	Board session to be held in April with final objectives to come back to Board in May 2023	24/05/2023	JB	On agenda **Action recommended for closure.**	
23/63	29/03/2023	Board Assurance Framework	To be discussed at Board session as above	24/05/2023	JB	Discussed at April session. **Action recommended for closure.**	
23/72	29/03/2023	Trust Green Plan Update	Increased promotion of plan required via social media and recruitment. LCJ to arrange for member of POD team to contact TP	24/05/2023	LCJ/AV	OD, Learning and Development and Comms colleagues all asked to work with QEF colleagues and support this work **Action recommended for closure.**	

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 7

Report Title:	**Nursing Apprenticeships – 4 year programme Proposal**			
Name of Meeting:	Trust Board			
Date of Meeting:	26th July 2023			
Author:	Amanda Venner, Jane Fay, Drew Rayner & Ops Directors			
Executive Sponsor:	Amanda Venner -Interim Executive Director of People and OD, Gill Findley, Chief Nurse, Jo Baxter, COO			
Report presented by:	Dr Gill Findley, Chief Nurse and Deputy Chief Executive and Amanda Venner, Interim Executive Director of POD			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☒	**Discussion:** ☐	**Assurance:** ☐	**Information:** ☐
	To seek approval for funding to progress this programme for two years from September 2023.			
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*	SMT in 2022 and on 16th February 2023 and May 2023.			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format*	• Significant nursing vacancies and current approaches are not meeting the need • New NHS Long term workforce plan demonstrates requirement to utilise apprenticeships to train our new registrants • This is an opportunity to open up a new pathway into Nursing at Gateshead - train students straight from college in a grow our own approach • 4 year programme including HCSW experience prior to TNA and RNDA programmes • Costs included to support the programme			
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	Board to approve recommendations detailed in the report to support the recruitment of two cohorts of 10 students on the programme. (23/24 and 24/25)			

<table>
<tr><td></td><td colspan="5">The costs of the programme and external funding already available leaves a residual funding shortfall of <u>£1,129,061</u> phased over 24-25 to 28-29 financial years.

Whilst a guaranteed funding source is not yet identified it is expected potential funding opportunities will arise and include:

• Further NHS England (Health Education England) funding as described in the NHS Long term Workforce Plan linked to increasing apprenticeships
• Re-direction of internal funding currently invested in the recruitment of international nurses to this programme

In recognition of the potential funding opportunities approval is sought to recruit 10 posts into the programme in both 23-24 and 24-25 with further updates to SMT in 2024-25 on final funding streams.</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">Achieving financial sustainability</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">Registered nurse vacancies</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 Apprenticeship programmes

1.0 Introduction

In July 2022 SMT approved ongoing support for the successful Trainee Nurse Associate and Registered Nurse Degree Apprenticeship programmes. These cohorts are to be 10 learners on each programme every year with funding coming from existing vacancies in the business units and further investment totalling £368,660.

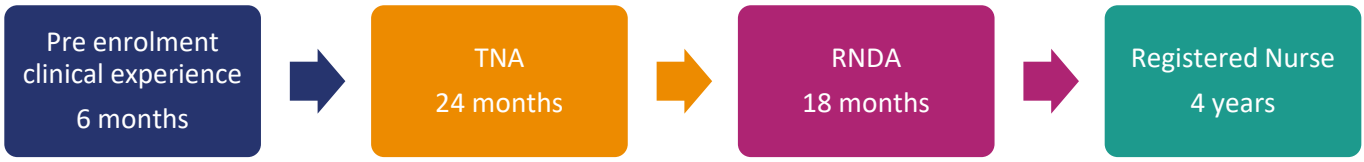
This is a consistent and effective supply of high quality, committed nursing staff for the Trust. Our conversion rates from the programme into registered nursing posts is high and programme of support during and after the programme is held in high regard.

During the process of agreeing the continuation of our existing approach we were asked to scope a new 4 year programme aimed at school leavers.

2.0 Four year programme

The four year programme will have two differences to our current approach:

1. We will aim this at school leavers, as an alternative to University
2. This means a period of pre enrolment is needed to gain the appropriate number of clinical hours experience (576 hours = 6 months)



Our current programmes are aimed at existing staff, predominantly healthcare support workers and the new approach will enable us to attract staff who are not already working in healthcare.

3.0 Clinical Hours

Pre-enrolment The newly recruited staff will be 18 years and over. They will be required to complete 576 clinical hours prior to commencement of TNA program as per NMC direction. This will facilitate the opportunity to complete core skills, care certificate and offers the potential to leave prior to an apprenticeship contract. The contract will be fulltime, with accrued annual leave as per AFC.

TNA's will work Full time over 2 years consisting of 30 hours in practice, 7.5 hours study leave. The NMC does not require TNA's to be supernumerary whilst learning in practice, and so are included in the staffing establishment of their base ward. However, the TNA's must have protected learning time. This is supervised time spent in practice with their designated Practice Supervisor/Practice Assessor. The Trust and the university recommend that a minimum of one shift per week is designated protected learning time.

RNDA's will work 22.5 hours per week in clinical practice, 7.5 hours theory study, and 7.5 hours undertaking directed learning.

Theory/Directed study days are every Thursday and Friday – this is particularly important to maintain so that they do not miss online, synchronous teaching.
Annual leave is fixed within the program – 300 hours so students should not take annual leave out of this timeframe.

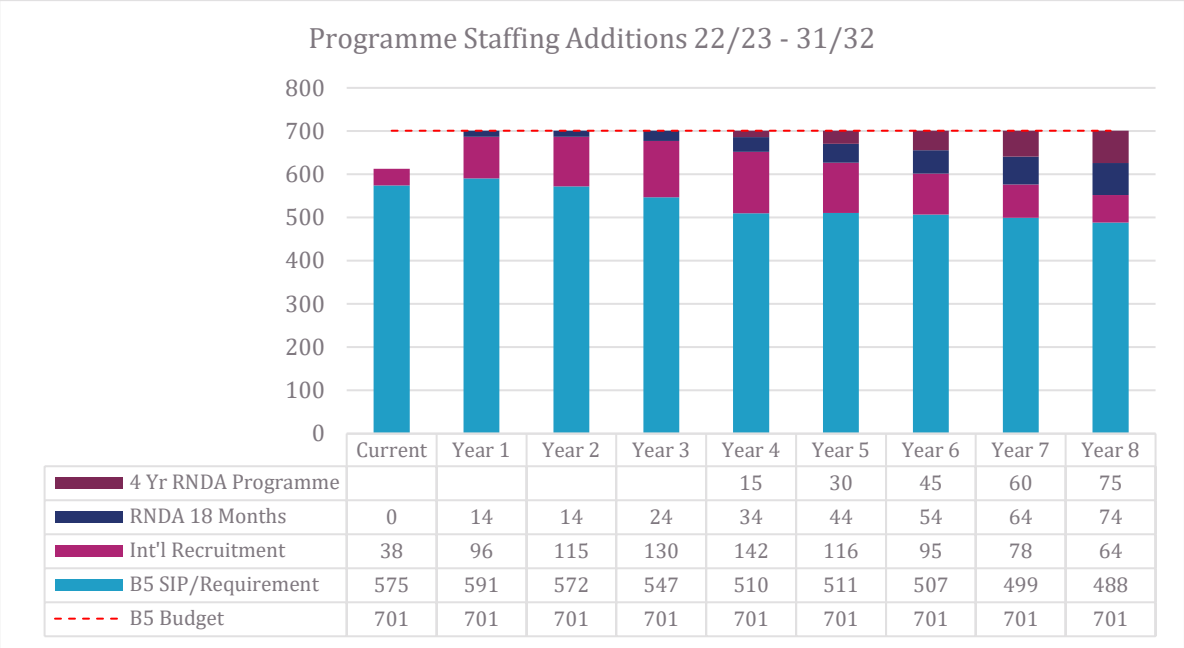
Program	Duration	Practice hours Per week	Theory hours Per week	Comments
6 months pre-enrolment	6 months	37.5	To be arranged as per care certificate program schedule.	New HCSW's who will be required to complete the care certificate. Core skills can be completed in this time.
Trainee Nursing Associate	24 months	30hrs	7.5 hrs	Part of staffing establishment on base ward 460 hours placement time external to base ward where TNA's are supernumerary.
Registered Nurse Degree Apprenticeship	18 months	22.5hrs	15hrs	Supernumerary

NB- the first cohort to be recruited in September 2023 may have a further 3 month training period to consolidate learning between TNA and RNDA programme due to academic programming, due to a slight delay in approval, this would not be the case with the second cohort of 10 in 2024.

3.1 Triangulation

The supply picture is complex within the future of the nursing workforce. As we see the numbers of student nurses within our universities and the tough financial climate for many, there will be a requirement for a number of initiatives to support the development of a sufficient pipeline to support our patients in the future, some of which will need ongoing investment. These include International recruitment, ongoing domestic recruitment and the existing TNA and RNDA programmes.

The chart below demonstrates the predicted numbers of registered nursing staff, their points of entry into the workforce and factors in a halt in international recruitment at Year 5, in which the 4 year RNDA programme at 15 entrants per year, would provide the pipeline required based upon current trends of turnover and domestic recruitment.



	Current	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8
4 Yr RNDA Programme					15	30	45	60	75
RNDA 18 Months	0	14	14	24	34	44	54	64	74
Int'l Recruitment	38	96	115	130	142	116	95	78	64
B5 SIP/Requirement	575	591	572	547	510	511	507	499	488
B5 Budget	701	701	701	701	701	701	701	701	701

Our overarching aim within Gateshead is to create a future pipeline of nurses through a "Grow your own" approach, which supports the local community with achievable entry points into their nursing career, with an alternative to the traditional routes via university.

4.0 Finances

The Trust has already approved a rolling programme of 10 students per annum commencing a TNA programme, leading to a 18-month RNDA programme.

If the programme is further developed to create a 4-year RNDA in addition to the current programme the cost will vary depending upon the number of students.

The cost of a 4-year RNDA programme totals **£60,633** per student over the duration of the 4 years, as detailed in Table 1. Assumptions supporting this cost include:

- Staff are paid at a Band 3 with a band 2 healthcare assistant post held as vacant
- For the TNA element of the course staff are part of the ward staffing numbers except for the theoretical element of the course which requires 0.2 wte backfill at a band 2
- For the RNDA element of the course staff are super-nummary for the whole duration at a Band 3
- External funding for TNA is available from Health Education England
- External funding for RNDA is not automatically available.

This cost will rise to **£606,030** for 10 students over the duration of the 4 years, as detailed in Table 1.

	Year 1		Year 2	Year 3		Year 4	Total
	6 Months Pre-enrolement	6 Months TNA	12 Months TNA	6 Months TNA	6 Months RNDA	12 Months RNDA	Total for 4 Years
	£	£	£	£	£	£	£
Band 3 Post	15,477	15,477	30,954	15,477	15,477	30,954	123,818
Backfill at Band 2 for Theory Hours TNA	0	2,820	5,640	2,820			11,279
Hold Band 2 Healthcare Assistant Vacancy	(14,099)	(14,099)	(28,198)	(14,099)			(70,494)
Health Education Contribution	0	(1,000)	(2,000)	(1,000)	0	0	(4,000)
Total Per Student	**1,378**	**3,198**	**6,396**	**3,198**	**15,477**	**30,954**	**60,603**
Total 10 Students	**13,784**	**31,982**	**63,964**	**31,982**	**154,772**	**309,545**	**606,030**
Total 10 Students 2 Years Intake							**1,212,061**

Table 1: Cost of RNDA 4 Year Training Programme

As the additional premium cost of covering a Band 5 registered nurse vacancy post at agency rates is estimated at £21,200 per annum each student completing the 4-year RNDA course will have a pay-back period of **34 months** from qualification.

To support a rolling programme of 10 students per year completing a 4-year RNDA apprenticeship prooramme it is proposed an intake of 10 students per year for the next 2 years is considered with with an option to review student numbers after the 2024-25 intake.

The cost of 10 students per annum on a rolling programme for the next 2 years totals £1,212,061 and is phased over the relevant financial years as detailed in Table 2:

	Oct 23 to March 24 23-24	24-25	25-26	26-27	27-28	28-29	Total
	£	£	£	£	£	£	£
10 Student Intake for 4 Years - Intake 1 - 23-24	13,784	63,964	63,964	309,545	154,772		606,030
10 Student Intake for 4 Years - Intake 1 - 24-25		13,784	63,964	63,964	309,545	154,772	606,030
Total Cost	**13,784**	**77,749**	**127,928**	**373,509**	**464,317**	**154,772**	**1,212,061**
Potential Funding Sources							
Re-direct £83,000 RNDA External Funding	(13,784)	(69,216)					(83,000)
Re-direct International Recruitment Funding							0
Potential Funding Request	**0**	**8,533**	**127,928**	**373,509**	**464,317**	**154,772**	**1,129,061**

Table 2: Phased Cost Profile of Proposed 4 Year RNDA Programme

Whist external funding for the RNDA course is not automatic the Trust has recently secured an additional £83,000 to fund a RNDA programme in 23-24. As the Trust has already approved the cost of the existing 18- month RNDA programme in its financial plan it is proposed the additional £83,000 income is re-directed to fund the cost of the 4 year programme in 23-24 and 24-25.

This leaves a residual funding shortfall of **£1,129,061** phased over 24-25 to 28-29 financial years as detailed in Table 2.

Whilst a guaranteed funding source is not yet identified it is expected potential funding opportunities will arise and include:

- Further NHS England (Health Education England) funding linked to the NHS Long term Workforce Plan
    - Increasing apprenticeships
    - Grow your own approach
    - Increase domestic supply
- Other Health Education England funding which can be re-directed to fund this programme
- Re-direction of internal funding currently invested in the recruitment of international nurses to this programme

In recognition of the potential funding opportunities approval is sought to recruit 10 posts into the programme in both 23-24 and 24-25 with a further update to SMT in 2024-25 on final funding streams.

5.0 Rationale

We know that 'growing our own' is a sustainable approach at Gateshead and we have had may years of success with recruiting TNA's who move into RNDA posts, from our own healthcare assistant workforce.

To actively target school leavers and those looking for a credible alternative to University is an area we have not yet explored. We know that CNTW have a very successful programme and can learn a great deal from their approach.

This could mean that in 4 years' time we will have no vacancies and a sustainable and reliable future supply of 15 Nurses per year from this cohort in addition to the established supply of 10 registered nurses per year from our internal intake of apprentices. This would give us 25 Gateshead trained and qualified Nurses who are committed to the Trust and feel supported and motivated to stay per year.

Whilst historically we have funded our apprenticeship programmes using vacant healthcare support vacancies, these must now be funded on a spend to save basis based on the reduction in bank and agency staff needed to cover gaps.
In 21/22 the annual agency spend for nursing was in excess of £2million and this approach will support the Trust CRP of reducing these costs.

Educational costs will be covered by the apprenticeship Levy and the current practice education team will support these learners in addition to our existing pre reg learners.

6.0 Summary and Considerations

To summarise the nursing shortage is a single largest and most critical issue needed to be addressed which has cultivated a real focus on increasing supply through the undergraduate nursing program as this is the largest and most effective supply route.

Board are asked to consider the content of this paper, in particular the financial impact of a four-year recurring recruitment programme into the Trainee Nurse Associate and Registered Nurse Degree both Top up and Apprenticeship route.

Finance and Performance Committee

Gateshead Health NHS Foundation Trust

Assurance Report Agenda Item: 8i

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☐
Committee Reporting Assurance:	Finance and Performance Committee			
Name of Meeting:	Board of Directors			
Date of Meeting:	Tuesday 27 June 2023			
Author:	Mrs K Mackenzie, Group Director of Finance & Digital			
Executive Lead:	Mrs K Mackenzie and Mrs J Baxter			
Report presented by:	Mr M Robson, Chair of Committee			
Matters to be escalated to the Board:	None			
Executive Summary: ***(outline assurances and gaps including mitigating actions)***	<u>Transformation Board Update</u> The report was presented informing the next steps for assurance include a complete review of the Transformation portfolio looking at the key priorities and revisiting the estates rationale ensuring the outcome aligns to the strategic objectives. The Quality Improvement methodology is being reviewed to ensure we align with the NHS improvement approach and once agreed a training and development programme will be developed to support a continuous improvement culture within the Trust. The Committee noted there is a gap in not just the financial and activity information but the overall strategy and leading indicators. <u>Integrated Oversight Report (IOR):</u> The report was presented informing the average number of G&A beds open has reduced in May 2023 from 448 to 436 and the length of stay has improved from 4.68 days to 4.26 days. 4 hour A&E waiting times has decreased to 73.4% and 5 12 hour trolley breaches with a high amount of ambulance handovers of 40.25%. It was noted as a result of the industrial action there were 65 cancelled sessions affecting 386 patients, if a partial booking system was implemented then these may have been identified earlier and need a better way to manage this. The Committee agreed for a summary of the discussions at the weekly performance clinic and what the activity			

	trajectory looks like as result of the actions to be brought to the Committee. <u>New Operating Model (NOM) Review</u> The report was deferred and acknowledged a lot has happened since the NOM has been implemented therefore it is not possible to draw definite conclusions as to the wider impact of the NOM. The Committee noted a gap in assurance of requiring a mitigation in place and an updated report to be presented to the next Committee. <u>2023/24 Financial Accounts</u> The report was presented informing the 2022/23 Final Accounts were received at the Audit Committee yesterday with a recommendation to approve at the Trust Board. We have reported a deficit of £296k and this report is for information noting the submission date of 30 June 2023. <u>Month 2 Financial Report</u> The report was presented informing this is the first formal reporting period for 2023/24 and reported an actual deficit of £2.8m. There was an increase in total pay expenditure due to the pay award in June 2023 but overall we are seeing a downward trajectory in the bill supported by continued reduction in agency spend. It was noted the financial plan is a deficit of £12.5m including the CRP target of £16m, noting that only small numbers have been transacted to month two as we have not completed the EQIA process on the CRP schemes. The report of CRP will be presented to the Committee at the next meeting within the Month 3 Financial Report. <u>Supply Procurement Committee Report</u> The report was presented informing there were 7 items requesting waiving of standing orders with 1 deferred and 2 via Chairman's actions totally £3.9k which included an award of a contract to Northern Power Grid for the provision of power supply to CDC. <u>Capital Plan</u> The report was presented informing that the proposed plan exceeds the funding available, acknowledging that there is usually slippage against capital spend in the year which enables the Trust to deliver within resources. The Committee approved the Capital Plan noting this will be presented to the Trust Board in July 2023. <u>Capital Steering Group Report</u> The report was presented informing this is the first report presented to the Committee and asked the Committee to

	receive the minutes and take assurance with emerging pressures. Community Diagnostic Centre MOU The report was withdrawn from the Committee as the proposal is not ready. The CDC Strategy Oversight Group (SOG) meet on a monthly basis after the Committee and proposed the discussion from the previous month and the papers for next meeting to be brought to the Committee. It was noted we are now aware the costs are likely to be higher than anticipated. Audit One Action Update The report was presented informing it was discussed at the last Committee for greater detail of actions and to provide greater narrative and assurance pending the Deloitte Review. It was agreed for an action on visibility of the Audit One Action Update report for retrospective Committees. ICB Sustainability Meeting The Committee acknowledged the immediate actions and financial sustainability were discussed at the ICB Sustainability Meeting on 21 June 2023 and we have committed to providing the figures by September 2023 with delivery of a breakeven financial plan by 1 April 2025. We have received information from the ICB as a set of sanctions and a copy of the closedown letter was recently received from NHS England. The Committee agreed to present the letter, self-assessment and letter of assurance in response to the next Committee. Corporate Objective Delivery: The report was presented informing the 3 objectives under this Committees responsibility and agreed for a report on Sustainability Services to be presented to the Committee in August 2023. Organisational Risk Register (ORR) The Committee reviewed the ORR noting there are 8 risks from the BAF and ORR that are reflected in the report. Board Assurance Framework (BAF) The Committee reviewed and updated the BAF. Oversight Meeting Minutes The Committee noted there were no minutes to be considered due to a new monthly process being implemented and will now have action delivery plans instead of minutes. Finance and Performance Committee Cycle of Business 2023/24

<table>
<tr><td></td><td colspan="2">The Cycle of Business was updated accordingly.</td></tr>
<tr><td>Recommended actions for Board</td><td colspan="2">The Board is requested to note the assurances and risks identified by the Committee and be mindful of this when reviewing and discussing related agenda items.</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:
(Including reference to any specific risk)</td><td>Aim 1
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☒</td><td>We will develop and expand our services within and beyond Gateshead</td></tr>
<tr><td>Financial Implications:</td><td colspan="2">As outlined in the Finance Report paper on the agenda.</td></tr>
<tr><td>Links to Risks (identify significant risks and DATIX reference)</td><td colspan="2">Three risks from the BAF/ ORR are reflected with a high score:
2982- (Medicine) Risk of delay in transfer to community due to lack of social care provision and intermediate care beds, due to increased numbers of patients awaiting POC up to 30 patients in medical wards (16).
2779 (NMQ) Trust fails to meet the CQC Fundamental Standards resulting in potential regulatory action, harm to patients, resulting in reputational damage (16).
Further risks are reflected:
3103 (Finance) Efficiency requirements cannot be achieved due to ongoing operational pressures resulting from COVID and demand on unscheduled care (16).
3102 Activity is not delivered in line with planned trajectories, resulting in the Trust having reduced access to core funding (16).
2868 (COO) Risk to the delivery of the new operating model due to the increase in activity and reduced workforce capacity (potentially due to Covid waves), resulting in adverse impact on key performance and recovery plans (12).</td></tr>
</table>

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

- **3128** (Finance) There is a Risk that the capital cost of delivery of the new operating model continues to increase resulting in revenue implications (9).
- **3127** There is a considerable risk that the trust will not be able to meet the planned trajectory of £12.588m adjusted deficit (12).
- **3186** (COO) Risk to maintaining business continuity of services and recovery plans due to the estate infrastructure, age and backlog maintenance requirements which exceed the Trusts capital allocation (12).
- **3148** (COO) Risk that the organisation is unable to release staff for mandatory training due to operational pressures and current vacancies in both medical and nurse staffing (12).

</td></tr>
<tr><td>People and OD Implications:</td><td colspan="5">Workforce planning assumptions will form part of the annual plan submission.</td></tr>
<tr><td>Links to CQC KLOE</td><td>Caring
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</table>

Gateshead Health NHS Foundation Trust

Assurance Report Agenda Item: 9ii

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☒
Committee Reporting Assurance:	Quality Governance Committee June 2023			
Name of Meeting:	Trust Board			
Date of Meeting:	21 June 2023			
Author:	Mrs A Stabler, Non-Executive Director			
Executive Lead:	Dr G Findley, Chief Nurse			
Report presented by:	Mrs A Stabler, Non-Executive Director			
Matters to be escalated to the Board:	The Committee have approved the Quality Account 2022-23 on behalf of the Trust Board.			
Executive Summary:	**Items received for assurance:** **EQIA Update** The report was presented informing following the establishment of CRP for 2023/24 in the Trust it has become mandatory for EQIAs to be completed against the cost reduction schemes that will impact or change service delivery. It was noted that 29 EQIAs have been completed of which 2 relate to CRP and 13 EQIAs have been closed. **Palliative Care Annual Report** The report was presented informing the 3 work streams meet bimonthly which are service effectiveness and risk, education and public engagement and service development. The Serious Illness Care Programme has a further 2 study days planned in 2023 and there is potential to develop a 12 week pilot of 7 day working for specialist Nurses. It was noted we have an opportunity to develop a Transformation Programme to improve the Palliative Care Service for a more improved pathway. **Medicines Quarterly Report** The report was presented informing the results in relation to oxygen prescribing has improved which was a must do action from the CQC inspection and looking to have the EPMA system embedded as part of the long term strategy. It was agreed for QEF Pharmacy to establish a regular report and be invited to the next Committee to share performance, quality and safety metrics.			

	IPC Bi Annual Report The report was presented informing we have reported incidence below threshold in two of the four identified categories with a raised incidence in the CDI and Klebsiella categories. It was noted there has been rising infections over the winter period and 0 Hospital acquired MRSA Bacteraemias in the last 6 months. It was noted there has been a rise in MSSA Bacteraemia and we are currently undertaking a campaign of not using gloves unnecessarily then will run a campaign on the appropriate management of cannulas. The C diff allowance has been reduced and agreed the rate will be one of the leading indicators. **Integrated Oversight Report** The Committee noted that this report has been previously received at the Trust Board in May 2023. **Maternity Oversight Report** A verbal report was received following agreement with the Chair noting that the service are having a governance review reset and the report will go to the SafeCare meeting in July followed by the Trust Board. The Committee noted the figures have been approved for the year 4 maternity incentive scheme that was signed off by the Trust Board in January 2023 and the technical guidance has been released. The committee were advised that there had been a listening and engagement event with SCBU staff; this has resulted in a number of actions including a staffing review supported by the Neonatal Network a follow up meeting is planned in 4 weeks. **Assurances from Strategic SafeCare Risk and Safety Council** The report was presented informing the Matrons walkabout had 89.5% compliance of 43/48 across all areas and a 100% compliance with COSHH files across all areas audited. The Resuscitation Trolley compliance is 81.39% and have a demo planned for a digital solution to improve the compliance. In relation to the SIRMS Thematic Report and Trust response Q4 it was noted an increase in incidents remains evident over Q4 of 421 in line with the rise noted in Q3 of 429. The Committee agreed to change the format of this report of removing the items for assurance that are already presented to the Committee then items for escalation from both SafeCare meetings to be included in the report as the Committee currently do not receive an assurance report from the meetings in between.

	Serious Incidents Update The quarterly report was presented informing this is the penultimate report as of September 2023 there will be no SIs as these will be replaced with a learning report. In Q4 there were 11 reports submitted with 27% received within the timescale of 60 days and the overdue actions have been significantly reduced which will be seen in the next report in preparation for the transition to InPhase. It was noted that 8 RCAs were not received within the 60 day timescale of which 4 reports have now been received, 3 are outstanding and 1 de-log has been requested pre- SI investigation as the Trust has been able to evidence no harm was caused by the Trust. **Safer Staffing Report** The report was presented informing wards where staffing fell below 75% of the funded establishment are shown within the paper for May 2023. The average fill rate for registered nurses / midwives in the day was 87.4% and the night was 88.8%. The average fill rate for care staff in the day was 123.8% and the night was 97.6%. It was noted the Trust Board approved the SNCT report to realign the budgets allowing the Ward Sisters to have 37.5 hours per week for supervision of the wards from September 2023. The areas of concerns of less than 75% were Ward 9 of 74.2%, Ward 21 Elective Ortho at 55.4% and Ward 22 of 70.2%. The Safer Staffing Report is being revised which will undergo a gap analysis and is planned to be received at the next Committee. **Complaints Update** The report was presented informing there were 43 informal complaints received in April 2023 and 46 in May 2023 with the top themes including communication, facilities and clinical treatment in Medicine. There were 30 complaints received in April 2023 and 34 in May 2023. A 100% of complaints were acknowledged within our target of 4 days. There were only 27 overdue complaints with a target to close by the end of June. **Quality Account 2022-23** The Committee have approved the Quality Account 2022-23 on behalf of the Trust Board noting the submission date is 30 June 2023. **Falls Update** The report was presented informing the Trust Falls Prevention Group re-established itself a year ago and focused on 3 pieces of work as follows. • A re-design of the falls investigation tool to proliferate learning

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- Digitisation on Nervecentre of falls assessments both pre and post fall
- A think yellow campaign to raise awareness of patients at risk of falls

It was agreed for the Committee to receive a 6 monthly report on Falls.

Items received by the Committee for information:

- Mental Health Act Compliance Minutes – March and April 2023
- Cycle of Business

The Committee acknowledged that there has been a reduction of inventions of violence around individualised personalised care and understanding trigger points.
</td></tr>
<tr><td>Recommended actions for Board</td><td colspan="6">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>
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<tr><td>Financial Implications:</td><td colspan="6">None to Note</td></tr>
<tr><td>Links to Risks (identify significant risks and DATIX reference)</td><td colspan="6">ORR Risks, 2879 – Maternity, 2779 CQC Compliance/ Improvement, 2868 – Further wave of Covid, 2880</td></tr>
<tr><td>People and OD Implications:</td><td colspan="6">Gaps in workforce in nursing, midwifery and mental health.</td></tr>
<tr><td>Links to CQC KLOE</td><td>Caring
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☒</td><td>Well-led
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	Obj. 3 ☐	Leaders within the Trust are informed and knowledgeable about the impact of business decisions on a diverse workforce and the differing needs of the communities we serve

Digital Committee

Gateshead Health NHS Foundation Trust

Assurance Report

Agenda Item: 8iii

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☐
Committee Reporting Assurance:	Digital Committee			
Name of Meeting:	Board of Directors			
Date of Meeting:	7 June 2023			
Author:	Mr N Black, Chief Information Officer			
Executive Lead:	Mrs K Mackenzie, Group Director of Finance & Digital			
Report presented by:	Mr A Moffat, Chair of Committee			
Matters to be escalated to the Board:	Two items were flagged for escalation to the Board. 1. The lack of progress on KPIs. The committee is not assured on the associated escalation process. 2. The recent limited assurance audit report into IT asset management has led to a reduction in committee assurance. 3. Although it isn't an item for escalation, Digital Committee thought it would be beneficial to make the Board aware of the plan to initiate a market engagement session to provide further clinical review of the solutions available. The EPR OBC will be updated following the clinical review.			
Executive Summary: ***(outline assurances and gaps including mitigating actions)***	<u>Organisational Strategic Objectives – Digital</u> Of the six 22/23 objectives, three have been completed: the remaining three have been replanned and incorporated into the 23/24 Objectives. The six 23/24 objectives are on track to meet their replanned dates and continue to be monitored by the Committee on an ongoing basis. <u>Digital Delivery Plan</u> The Digital Delivery Plan was presented to the Committee. Four projects were reported as complete, thirty on track and seven indicated as operating under some risk. These seven all have mitigations documented to address the risk. Cross cutting risks that may impact on the overall programme were flagged: • Insufficient resource to deliver the digital transformation programme and maintain business as usual. • Single point of failure due to technical expertise.			

	To mitigate these risks, DTG is actively managing the programme change control based on the agreed prioritisation matrix, with any new requests to follow the formal process. Additional work is underway to benchmark the service and to understand where additional resource could be allocated to mitigate the risks. <u>Integrated Electronic Patient Record update</u> An EPR business case update was provided. The OBC agreed in February 2023 will now incorporate a Market engagement event for EPR/system suppliers to be scheduled in September/October. The focus of this session is to ensure rich clinical engagement to understand the possibilities and to allow system suppliers (especially suppliers to local trusts) to demonstrate their solutions to the Trust. Following this event, the OBC will be updated. <u>What Good Looks Like – Digital Maturity Assessment</u> A high-level view of the national Digital Maturity Assessment was presented, showing the level of the digital maturity of the Trust compared to best practice. This peer assessed view will be enriched over the coming months, to enable benchmarking. Of the fifty measures, the Trust scored the lowest score of one on five measures. • How mature is your digital leadership and strategy? • How mature is your digital front door and patient portal? • How mature is your self-triage capability? • How mature are your citizen accessible health records? • How mature are your appointment booking systems? Further work is underway to understand how the Trust can improve the scores, and any other area where it is flagged as an outlier. This will be reported through EMT. <u>Digital Service Key Performance Indicators</u> The KPI report continues to be refined but due to timing of meetings the updated KPI reports were not available to review. The focus of the KPI measurement is the action required if an indicator performance declines. Focused work is taking place ensuring that the KPIs are fit for purpose and that an appropriate escalation process is embedded within the organisation. It was noted that there remain areas whose performance is below target, despite escalation to SMT and compliance group; e.g. those relating to Information Asset Management. This is to be escalated to Board.

	Unplanned downtime analysis Work undertaken to review the impact of unplanned downtime over a period of three months. Four unplanned events occurred, three of these were internal and two required downtime to fix the issue. This review of unplanned downtime will be developed into a KPU and reported through DAG going forward. Regulatory and Governance The internal audit actions were reviewed. There are currently no overdue actions, although one has requested an extension to enable formal approval of the business continuity arrangements at Digital Assurance Group. The IT Asset Management Audit rated as limited assurance was presented. This audit was commissioned to ensure that appropriate asset management procedures had been reintroduced post covid. There are several management actions that will be tracked to ensure assurance can be given on IT Asset Management. A follow up audit is planned for Q4. External Reviews - Dionach Audit update The external Dionach audit was reviewed, with seven vulnerabilities resolved, one mitigated and five partially mitigated. Those partially mitigated are all on track for completion by September, with three gathering evidence that the mitigation implemented fully addresses the vulnerability. Digital Transformation Group and Digital Assurance Group Assurance Reports & minutes of last meetings After a few months of standing down meetings, DTG met on the 17 May 2023 and the DTG Assurance Report was received. There were no additional items for escalation to the DC reported. The DAG Assurance Report was received and there were no items for escalation to the DC reported. For the next meeting, where the subgroups escalate actions to SMT, the report will be included in the Committee papers. Organisational Risk Register Feedback was provided following the Exec risk management review. That review requested a full reassessment of the digital risks and understand why some have been in existence since 2014. This has now been completed. Board Assurance Framework (BAF) The Board Assurance Framework was updated accordingly.

Recommended actions for Board	The Board is requested to note the assurances and risks identified by the Committee and be mindful of this when reviewing and discussing related agenda items.				
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)	There are no significant risks on Datix relating to the business conducted at this meeting.				
People and OD Implications:	None to note				
Links to CQC KLOE	Caring ☒	Responsive ☒	Well-led ☒	Effective ☒	Safe ☒
Trust Diversity & Inclusion Objective that the report relates to: (including reference to any specific implications and actions)	**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: 8iv

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☐
Committee Reporting Assurance:	People and OD Committee – 11 July 2023			
Name of Meeting:	Trust Board			
Date of Meeting:	July 2023			
Author:	Amanda Venner, Interim Director of People & OD			
Executive Lead:	Amanda Venner, Interim Director of People & OD			
Report presented by:	Ms M Pavlou, Non-Executive Director			
Matters to be escalated to the Board:	No formal points of escalation.			
Executive Summary: ***(outline assurances and gaps including mitigating actions)***	**Items received for assurance:** **EDS2 Stakeholder Engagement Update:** The Committee received a verbal update and noted that the Stakeholder event had now been relaunched. The EDS2 is part of an improvement plan and a decision needs to be agreed on how to take this forward to the next stage. A written report will be produced for the next meeting. **Corporate Objective Update Report:** The report was presented advising of the progress made in delivering against the three corporate objectives that contribute to our corporate aim of Being a great organisation with a highly engaged workforce. KPI reporting will be provided on a quarterly basis going forward. **Disclosure and Barring Service Position Update:** The report was presented informing the Committee of the DBS position as follows as of 28 June 2023: • 689 are now compliant • 148 are in progress • 47 remain outstanding It was requested that thanks be relayed to Mr D Bosworth and the team for the work that has been achieved in reducing the DBS checks as this has been a huge undertaking.			

Vaccination Programme:
The Committee received a verbal update and noted that the vaccination programme had now been reconvened. There will be an opportunity for staff to have a dual vaccination for Flu and Covid along with the Whooping Cough vaccination for those members of clinical staff who are in close contact with severely ill young infants and pregnant women. Going forward a written update will be provided.

Industrial Action Update and Report:
The report was presented and it was noted that this report has been discussed at the internal Planning Group and Industrial Action co-ordination cell. The upcoming strike action will have a significant impact on Trust Services and this will be overseen by the Medical Director.

Integrated Oversight Report:
The Committee received the report and noted the key performance headlines specifically the reduction in sickness absence and agency spend. There has also been an increase in Appraisals from 79.8% to 82%, however the Trust has not yet achieved the target of 85%. There has also been an increase in the Safe guarding training.

People and OD Additional Metrics:
The Committee received an update which highlighted the key areas of focus across the 4 portfolio areas of the directorate.

<u>People Services:</u>
- 13 Employee Relations cases are ongoing with 2 live suspensions.
- 113 individuals were recruited between 1 April – 31 May 2023.
- Medical revalidation is now at 100%.

<u>Leadership OD and Staff Experience:</u>
- Leading Well training will be re-scheduled as this was heavily impacted by the industrial action, and Coaching continues to be delivered.

<u>Education, Learning and Development:</u>
- There has been increasing demand across all services including Leading Well.
- There are increases in DNAs and this continues to be monitored.
- The Managing Well Leadership programme is fully booked until December 2023.

<u>People Planning, Performance and Quality:</u>
- Exit interview data continues to be reviewed.
- Recent additions to the portfolio of reports includes Nursing and AHP oversight report, FTSU report.

	Culture Programme Update: The Committee noted that this is a moving piece of work and this has been shared with the Chief Executive in order to agree how this will align with the Board of Directors. It was agreed that this item would be on the Agenda for the September meeting in order to have more time to discuss. **Pulse Survey Results – April 2023:** The Committee noted the results for information. **Freedom to Speak Up Report:** The Committee received the report and noted that there are now 9 new trained FTSU Champions. **EDI Strategy:** The Committee received the report and noted that it is essential for the Trust to have a culture that is diverse, inclusive, and engaged with all aspects pertaining to Equality, Diversity and inclusion. There are 5 main areas within the Strategy. **NHS EDI Improvement Plan:** The Committee received the report for information and that work will continue to be ongoing. **External Reports/Emerging Regulatory Guidance NHS Long Term Workforce Plan:** The Committee noted that this will be an important piece of funded work, and that Comms would be circulated in due course relating to this. **People and OD Organisational Risk Register:** The Committee received the report and noted that that are 4 risks from the BAF/ORR for the POD Committee with a reviewed score of 16 which will continue to be reviewed. The Committee also noted that the Trust are the first organisation to sign the Unison Anti-Racism charter.	
Recommended actions for Board	Note main assurances against the strategic People and OD themes detailed and key associated risks.	
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
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	Aim 5 ☐	We will develop and expand our services within and beyond Gateshead

<table>
<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
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Gateshead Health NHS Foundation Trust

Assurance Report

Agenda Item: 8v

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☐
Committee Reporting Assurance:	Audit Committee Assurance Report from Meeting held on 26 June 2023			
Name of Meeting:	Audit Committee			
Date of Meeting:	26 June 2023			
Author:	Mrs K Mackenzie, Group Director of Finance and Digital			
Executive Lead:	Mrs K Mackenzie, Group Director of Finance and Digital			
Report presented by:	Mr A Moffat, Non – Executive Director			
Matters to be escalated to the Board of Directors:	None			
Executive Summary: ***(outline assurances and gaps including mitigating actions)***	<u>Financial Accounts</u> The paper discussed the Groups audited financial performance and financial statements for the 2022/2023 financial year. It was reported the Group including charitable funds returned a £32k deficit for the period, removing the consolidated charitable fund surplus of £41k in the year increases the net deficit to £73k. The adjusted financial performance for the year after reversal of impairments, charitable funds, capital donations, prior period adjustments, centrally procured inventories and returned covid assets is a deficit of £296k. The recommendation to Committee is to receive the report, discuss the potential implications and record assurance as to the audited financial outturn and the production of the Group's annual financial statements in accordance with NHS Foundation Trust Annual Reporting Manual 2022/2023. The Group's cash reduced by £6,238k in the year with an analysis of movements presented in the cash flow statement. The report provided by Mr M Smith included a statement. of comprehensive income for the year until 31.03.23 There were some errors highlighted in the report and these will be rectified prior to going to board.			

	The Committee resolved to recommend approval of the accounts to Trust Board. <u>Annual Report including Annual Governance Statement</u> The reports content is strictly prescribed by the Annual Reporting Manual (ARM) and a checklist has been devised to assist the Audit Committee in assuring itself that all elements of the ARM have been complied with. The checklist includes the section references where each requirement has been addressed. There are still 2 outstanding queries, and these are with external audit colleagues, but this will be resolved soon. The annual governance statement has been received in detail by both the Chair and the Chief Executive Officer (CEO), with some feedback given and it has now been included. The compliance process was queried by the Chair. This gets fully reviewed and shared with the executive team and external colleagues. Audit are also required to check this to make sure there are no inconsistencies and this committee are also require to make checks Any additional comments would need sent through to be collated. The committee resolved to approve the report. <u>Self-certifications and Corporate Governance Statement</u> This is the last year we will need to complete this self-certification, although the regulator reserves the right to further audit when they feel it's appropriate. It is proposed that the Audit Committee confirms compliance with licence conditions GC6 (processes and systems in place to identify and manage risks to compliance) and FT4 (systems and processes for good governance). It is important that any risks to compliance with the licence conditions are identified as part of the self-certification, alongside identified mitigations. Board is required to confirm compliance with GC6. It is recommended that the Audit Committee confirms compliance with both GC6 and FT4 as part of its annual self-certification process for this financial year-end, recognising that there are a number of actions for improvement and enhancement as outlined within the thematic review delivery plan. The Audit Committee is requested to make a recommendation to the Board of Directors to formally confirm this compliance.

	Changes to some of the wording has been made and board's agreement on compliance will be sought. This committee resolve to recommend for approval to board Going concern review Directors need to make an assessment if we remain a going concern. The use of the 23/24 framework means we are following same regime and cashflow plans have been made on the assumptions of this framework. The recommendation was to adopt this. 2023/24 sees a continuation of the previous year's financial framework. This is blended tariff approach which consists of fixed and variable payments, with most services being on a fixed payment. For those services on a variable tariff income will be earned based on volume of activity at national tariff and is consistent with the historic PBR (payment by results) funding model. In addition, Elective Recovery Fund income (ERF) can also be earned on the achievement of nationally published activity trajectories. The Trust has planned to achieve these activity targets and therefore has assumed this income within the plan. We recognise that this is potentially uncertain but as it amounts to less than 2% of income to the Trust, we regard this as immaterial to the Going Concern assessment. The Trust has produced its financial plans based on these assumptions which have been approved by the Trust Board. Committee resolved to approved the statement and recommend to board. ERMG Group Update and Assurance Report This group continues to meet with the most recent dates in May and June and will now be moving to monthly meetings. Business units will discuss any 12+ risks with all directorates and the digital team. The CEO now chairs this meeting, and the general feedback is it is going well. It was felt that some work was needed around QEF and the report to include the areas external to the trust and it was agreed that their risk register would be updated. There will be a wait for Deloitte investigations to be final to see what else needs included. There is particular focus on the risk actions on the ORR in preparation for moving to the new system- In phase. The committee resolved to receive the report for assurance. Internal Audit Progress Report They have finalised ten final reports for 22/23 since last committee. There are currently nine reports out as draft

	awaiting agreement of management responses and two draft reports pending review stage. A further six audits are in progress. One final report for 23/24 has been issued relating to the Data Security and Protection Toolkit – Final Assessment 2023. The progress against internal audit plan was discussed along with considerations on the impact of issues raised. The Trust have requested that the planned audit of Occupational Health is cancelled. It is understood that a Rapid Process Improvement Workshop has been recently undertaken and has resulted in a large number of key improvement areas being identified. It is therefore requested that the audit be deferred and undertaken once these improvements have been fully implemented. As such, inclusion of this audit will be considered as part of 2024/25 annual planning discussions, subject to Audit Committee approval. Committee members agreed. The Committee resolved to receive the report for assurance. <u>Internal Audit Annual report inc head of internal Audit Opinion</u> Sufficient work has been completed to at least draft report stage to support a robust opinion for 2022/23. The overall opinion assurance level is 'Good' which is consistent with the previous year. The Board Assurance Framework and Risk Management review has contributed positive assurance to the overall opinion. 30 audit reports contribute to the overall opinion with the split of assurance levels as Substantial (5), Good (11), Reasonable (4), Limited (6), and Advisory (4). 91% of management actions due in year have been notified as implemented. Details of one older outstanding action are included in the report along with outcomes of our review of those 'High' priority actions notified as complete; we sought evidence and have raised some further remedial action for three out of 11 of those areas. We are in a stronger position than we were last year, although there are still areas of improvement. There are some outstanding and some risks areas to be looking at but it is reassuring that this organisation takes the recommendations seriously and implements. Improvements have been made and the internal progress is noted along with the resource issues. QEF governance related issues on reflection were used as an opportunity to

	say we may not have had the improvements we did had these issues not occurred. The Committee resolved to receive the report for assurance. <u>Annual Internal Audit Plan 23824 for approval</u> Final approval required as draft was brought in March. 9 audits removed and 4 others added. There has been some movement between core and non-core to get the categories more balanced. Discussions have been had regarding following up limited reports. Some of these are in draft at the moment and they are not included in the report yet. There is a mid-year review to see what is still left and to look at the limited areas to see if they need replaced. The committee resolve to approve the final internal audit plan. <u>Counter fraud progress report</u> The plan ends on the 30th June. 44 tasks are in the report, but half are end of year tasks that can close at the end of June. There have been a few new referrals in and 1 closed with 8 now down to 3 and some revised dates. As part of compliance group, this committee agreed to wrap up the 3 outstanding items into the other work. The committee resolved to receive the report for assurance. <u>Counter fraud 21/22 annual report</u> A delay in this report due to timing issues. The committee resolved to receive the report for assurance. <u>Counter fraud annual plan</u> 2022/23 plan will be circulated in September. There will be work ongoing to improve the numbers around the amber ratings and QEF inclusion. The committee resolved to receive the report for assurance. <u>External audit report on year end audit</u> Some outstanding work remains on value for money, it is anticipated that there will be no significant weaknesses in arrangements to secure VFM. We are in a much better place than last year and most of the work has been completed, although we still have final review to complete.

	Mazars anticipate reporting to the National Audit Office that the Trust's consolidation data is consistent with the financial statements. There are significant matters that remain outstanding to be completed prior to finalisation: these are Audit work on the cash flow statement, to ensure IFRS16 disclosures are made in line with the GAM and agree to Trusts supporting documents. No significant findings were reported, and the trust accounts were of good quality. Significant matters relating to provisions, review of the fixed asset register and IFRS 16 were discussed with management during the audit. No significant difficulties were encountered during the audit. There are some recommendations. One new medium internal control recommendation has been made. Previous recommendation relating to contract and letters of employment remains open. Previous recommendation relating to QEF segregation of duties and bank reconciliation remains open. Final review procedures are better than last year and there has been no fundamental changes to audit approach. The QEF audit is set to finish later in the year and there should be no significant risks to report on this or on any other areas. Nothing significant to report for time spent on evaluation of equipment but there is the need to rethink I4S16 at national level. Some risk identified around lease and sighting of any formal lease agreements. Mazars felt this has been a smooth audit with us in an improved and strengthened position. The opinion is that this has been a good report and the committee resolved to receive the report for assurance. <u>Audit committee annual report</u> The Annual Report is required to include a section on the Audit Committee in accordance with the section C.3.9. of the Code of Governance. This should include: • The significant issues that the Committee considered in relation to financial statements, operations, and compliance, and how these issues were addressed.

	• An explanation of how it has assessed the effectiveness of the external audit process and the approach taken to the appointment or re-appointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted; and • If the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded. The attendance statistics for the audit committee were included, and they are in the board composition tables. Assurance given the information is complete. This committee need to consider BAF to assess system and controls with the need to reflect if there are other things to do and can it be phased in. The committee resolved to approve the report. <u>Compliance with standards of business conduct policy</u> Assurance was given that the policy aligns to the model set out by NHS England. There were a few items to note. Firstly, the partial compliance with the requirement for all decision-making staff to make an annual declaration and that secondary employment declaration compliance will be assessed throughout the year and reported to the Audit Committee in the 2023/24 compliance report. There have been minimal declarations of gifts and hospitality made in 2022/23. This will be promoted in Trust communications to ensure that colleagues understand what gifts and hospitality can be accepted and what must be declared. Further work with People & OD colleagues will be had on this, and further updates will be provided to this committee next year. The report demonstrates compliance. Concern was expressed around what's included and to reinforce the policy ensuring all relevant detail is included. There have been elements added to the new policy to address such issues. A meeting with QEF will be arranged to explore a group policy. The committee resolved to receive the report for assurance.

<table>
<tr><td></td><td colspan="6"><u>Schedule of losses and special payments</u>

The committee approved payment and noted the losses with the Director of Finance (DOF) and the CEO to sign the register.</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>
<tr><td>Aim 2
☐</td><td colspan="5">We will be a great organisation with a highly engaged workforce</td></tr>
<tr><td>Aim 3
☒</td><td colspan="5">We will enhance our productivity and efficiency to make the best use of resources</td></tr>
<tr><td>Aim 4
☐</td><td colspan="5">We will be an effective partner and be ambitious in our commitment to improving health outcomes</td></tr>
<tr><td>Aim 5
☐</td><td colspan="5">We will develop and expand our services within and beyond Gateshead</td></tr>
<tr><td>Financial Implications:</td><td colspan="6">None to note</td></tr>
<tr><td>Links to Risks (identify significant risks and DATIX reference)</td><td colspan="6">There are no significant risks on Datix relating to the business conducted at this meeting.</td></tr>
<tr><td>People and OD Implications:</td><td colspan="6">None to note.</td></tr>
<tr><td>Links to CQC KLOE</td><td>Caring
☐</td><td>Responsive
☐</td><td>Well-led
☒</td><td>Effective
☐</td><td colspan="2">Safe
☒</td></tr>
<tr><td rowspan="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>
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<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>
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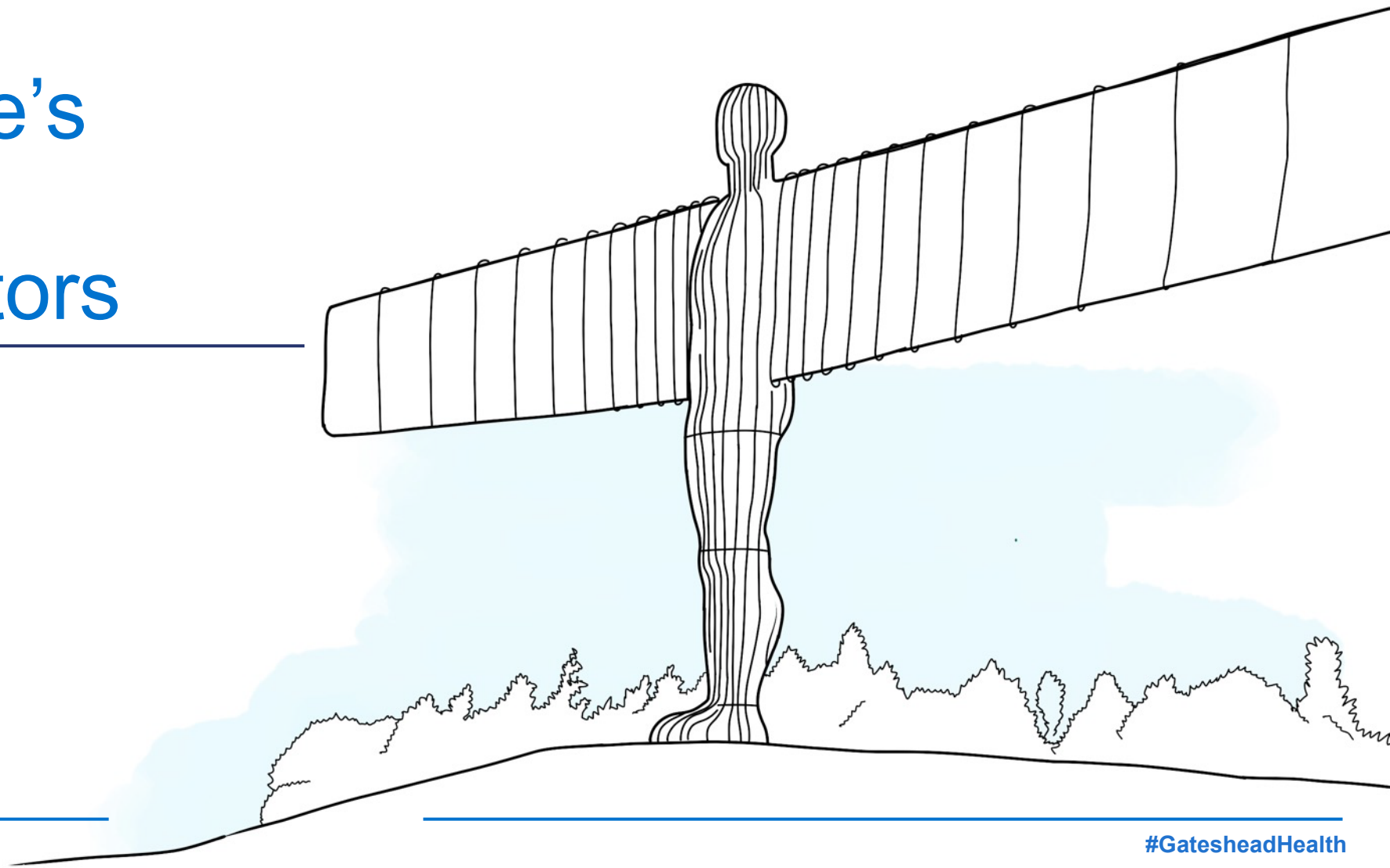
NHS
Gateshead Health
NHS Foundation Trust

Chief Executive's Update to the Board of Directors

Trudie Davies

26 July 2023



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

Gateshead Health NHS Foundation Trust

- Achieved a CQC 'good' rating for our maternity services following an unannounced focussed CQC inspection in February 2023.
  - Inspection carried out as part of CQC's national maternity services inspection programme.
  - Highlighted the leadership as 'good', showing the service is managed by capable leaders with the right skills and abilities.
  - Also outlined how well the maternity team work together to provide high quality and safe care to all women and birthing people.
  - Highlighted some areas of outstanding practice including:
    - the work of our **diabetes specialist midwives** creating an educational session for Gestational Diabetes Mellitus (GDM) and offering one-on-one sessions to non-English speaking women and birthing individuals with interpreting services
    - a **grab bag** project that was established to provide basic necessities to vulnerable women and birthing individuals who are fleeing domestic violence
    - the service implemented postnatal contraception and provided **advice and information** on pre-conceptive advice, tobacco dependency, alcohol misuse, positive mental health, nutrition, and physical activity within antenatal clinics to support women.
- Achieved compliance with the **Maternity Incentive Scheme**. This is a measure of safety and enables us to invest back into services.
- Continued focus on length of stay and patient flow. There were **no 12 hour DTAs** (decision to admit) in June 23, although the beginning of July has been challenging.
- A **Major Trauma peer review** visit was conducted by the Northern Trauma Network. We have responded to the findings, and the Quality Governance Committee will lead on seeking assurance over our response.

Engagement, involvement and visits:

- Research team
- Anaesthetics team
- Pathology network meetings
- Chief matrons
- Service line managers
- Business Unit oversight meetings

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

Gateshead Health NHS Foundation Trust

- **Industrial action** continued with junior doctors' strike action from 7am on Thursday 13 July to 7am on Tuesday 18 July and consultants' strike action on Thursday 20 and Friday 21 July. This has presented operational challenges resulting in the cancellation of some elective activity.
- First employer in the northern region to sign **Unison's Anti-Racism charter** – demonstrates our deep commitment to racial equality, diversity and inclusion and challenging racism both internally and externally.
- The international recruitment team has been awarded the **NHS Pastoral Care Quality Award** as part of NHS England's International Recruitment Programme. The award recognises commitment to providing high-quality pastoral care and the positive impact this has on staff wellbeing.
- NHS Long Term Workforce Plan published by NHS England. This includes a commitment to deliver the biggest increase in training numbers in the NHS's history as well as plans to retain staff and use technology to free up time to care.
- We welcome the publication of the national NHS equality, diversity and inclusion improvement plan. We will review and implement the high impact actions identified for NHS organisations.
- We celebrated the fantastic work of our **volunteers**, including Sandra who recently retired after an incredible 29 years of volunteering!
- **Freedom to Speak Up** – plans to reinvigorate this important function are now being delivered. A full time Guardian has been appointed and 9 Champions have been trained. An update has also been published.
- **DBS** update – significant progress made in resolving historic recording issues.
- Making progress towards our ambition of being a clinically-led and management supported organisation – **engaging our clinical leaders** in our key committees and meetings and broadening clinical representation.

Engagement, involvement and visits:

- Medical Staff Committee
- Corporate inductions
- Culture and leadership session with clinical leaders
- Volunteers' evening
- Unison NHS75 celebrations

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

- We are working with the ICB to review our **communications and engagement** processes and plans to support us to be a clinically-led and management supported organisation.
- Our **annual accounts and annual report** have been approved by Board and submitted to NHS England, with an unqualified audit opinion on the accounts. They will be made publicly available in time for our Annual General Meeting in September once the auditors complete their work on the 'value for money' opinion.
- Work has continued on the development of our **leading indicators** as showcased later in the agenda.
- **Winter planning** – taking place earlier this year. In the North East and North Cumbria plans are being developed for sign-off in late August ahead of a national deadline of early September. This will require delegated authority from the Board to enable the deadline to be met.
- **Core Urgent Treatment Centre (UTC) principles** developed for the region following a continuous improvement event in March 2023. This includes active promotion of co-located 'front of house' UTCs and planning for surges in demand in winter. We are working at place with partners to support the implementation of these principles.
- Key focus on **outpatient transformation** and the implementation of **partial booking** processes.

Engagement, involvement and visits:

- ❖ Robotic surgery learning event in London
- ❖ ICB finance and quality meetings

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

NHS Gateshead Health NHS Foundation Trust

- Alongside Newcastle-upon-Tyne Hospitals NHS FT we have now signed a long-term lease with the Metrocentre for the new **Community Diagnostic Centre** (CDC). This will provide improved access to screening and diagnostic services outside of a hospital setting.
- Quality Governance Committee received a comprehensive annual report from our **specialist palliative care and end of life care services**. The report showcased the achievements of the team and provided assurance over the standards of care provided in the community and within the hospital setting. We are committed to working with place-based partners to deliver wider palliative care objectives.
- Worked together with our partners to launch the Gateshead Health and Care Academy to provide people in Gateshead with a unique training qualification to support them to achieve a career in health and social care.
- Gateshead **Health and Wellbeing Board** has approved a plan for Gateshead place, which focuses on the ICB strategic priorities as well as health inequalities. We will be an active partner in taking this forward
- North East and North Cumbria Provider Collaborative Leadership Board – sharing of the draft Joint Forward Plan 2023/24 – 2028/9. This complements the Integrated Care Partnership Strategy. We will be responding as part of the consultation before the deadline of 31 August.
- **Special Educational Needs and / or Disabilities (SEND) inspection** took place in Gateshead local area in May 2023.

Engagement, involvement and visits:

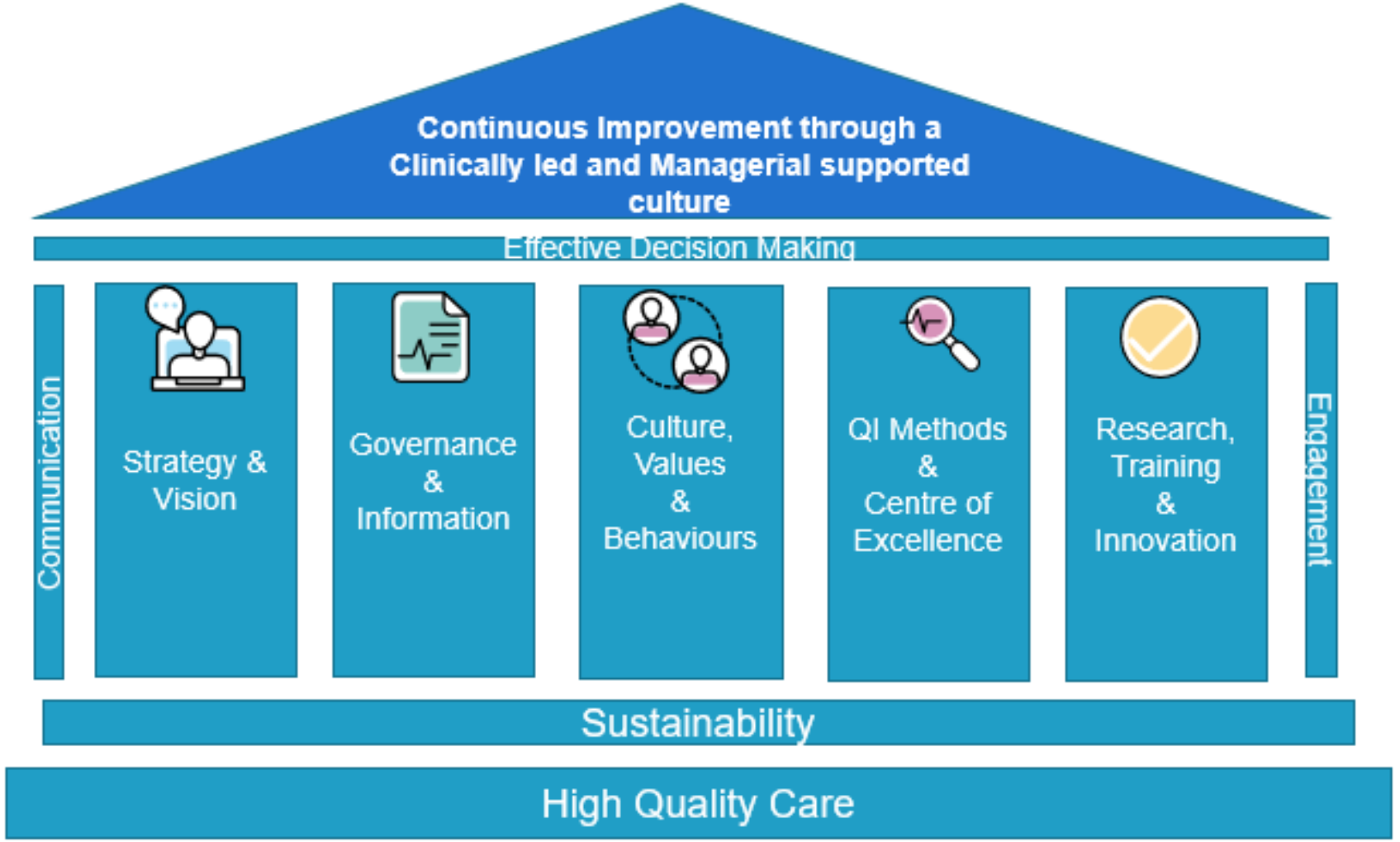
- Provider Leadership Board
- North Provider Collaborative CEO meetings
- Gateshead Committee at Place
- ICP and A&E Delivery Board
- Women's Health Roundtable Event
- Integrated Care System Leadership Group

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

- Successfully **resecured the delivery of the AAA screening programme** across the North East and North Cumbria, having delivered the contract for the last 12 years.
- EMT have supported the screening service request to submit a tender for the re-provision of the Lancashire service. A service we have provided since its inception. Closing date 24 July.
- Hosted our **Open Day** on 8 July – all 350 free tickets were reserved by members of the public. The Open Day was a great opportunity to share information on health screening programmes, community services, recruitment opportunities, engagement and involvement and our charity.

Our framework for delivery

Aim: *a coordinated collection of strategic processes and decisions that together enable the most effective balance of organisational change and business as usual*



National Context

- NHS Impact ‘improving patient care together’ is the term we are using for the new single, shared NHS improvement approach. This includes the five components which form the ‘DNA’ of all evidence-based improvement methods, which underpin a systematic approach to continuous improvement:
    - Building a shared purpose and vision
    - Investing in people and culture
    - Developing leadership behaviours
    - Building improvement capability and capacity
    - Embedding improvement into management systems and processes
- When these 5 components are consistently used, systems and organisations create the right conditions for continuous improvement and high performance, responding to today’s challenges, and delivering better care for patients and better outcomes for communities.

NHS Improvement Approach

Gateshead Health NHS Foundation Trust

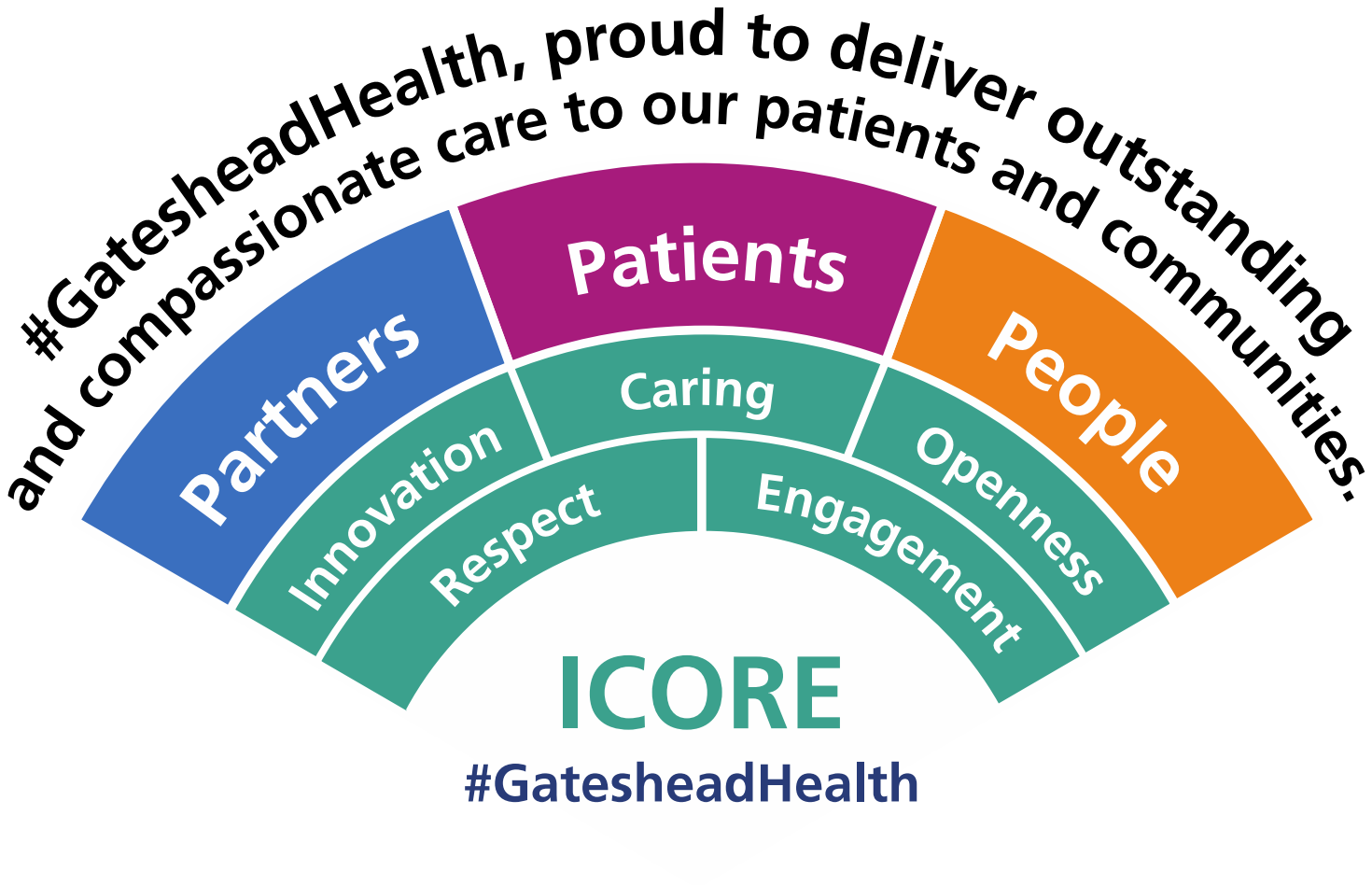
- NHS England will set an expectation that all NHS Providers, working in partnership through integrated care systems will embed a quality improvement method aligned to the NHS improvement Approach

Drivers and Enablers

- Coproduction with people and communities
- Clinical Leadership
- Workforce, training and education
- Digital Transformation
- Addressing Health Inequalities

Building a shared purpose and vision Our workforce, trainees and learners understand the direction and strategy of the organisation/system, enabling an ongoing focus on quality, responsiveness and continued learning	Pillar 1 – Strategy and vision
Building improvement capability All our people (workforce, trainees and learners) have access to improvement training and support, whether embedded within the organisation/system or via a partner collaboration	Pillar 4 – Quality Improvement and COE
Developing leadership behaviours for improvement A focus on instilling behaviours that enable improvement throughout organisations and systems, role modelling consistently by our Board and Executives	Pillar 3 – Culture Values and Behaviours
Investing in culture and people Clear and supported ways of working, through which all staff are encouraged to lead improvements	Pillar 3 & 4
Embedding a quality management system Embedding approaches to assurance, improvement and planning that co-ordinate activities to meet patient, policy and regulatory requirements through improved operational excellence	Pillar 2 – Governance and Information (Facilitates the running of the whole house)

Gateshead Health
NHS Foundation Trust



Gateshead Health NHS Foundation Trust

Report Cover Sheet

Agenda Item: 9

Purpose of Report	Decision: ☐	Discussion: ☒	Assurance: ☒	Information: ☒
Report Title:	Mental Health Services Overview			
Name of Meeting:	Board of Directors			
Date of Meeting:	26 July 2023			
Author:	Joanna Clark, Director of Operations, Community and OPMH			
Executive Lead:	Trudie Davies, Chief Executive			
Report presented by:	Trudie Davies, Chief Executive			
Executive Summary:	The attached briefing outlines ICB priorities for mental health and learning disability care across the North East and Cumbria. Local context is included within this so that the situation for Gateshead residents is explicit. A key focus for the Trust will be working with partners to further develop community teams with a range of professional and voluntary sector membership. These will assist to address the wider determinants of health. Other priorities are to reduce waiting times for assessment and treatment for children with autism and ensuring that our OPMH services deliver safe, effective, patient focussed care.			
Recommended actions for Board/Committee)	To discuss and note the contents of the report.			
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:	N/A			
Links to Risks (identify significant risks and DATIX reference)	N/A			
People and OD Implications:	N/A			

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

Trust Diversity & Inclusion Objective that the report relates to: (including reference to any specific implications and actions)	**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

Mental Health Services Overview

Situation

NENC ICB are currently developing a draft forward plan for mental health and learning disability. This will shape the delivery of four key priorities in relation to mental health and three key priorities in relation to learning disability

Mental health:

- improving access to community services,
- preventing suicide,
- children and young people's mental health
- Developing a safe, rights based approach to inpatient therapeutic care.

Learning Disability:

- building the right support,
- improving health outcomes
- improving quality standards

This paper outlines our position at place in Gateshead and how this aligns to regional and local areas of challenge and ongoing strategic focus as well as detailing the objectives proposed by the ICB.

Background

NENC ICB have made a commitment to parity of esteem between physical and mental health across the patch, building on a previous commitment to develop delivery plans and frameworks for mental health and learning disability.

The ICB recognise that the NHS alone cannot influence this and that the wider determinants of mental ill health are an important consideration. Partners (local authorities, public health, the police, the voluntary sector and physical health providers) will need to work together to tackle issues such as substance misuse, poverty, unemployment and social isolation.

The ICB outlined four areas of significant concern:

- Waiting Lists of IAPT (Psychological Therapies)
- Dementia Diagnosis
- Children and Young People with Eating Disorders
- Children and Young Person's Neurodevelopmental Waiting Lists

There is a proposal to create a "select mental health" option for 111, this should direct individuals to the right place for their concerns and potentially reduce ambulance conveyances for MH conditions.

There is a further proposal that Police will no longer do routine welfare checks. It will be our duty to locate a patient if they abscond and are detained under MHA (unless they are a risk to themselves or others). This is in place within Gateshead currently for patients on the MH wards.

The assessment below outlines the areas of focus in more detail and provides a Gateshead specific context to the current position.

Assessment

Improving Access to Community Services

There is a commitment to services being delivered locally. A suggestion is that existing PCN footprints can be used as a mechanism for this. This would include a reform of 111 referrals (as suggested above), along with support from IAPT practitioners and social prescribers to address the impact of wider determinants of health.

From a Gateshead Health perspective our work with Changing Futures in ED, with GP's across the Locality teams as well as our OPMH Community Mental Health teams will feed into this. Success will mean fewer admissions for mental health reasons, timely access for assessment and treatment, as well as individuals being supported to lead fulfilling lives with improved outcomes. This is a potential growth area for us as some services within Gateshead are delivered by partner agencies but may be more appropriate to be provided by us in the future.

Access to IAPT (provided by STSFT) within Gateshead is timely (less than 12 weeks currently) so while a regional concern, the local position is much better. Access to dementia diagnosis is provided by CNTW for Gateshead and could effectively be supported by our Admiral Nurses and Older Person's Mental Health teams.

Preventing suicide

Gateshead's most recent suicide rate is 9.1 per 100,000. This is against an average of 11.1 for Tyne and Wear. The regions more southerly areas (Cleveland, Durham, Sunderland) experience higher rates than the north of the patch. Gateshead Health will want to be a key partner is tackling this with multi-agency colleagues and this is reflected in the Gateshead place based plan.

Inpatient Care children and young people's mental health

Children and Young People will have their own work-stream examining improvements that can be made from perinatal mental health support to referral into CYPS. Eating disorders will have a specific focus. Gateshead Health refer to other providers for much of the support provided to young people within the Borough. These services are provided either by CNTW, STSFT or voluntary sector partners and while we have good referral pathways to these providers, there is wider concern that these pathways are not meeting the needs of children with eating disorders.

We do provide Paediatric Services, including Paediatric therapies (SALT, OT, physio) and autism assessment which have significant waiting lists. The solution to this will be working alongside system partners to support children and young people to access services appropriately and we are already doing work to scope out good practice in other areas to bring this, with our partners (schools and social care) to Gateshead.

Developing a safe, rights based approach to inpatient therapeutic care.

An ongoing focus for mental health is to deliver more care closer to home, in the community. Aligned to this is an ambition to ensure that care delivered within inpatient settings is patient focused and of high quality. Gateshead Health has two mental health inpatient wards for older people, Cragside and Sunniside, with an ambition that all Gateshead older adults who require an inpatient admission receive this from us and are not sent out of area. The teams' actively seek to avoid admissions where possible and work effectively with the older adults crisis team (provided by CNTW) and community mental health teams to facilitate this. A more streamlined pathway would include the transfer of Older Person's Crisis services to within our Trust. Current work around establishing step up and step down beds (instead of inpatient beds) is underway to support a reduction in length of stay.

Working age patients are treated by CNTW in Newcastle, crisis response and availability of beds affects our ED department when these are not available.

Learning Disability

The document reflects an ambition to care for more people with LD in their local communities and recognises that services will need to be developed in order for this to occur. We hold the contract for LD within Gateshead but this is sub contracted to CNTW. The Mental Health Long Term plan indicates that a more complex cohort of patients would be better cared for within their local communities and will require more support than is currently available. They should be involved in designing this support and mental and physical health should be as joined up as possible. Our community teams already care for a number of individuals with learning disabilities and linking more cohesively with the mental health teams will support this ambition, building on existing MDT support.

Recommendation

The Board of Directors is asked to note the ambitions above and endorse Gateshead's position at place in respect of:

- Actively partnering with other colleagues from across the system to influence the wider determinants of health (including MDT working at PCN level with Community teams, GP's voluntary sector)
- Examining the range of services provided by Older Person's Mental Health to see if we can expand these to support admission avoidance.
- Appropriate support for children and young people by joining with partners to support them while waiting for a health intervention.

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 10i

Report Title:	**Quarterly Strategic Aims and Objectives Update**			
Name of Meeting:	Trust Board			
Date of Meeting:	26 July 2023			
Author:	Executive Directors Nicola Bruce, Interim Director of Strategy, Planning and Partnerships			
Executive Sponsor:	Executive Directors			
Report presented by:	Nicola Bruce, Interim Director of Strategy, Planning and Partnerships			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
	To provide assurance over progress made towards the delivery of the strategic objectives for 2023/24.			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☒ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	Board committees have considered the objectives which have been mapped to them.			
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 Board of Directors approved the strategic objectives for 2023/24 at their meeting in May 2023. • Strategic objective delivery action plans have been developed by Executive Director owners of each of the objectives since this time. • They have been reviewed by the relevant Board Committee. • This report presents a Quarter 1 update on the delivery of the strategic objectives for 2023/24. • Note that there has been a request to update the expected outcomes / measures for two of the strategic objectives, namely SA2.3 and SA4.2. The proposed change to SA2.3 is to align and ensure consistency with the work underway to develop Leading Indicators. The proposed change to SA4.2 is to better reflect the work that is underway at Gateshead Place. The requested changes are highlighted in red in the attached action plan summary.			

<table>
<tr><td>Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper</td><td colspan="6">The Board is requested to:

• review the accompanying action plan summary contained within this report
• consider and approve the request to update expected outcomes / measures for SA2.3 and SA4.2
• note progress towards delivery of the strategic objectives in 2023/24.</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>Links to CQC KLOE</td><td>Caring
☒</td><td>Responsive
☒</td><td>Well-led
☒</td><td>Effective
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☒</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">Risks which may pose a threat to the delivery of the corporate objectives are recognised via the Board Assurance Framework.</td></tr>
<tr><td>Has a Quality and Equality Impact Assessment (QEIA) been completed?</td><td colspan="2">Yes
☐</td><td colspan="2">No
☐</td><td colspan="2">Not applicable
☒</td></tr>
</table>

				Quantity		0	10	31	2			
Strategic Objective	**Summary of Actions**	**How**	**Action Owner**	**Start Date**	**End Date**	**Overdue**	**Some Risk**	**Work in Progress**	**Action Complete**	**Completion Date**	**Expected Outcomes/measures**	**Comments/progress**
SA1.1 Continue to improve our maternity services in order to improve performance against key indicators and ensure improved patient outcomes by March 2024. **Executive Lead - Chief Nurse** **Assurance Committee: Quality Governance Committee**	Assess and benchmark performance against key national inquiry reports in order to assure safety and promote learning	Action plan to be developed and implemented according to findings and monitor impact via quality committee.	JC	Apr-23	Mar-24						**Delivery of the 19 safety priorities and improvement in the maternity metrics outlined and reported in the IOP**	National maternity and neonatal plan has now been published. Gap analysis has been completed and we have joined with the regional team to agree how we implement some of the actions. We are linking this year 5 maternity incentive scheme. Concerns remain about our ability to achieve safety action 8 because of the significant cost of training and backfill. Options are being considered
	Assess and Implement the agreed plan for maternity Continuity of Carer and seek to measure improved outcomes according to expected benefits aligned to leading indicators.	Maternity team to be reconfigured to meet actions outlined in the MCOC plan	JC	Apr-23	Dec-23					Jun-23		We have met with staff and consulted on a range of options. The option chosen was to continue with one team and some enhanced support for the most vulnerable women. This has been implemented and is being evaluated. No further changes will be made at this stage.
	Implement any actions from the maternity CQC inspection 2023	Develop and implement action plan once final report is received and measure the impact, reporting via quality committee	GF/JC	Apr-23	Mar-24							The final CQC report has been received and actions have been added to the Trust wide CQC plan
SA1.2 Develop and implement a continuous Quality improvement plan that enables the delivery of improved performance against key indicators by March 2024 **Executive Lead - Chief Nurse** **Assurance Committee: Quality Governance Committee**	Review, refresh and implement Quality Account Priorities to ensure that they align with Trust core goals and contribute to the agenda of reducing LOS	Implement the actions within the Quality Account and monitor the progress and impact on a monthly basis via divisional performance and quality governance meetings	GF	Apr-23	Mar-24						**Quality Account Priorities achieved**	Quality account actions have been presented to Quality Governance Committee and agreed. Actions will be monitored via the safecare risk and patient safety
	Monitor Quality Account Priorities implementation	Monitor the implementation plan for the Quality Account Priorities at SafeCare, Risk and Patient Safety Council	GF	Apr-23	Mar-24							Action plan is on the cycle of business for the safecare, risk and patient safety council.
SA1.3 Ensure that there is a Digital first and data led approach to transformation and improvement across all domains of activity in order to contribute to delivery of the key indicators by March 2024 **Group Director Finance and Digital** **Assurance Committee: Digital Committee**	Enhance the basics - We will provide fast, modern, safe technology and services that users want and can rely on	Undertake the national Digital Maturity Assessment, user experience surveys and develop an improvement plan.	NB	Feb-23	Sep-23						**Agreed Electronic Patient Record plan** **Improved data quality and data driven decision making** **Improved patient outcomes and staff experience**	Digital Maturity Assessment completed in draft; gap analysis currently taking place and will inform the specification for the EPR proposal.
		Implement the data quality strategy and develop indicators that provide assurance on clinical systems use and clinical coding depth.	NB	Dec-23	Mar-24							Some digital indicators developed and built into DAG reporting. This will be shared with service representatives to support an increase in this area. Looking at KPIs to track both digital performance and trust compliance with the ability to drill down to business units/service level.
	Deliver Improvements - We will provide technology to reduce inefficiencies, poor processes and duplicate records	Develop and agree the electronic patient record outline business case with full clinical ownership.	CB	Dec-21	Dec-23							Outline business case agreed in February 23. Checkpoint requested to ensure full clinical ownership. Market engagement sessions to be arranged Autumn 2023 to agree the right strategic direction for the Trust.
		Develop a systems and data exploitation plan that supports the delivery of leading indicators, supporting safe and efficient patient care.	DT/DR	Apr-23	Mar-24							Procedure for system exploitation management currently being developed. Initial roadmap to focus on agreed activity for 23/24. Longer term developments not started - longer term plan linked to the outcome/discussions regarding EPR.

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	Open, share and transform - We will focus on joining up the needs of the user across the whole patient pathway	Expand access to patient record, results and images from across the region; sharing our data to support patient care cross the ICS.	CB	Dec-22	Mar-24							Global worklist testing completing, awaiting neighbouring Trusts. Delays in project due to regional timescale and cross organisational clinical sign off.
		Implement a patient portal to empower patients to manage their own health and care, and enable services to interact digitally with the patient.	CB	Mar-23	Dec-23							Contract in place, project work underway. Pilot clinic (breast) to go live July 23 with other areas to follow. GHFT to be the first trust to go live with supporting correspondence (linked to hybrid mail solution)
	Invest in people - We will focus on enhancing the skills and knowledge of the user involving them in digital	Implement the digital skills and inclusion plan for staff and patients; undertaking a workforce survey, completing a business case if required.	CB	Nov-22	Sep-23							Talent management discussions have started in Dec 22, with a view to implement Scope for Growth talent management. Action plan currently being developed with the support of OD. Digital inclusion for patients - linked in to discussions at a place level.
SA2.1 Caring for our people in order to achieve improved compliance of key indicators by March 2024 **Executive Lead - Executive Director of People and OD** **Assurance Committee: People and OD Committee**	Getting the basics right and looking after you in every way we can.	Providing a working environment where all basic needs are met for all colleagues working within the organisation.	LF	Apr-23	Mar-24						**Key Indicator: Absence rate reduction to 5% by March 2024** **Even better if target of 4.8% by March 2024**	Vending machines have been changed across the site to enable card payment. Out of hours catering offer continues. During strike action, free catering provision continues to be provided as part of the standard response. Work underway to place coffee machines in the Surgery Centre and on the Bensham site. Two junior doctor messes that have been renewed, refreshed and are accessible across the QE site.
		Working in partnership with managers to support the needs of our people.	DB	Apr-23	Mar-24							Managing Well and Leading Well embedded as part of the development offer for people managers and leaders across the organisation. Professional policy training has been commissioned by Capsticks to provide a legal lens in addition to internal training supporting key policies including Grievance, Investigation/Disciplinary and Promoting and Supporting Attendance. Matrix approach and model of working across POD is well embedded, provides the foundations for supporting managers and providing access to specialist skills and expertise to support them in meeting the needs of their people.
		Embedding an organisational wellbeing culture embedded and aligned to the national Health & Wellbeing Framework.	LF	Apr-23	Mar-24							Continue to deliver against the three workstreams set out in the HWB strategy. The HWB programme board to shortly be brought to a close, as it has delivered what was originally intended and is a testament to the success of the programme. The HWB Manager position has now been permanently recruited too. The Trust have also been awarded Silver Status for the Better Health at Work Award - which measures our activity against nationally recognised benchmark standards.
		Target driven, efficient and effective approach to promoting and supporting attendance and a coaching approach to supporting managers.	DB	Apr-23	Mar-24							Absence management policy refreshed and relaunched on 1 October 2022. A collective leadership approach has been taken between POD team and operational around short term absence in addition to a target setting approach via case conferences having being introduced for long term absence. Professional training for managers has been designed and delivered by Capsticks, going forward this training will be carried out locally with our POD Advisory and L&D Teams. Current absence data continues to show a positive reduction in absence rates across the Group with both the Trust and QEF heading towards 4% Target.
SA2.2 Growing and developing our people in order to improve patient outcomes and reduce reliance on high cost agency staff by March 2024 **Executive Lead - Executive Director of People and OD** **Assurance Committee: People and OD Committee**	Building our workforce and helping you be the best you can be.	Providing a professional and comprehensive customer focused Education, Learning and Development service to the organisation, working with services to ensure our people have the appropriate learning and professional development alongside a well-established core skills training programme.	SN	Apr-23	Mar-24						**Key Indicator: Vacancy rate reduction to 5% by March 2024** **Even better if target of 4% by March 2024**	The Trust's first Learning at Work week was launched and ran in May 2023. L&D Facilitators have been working in partnership with business units to identify performance and development gaps and undertaking a comprehensive gap analysis. As a Trust we have also developed a key partnership with CBC, the voluntary sector and the local authority to run place based joint workforce development offer and approach through the Gateshead Health and Care Academy. Ongoing engagement with professional leads to begin current core skills mapping with the aim of agreeing the requirements for all staff groups across the organisation to more accurately reflect the core skills position.
		Develop a Trust wide strategic approach to workforce planning that is informed by population health needs, local and national strategy. With an ability to forecast and horizon scan.	NB	Apr-23	Mar-24							Work completed with Whole Systems Partnership to lead us through a process to explore and adopt a strategic approach to workforce planning. Final report received, which has been developed into a draft action plan. To be discussed with Trust management to then operationalise and ensure integration and alignment. Delays in progressing this since last PODC due to unforeseen, extended absence. An Interim Director of Strategy, Planning and Partnerships has been appointed and there is a plan to present a piece to Board around the Trust's approach to strategic planning, which will include workforce.

				Quantity		0	10	31	2			
Strategic Objective	**Summary of Actions**	**How**	**Action Owner**	**Start Date**	**End Date**	**Overdue**	**Some Risk**	**Work in Progress**	**Action Complete**	**Completion Date**	**Expected Outcomes/measures**	**Comments/progress**
		Have an agreed Trust wide retention strategy which includes a customisable range of high impact, effective tools that are deployed at a local level, depending on service need.	NB	Apr-23	Mar-24							A review of the Trust's current retention offer is planned, evaluating the impact and effectiveness of this. Consideration to be given to new and/or innovative retention initiatives, piloting and evaluating in high turnover areas initially. To develop a draft strategy and plan for discussion at September POD Committee, with actions to follow.
SA2.3 Being a great place to work in order to improve staff survey outcomes and impact upon patient outcomes within 2-years. **Executive Lead - Executive Director of People and OD** **Assurance Committee: People and OD Committee**	Being a values led organisation with compassionate and inclusive leadership, where you have a long, lasting and valuable career.	Leaders will role model compassionate, inclusive and collective leadership in all of their interactions, aligning with our ICORE Values and the national Our Leadership Way Framework.	LF	Apr-23	Mar-24						**Key Indicator: Increase staff engagement score to 6.9 by March 2025** **Even better if target of 7.4 by March 2025**	One area of improvement noted in the 2022 staff survey was around "Your Manager", which saw the scoring for every question significantly improve, indicating a positive shift. Both Managing Well and Leading Well are successful, well embedded development programmes across the Trust but as part of POD's commitment to continuous improvement are due a review to ensure that these are still current and reflecting our direction of travel as an organisation under new leadership to best support the organisation to be clinically led and managerially supported. Although not yet started, a plan is being developed to design a type of Zero tolerance campaign which encourages everyone to be open and honest about when behaviour falls below the levels expected and work with colleagues to educate, train and advise them on alternative and compassionate behaviours.
		Flexible working practices will be commonplace across all staffing groups.	AV	Apr-23	Mar-24							The Trust's Flexible Working Policy has been updated to reflect changes to Section 33 of the national terms and conditions and also the NHS People Promise. Comms has started around this including why flexible working matters and that it is for everyone regardless of role, grade, or the reasons for wanting to work flexibly, with further communication and access to information planned. The Trust's Homeworking policy is due to be updated and this will consider Agile Working more broadly that just home working. However a true cultural shift is required to make this common place moving forward, with role modelling at all levels of the organisation, with awareness being raised through a presentation to SMT. A workshop is also scheduled for August including operational management and professional nursing lead representatives.
		Continue to work closely with our Freedom to Speak up Guardian, enabling and supporting colleagues to Raise Concerns where they need to, encouraging and facilitating a working environment where we can all speak up and speak out about issues that concern us.	AV	Apr-23	Mar-24							New National FTSU Policy and guidance launched, and Trust paperwork being updated. Recruitment process for full time Guardian commenced. FTSU Guardian to move to sit within the POD Directorate. 9 voluntary Champions have been appointed, all of whom have received induction training, with an on-going comms / recruitment plan in place to recruit more Champions. A national reflection and planning tool has been completed with actions to be reviewed on an on-going basis.
		Work closely with the Trust EDI and engagement lead to provide support, experience and opportunities to promote, embed and champion the Inclusion agenda and Trust strategy.	AV	Apr-23	Mar-24							The Trust's EDI and Engagement Manager joined the POD Directorate at the beginning of July 2023. The Trust's EDI strategy has been approved by SMT and the HREDI Programme board have deliberated the strategy and incorporated this into the overarching EDI action plan.
SA3.1 Improve the productivity and efficiency of our operational services through the delivery of the New Operating Model transformation plans in order to meet required performance standards/recovery requirements by March 2024 **Executive Lead - Chief Operating Officer** **Assurance Committee: Finance and Performance Committee**	The New operating Model transformation programmes will be delivered demonstrating an improvement impact on both unscheduled care pathways and elective and planned care recovery metrics in order to achieve annual plan submissions	Detailed workplans have been developed for 23/24 for both the Unscheduled Care Programme and the Elective and planned recovery programme. These are monitored through the NOM programme Board and reported to F&P Committee through Transformation Board	JMB	Apr-23	Mar-24						**Monitored through the achievement of the key indicators (to be referenced once confirmed)**	A paper is in draft to demonstrate progress against objectives so far and due to be presented at F&P Committee. Estates works are ongoing and due for completion later in 2023.
	Ensure estates changes relating to the new operating model are realised and the impact is assessed and measured through staff and patient satisfaction surveys	working collaboratively with QEF to realise plans, bring in on time and on budget	JMB	Apr-23	Mar-24							We are currently part way through the estates changes. Full impact and benefits will be assessed when estate changes come online.

				Quantity		0	10	31	2			
Strategic Objective	**Summary of Actions**	**How**	**Action Owner**	**Start Date**	**End Date**	**Overdue**	**Some Risk**	**Work in Progress**	**Action Complete**	**Completion Date**	**Expected Outcomes/measures**	**Comments/progress**
SA3.2 Achieve financial sustainability by in-year delivery of Trust CRP plan and development of robust sustainability plan for delivery within 3-years **Executive Lead - Group Director of Finance and Digital** **Assurance Committee: Finance and Performance Committee**	In year activity to deliver against the financial plan through the development, implementation and monitoring of clinically led CRP plans	Use of financial accountability framework and internal focus on delivery of cost improvement programme. Supported by robust budget monitoring and reporting to F&PC - capital and revenue. Establish a monitoring forum to manage and report in month variance to plans.	KM	Apr-23	Mar-24						**Delivery of the financial projections as per submitted phased plan.** **Production of robust and achievable financial sustainability/recovery plan that returns the organisation to financial balance.**	Weekly CRP working group established to enhance engagement and ensure early traction and transaction against efficiency target. Focus is on monitoring divisional performance but also in mobilising action needed for cross cutting corporate schemes.
	Ongoing focus on financial sustainability to improve the underlying financial position through assessment of service vulnerability and sustainability and using benchmarking tools to robustly assess efficiency at scale.	Ongoing assessment of underlying run rate, increase in effective organisational communication and engagement, use of benchmarking information and HFMA checklist. Continually horizon scan for developments and opportunities. Optimise estate strategy to reduce estate and seek to increase home working to optimise recruitment and minimise costs.	KM	Apr-23	Mar-24							HFMA checklist, grip and control tool and internal audit actions being monitored by finance and performance committee. Restructure of finance function established a small team dedicated to efficiency and transformation, including use of benchmarking information. Team lead recruited to and due to commence in role in August.
	Automation of transactional processes optimising digital impact and reducing cost.	Work collaboratively with digital and transformation teams to utilise RPA function.	KM	Apr-23	Mar-24							Digital service have requested services propose further projects that virtual workers could be deployed to support.
	Enhance capacity and capability of the finance team.	Complete recruitment to new structure and supporting organisational development programme of work.	KM	Apr-23	Mar-24					Jul-23		Organisational development work is underway with the finance team. Commencing with clarity in roles and responsibilities and ensuring tasks are allocated appropriately. Operational workplan is aligned to delivery of priorities and Trust Strategic objectives.
SA4.1 Identify key local health inequalities challenges and ensure improvement plans are in place by March 2024 **Executive Lead - Medical Director** **Assurance Committee: Quality Governance Committee**	Mitigating against 'digital exclusion' ensuring providers offer face to face care to patients who cannot use remote services and ensure more complete data collection to identify who is accessing face to face /telephone/video consultations is broken down by patient age, ethnicity, disability status	Included in the data scoping will be to review DNA and link with the learning disability team and also the MECC community teams.	AB	Apr-23	Mar-24						**The delivery of an agreed health inequalities action plan and implementation of the Health Inequalities Strategy**	Work in progress around outpatient transformation
	A framework for action across the NHS: Core20plus5 is NHS England's new approach to tackling health inequalities. It focuses on improvements for the most deprived 20 per cent of the population (core20), reducing inequalities for population groups identified locally (plus) and accelerating improvements in five clinical areas (5).	A gap analysis to be completed across the 5 clinical areas. Maternity, severe mental health, chronic respiratory disease, early detection of cancer and hypertension.	AB	Apr-23	Mar-24							Work not yet started
SA4.2 Work collaboratively as part of Gateshead Cares system to improve health and care outcomes to the Gateshead population **Executive Lead - Chief Operating Officer** **Assurance Committee: Quality Governance Committee**	Work in partnership to influence and shape the place based vision. Increase clinical visibility within place	Map out meetings to ensure appropriate representation from the trust and carry out engagement by CEO & MD with key stakeholders	AB	Apr-23	Mar-24						~~**Gateshead strengthened commitment to tender for wider services for example 0-18yr old service**~~ **Secure our alignment to Gateshead Place to achieve best outcomes for residents closer to home and reduce the reliance on the acute Trust.** **Develop strategic partnerships to ensure we are the delivery partner of choice within Gateshead.**	Gateshead Health continue to be an active partner within Gateshead Cares System Board. Focus has been on health, housing and safety with all staff within Community Division now aware of recent guidance to improve this and referral routes to LA. Worked with LA to develop and submit the Better Care Fund submission focusing on improving and expanding health and social care services outside hospital to reduce admissions and improve health. Support to Health and Wellbeing Board to review and agree the "Gateshead Plan" relating to ICB metrics. Increased clinical presence in place based discussions following re-direction of MD job plan and introduction of MD of Operations.

				Quantity		0	10	31	2			
Strategic Objective	**Summary of Actions**	**How**	**Action Owner**	**Start Date**	**End Date**	**Overdue**	**Some Risk**	**Work in Progress**	**Action Complete**	**Completion Date**	**Expected Outcomes/measures**	**Comments/progress**
SA5.1 We will look to utilise our skills and expertise beyond Gateshead in order to ensure organisational sustainability and contribute towards innovative care and provision within 23/24 **Executive Lead - QE Facilities Director** **Assurance Committee: Finance and Performance Committee**	Undertake SWOT analysis of future commercial opportunities for the trust and QEF in order to prioritise and establish commercial strategy for delivery.	Stakeholder engagement internal and external	SH	Apr-23	Dec-23						**Development of a commercial Strategy**	Presentation by QEF shared at Trust Strategy session held on 26/4/23 which included a SWOT analysis and areas of potential growth. This was further shared at the Medical Staff Committee held on 20/6/23 to understand the aspirations of clinicians and how QEF can help realise these linked to work being undertaken on sustainable services and Trust strategy.
	Identify through the Making Services Sustainable work which services we can grow and develop	Engage with CSG. Clinical services to complete a review making recommendations for consideration;	NBr/KR	May-23	Dec-23						**Service Sustainability Plan developed for board approval by December 2023**	Work shared with CSG 10/5/23 followed by the development of a template for completion by teams to determine the clinical assessment of services - fragile, vulnerable or exceptional (phase 1). Numerous returns received that are being worked through to determine any gaps or immediate vulnerabilities. Corporate working group established and met 13/6/23 with clinical leadership from the Medical Director of Operations

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 10ii

Report Title:	**Board Assurance Framework 2023/24**			
Name of Meeting:	Board of Directors			
Date of Meeting:	26 July 2023			
Author:	Jennifer Boyle, Company Secretary Executive Directors			
Executive Sponsor:	Gillian Findley, Chief Nurse			
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:** ☐
	This report provides the Board with the current Board Assurance Framework 2023/24 for review and assurance, following scrutiny by each of the mapped Board committees.			
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*	Executive Directors Board Committees			
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 BAF has been developed for 23/24 based on primarily the same format at the previous year. • The strategic objectives, summary risks and target scores have been updated. • Actions closed in 22/23 were removed from the action columns, ensuring a corresponding entry was made in respect of a positive control or assurance to recognise the closure of a previous gap. • Outstanding actions as at 1 April 23 remained live on the BAF for the consideration and scrutiny of the committees, given that there was not a fundamental change in the strategic objectives compared to 22/23. • The 23/24 BAF has now been reviewed at each Board committee at least once. Graphs to track the current risks scores will be incorporated into the BAF once each extract has been reviewed twice by its respective committee.			

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

The BAF key is as follows:

<table>
<tr><th>Key</th><th>Description</th></tr>
<tr><td></td><td>Not yet started</td></tr>
<tr><td></td><td>Started and on track no risks to delivery</td></tr>
<tr><td></td><td>Plan in place with some risks to delivery</td></tr>
<tr><td></td><td>Off track, risks to delivery and or no plan/timescales and or objective not achievable</td></tr>
<tr><td></td><td>Complete</td></tr>
</table>

There are no summary risks that have reached their target score at this point in the year. Given that the BAF is reflecting the Q1 position, this is in line with expectations.
Assurance can be provided that the Board committees review the BAF at the end of every meeting for triangulation, completeness and updates.

</td></tr>
<tr><td>Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper</td><td colspan="6">The Board is requested to review the BAF, noting that it is under continuous review and update at the relevant Board committees.</td></tr>
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<tr><td>Trust corporate objectives that the report relates to:</td><td colspan="6">This relates to all corporate objectives, assisting in the management and mitigation of risks which may pose a risk to delivery.</td></tr>
<tr><td>Links to CQC KLOE</td><td>Caring
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<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">Risks identified on the BAF itself.</td></tr>
<tr><td>Has a Quality and Equality Impact Assessment (QEIA) been completed?</td><td colspan="2">Yes
☐</td><td colspan="2">No
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☒</td></tr>
</table>

Quality Governance Committee BAF (SA1.1, SA1.2, SA4.1, SA4.2)

Strategic objective:	SA1.1 Continue to improve our maternity services in order to improve performance against key indicators and ensure improved patient outcomes by March 2024.						
Executive Owner:	Chief Nurse						
Board Committee Oversight:	**Quality Governance Committee**						
Date of Last Review:	June 23 Quality Governance Committee						
Summary risk							
This is a risk that the Trust is unable to maintain the level of improvements required to enhance maternity services due to resource capacity (finance, staffing and estates for example), impacting upon the quality of maternity services and a decline in performance against the maternity metrics and patient outcomes.	*Graph to be populated once the BAF has been considered twice at Committee*	**CURRENT RISK SCORE**			**TARGET RISK SCORE**		
		Likelihood	Impact	Score	Likelihood	Impact	Score
		2	4	8	2	4	8
Links to risks on the ORR (scores as at June 23):	COO 2868 - New Operating Model - Risk to the delivery of the new operating model resulting in adverse impact on performance & recovery plans (12) POD 2764 - Workforce - Risk of not having the right people in right place at the right time with the right skills. (16) SURGE 2398 - Risk that MDT are delayed to a maternity emergency/delayed CCU transfers for maternity patients due to separate buildings (12) COO 3186 - There is a risk to ongoing business continuity of service provision due to ageing trust estate (12) NMQ 2779 - The Trust fails to meet the CQC Fundamental Standards. (16)						

Controls	**Gap in controls and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Maternity workforce plans developed, with some specialist roles already appointed to	The listening event held with SCBU staff identified a need to undertake a staffing review to determine whether an uplift of staff is required. Staffing review to be supported by the Neonatal Network with an update planned for one month's time.	JC	August 23		
Face to face training in place					

Estates strategy in place and work commenced on maternity estates improvements						
Action plans in place for Maternity Incentive Scheme and Ockenden have been developed						
Gap analysis undertaken against Ockenden reports						
Neonatal Badger implementation complete resulting in improved integrated and digitisation of records.						
Maternity Birth Rate Plus assessment scheduled for Oct 23						
Maternity and neonatal delivery gap analysis in place						
Special Care Baby Unit listening and engagement event held						
Assurance (Level 1: Operational Oversight)		**Gaps in assurance and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Performance is monitored within the department at governance meetings						
Maternity forms part of the Surgery Quality Oversight Meetings where performance is overseen by the exec team						
Action plan for Ockenden monitored at Maternity and SBU Safecare						
Action plan completed for Maternity Incentive Scheme						
Assurance (Level 2: Reports / metrics seen by Board / committee etc)						
Ockenden assurance report to Board in March – Ockenden one year on						
Maternity Integrated Oversight Report now in place and presented to the Quality Governance Committee and the Board of Directors. It will continue to evolve.						
Maternity assurance report presented at every Quality Governance Committee meeting						
Ockenden assurance report to Board in May 2022						

Patient safety walkabouts with Executive Directors and Non- Executive Director held monthly						
Assurance (Level 3 – external)						
Feedback received from regional team regarding Ockenden evidence submission						
Maternity Voices Partnership provide regular feedback to the unit on patient experience						
Friends and Family test score results are positive and provide good assurance over the quality of care						
Chief Midwifery Officer visit to the Trust. Awards presented to colleagues in Maternity for the provision of excellent care, leadership and inspiration to colleagues and patients.						
CQC maternity survey ranked the Trust as 8th in England for its maternity services						
CQC report received – 'good' rating for maternity (added post-QGC meeting)						

Strategic objective:	SA1.2 Develop and implement a continuous Quality improvement plan that enables the delivery of improved performance against key indicators by March 2024						
Executive Owner:	Chief Nurse						
Board Committee Oversight:	Quality Governance Committee						
Date of Last Review:	June 23 Quality Governance Committee						
Summary risk							
Pressures on performance, people and finance coupled with external influences may place significant risk on the ability of the Trust to achieve national quality standards and deliver the quality improvement plan	*Graph to be populated once the BAF has been considered twice at Committee*	**CURRENT RISK SCORE**			**TARGET RISK SCORE**		
		Likelihood	Impact	Score	Likelihood	Impact	Score
		2	4	8	2	4	8
Links to risks on the ORR (scores as at June 23):	MEDIC 2982 - Risk of delayed transfers of care and increased hospital lengths of stay (16) POD 2764 - Workforce - Risk of not having the right people in right place at the right time with the right skills. (16) NMQ 3089 - Quality - Risk of quality failures in patient care due to external causes such as delayed discharges and external pressures. (12) POD 3095 - Risk of Significant, unprecedented service disruption due to industrial action (20) NMQ 2779 - The Trust fails to meet the CQC Fundamental Standards. (16)						

Controls	**Gap in controls and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Gap analysis undertaken against CQC standards					
Core standards action plan has been developed					
Clinical audit programme in place					
Quality Governance Committee and sub-groups in place					
Equality and Quality Impact Assessment (EQIA) programme in place					
Transformation and Quality Improvement Programme in place					
Datix and incident reporting systems in place to record risks and incidents and capture learnings					

Nursing strategy in place						
Good Governance Institute work completed re: assessment of compliance and controls regarding well-led.						
CQC task and finish group established						
New Compliance Group established						
Quality Strategy ratified at Board in March 2023 and now live						
Good Governance Institute undertaking a review of meetings to ensure appropriate coverage, escalation, assurance etc.						
Continuous improvement framework in development						
Assurance (Level 1: Operational Oversight)		**Gaps in assurance and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
SafeCare meetings in each operational business unit						
Quality is a key component of the Quarterly Oversight meetings						
Compliance Manager is in post and has action plan for compliance						
CQC task and finish group in place to provide oversight of CQC action plan						
Assurance (Level 2: Reports / metrics seen by Board / committee etc)						
IOR includes quality metrics mapped to the key lines of enquiry – reviewed by the Quality Governance Committee and Board bi-monthly						
Patient and staff stories presented to Board at every meeting						
Clinical audit outcomes reported to Quality Governance Committee						
Complaint triangulation report presented to Quality Governance Committee						
Assurance (Level 3 – external)						

CQC process audit by AuditOne – outcome awaited	[redacted]					
AuditOne audits from 2021/22 – NICE Guidance (good) and Duty of Candour (good)	[redacted]					
Medicines optimisation service received 'good' rating from CQC	[redacted]					
Screening Quality Assurance Service (SQAS) visit to colposcopy with positive feedback	[redacted]					

Strategic objective:	SA4.1 Identify key local health inequalities challenges and ensure improvement plans are in place by March 2024						
Executive Owner:	Medical Director						
Board Committee Oversight:	Quality Governance Committee						
Date of Last Review:	June 23 Quality Governance Committee						
Summary risk							
There is a risk that due to competing pressures (such as financial constraints and the need to meet national operational targets) the Trust does not deliver on its health inequalities action plan, resulting in continued decline in health within the local population	*Graph to be populated once the BAF has been considered twice at Committee*	**CURRENT RISK SCORE**			**TARGET RISK SCORE**		
		Likelihood	Impact	Score	Likelihood	Impact	Score
		4	2	8	4	2	8
Links to risks on the ORR (scores as at June 23):	POD 2759 - We are not able to appropriately support the health and wellbeing needs of our workforce (12) COO 2945 - Risk of ineffective and inefficient management of services due to availability and access to appropriate and timely BI. (12)						

Controls	**Gap in controls and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Health Inequalities Lead and SRO identified	Lack of knowledge and expertise – resource to be identified internally. Maintain strong links with ICS team and Gateshead Director of Public Health	Medical Director	December 22	June 23 – dedicated resource not yet identified. Agreed to ensure operational oversight at divisional level with reporting to the Inequalities Board and SMT. Consideration to be made to adding health inequalities to the cover sheets.	

Health Inequalities Board established with members including the Director of Public Health for Gateshead						
Waiting lists record deprivation score index and data sets also record ethnicity						
Trust engagement in Making Every Contact Count						
Engagement in Gateshead Cares System Board						
Engagement with Gateshead Citizens' Advice to provide support to patients and staff						
Quality Governance Committee established as the reporting line for Health Inequalities Board						
Health Inequalities action plan in place						
Increased capacity to develop strategic relationships at pace due to the appointment of the Medical Director of Operations freeing up capacity for the Medical Director to lead in this with the CEO						
Assurance (Level 1: Operational Oversight)		**Gaps in assurance and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Assurance (Level 2: Reports / metrics seen by Board / committee etc)						
Presentations to the Board of Directors on health inequalities by the Trust lead, ICS lead and Director						

of Public Health for Gateshead – provides assurance over commitment and progress to-date						
Reports to Board on the Citizens' Advice collaboration and outcomes – last report November 2021						
Health inequalities metrics included in the IOR.						
Board consideration of place-based governance and working arrangements proposal which outlines proposed next steps for Gateshead Cares.						
Quarterly reporting on health inequalities presented to Quality Governance Committee.						
Health inequalities action plan monitored at the Health Inequalities Board meeting						
Assurance (Level 3 – external)						
Feedback from ICB and Place Based Partners on Health Inequalities work and outcomes						

Strategic objective:	SA4.2 Work collaboratively as part of Gateshead Cares system to improve health and care outcomes to the Gateshead population						
Executive Owner:	Chief Operating Officer						
Board Committee Oversight:	Quality Governance Committee						
Date of Last Review:	-						
Summary risk							
There is a risk that health and care outcomes for the population of Gateshead are not improved, so the Gateshead Care priorities and action plan fail to collectively deliver and the health and care outcomes at place-level are not delivered	*Graph to be populated once the BAF has been considered twice at Committee*	**CURRENT RISK SCORE**			**TARGET RISK SCORE**		
		Likelihood	Impact	Score	Likelihood	Impact	Score
		4	3	12	2	3	6
Links to risks on the ORR (as at April 23):	MEDIC 2982 - Risk of delayed transfers of care and increased hospital lengths of stay (16) NMQ 3089 - Quality - Risk of quality failures in patient care due to external causes such as delayed discharges and external pressures. (12)						

Controls	**Gap in controls and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Joint session planned with the system to review priorities and set objectives for 22/23	Membership of Gateshead Cares Board does not include representatives from areas such as education and housing, which contribute towards health outcomes. Note this is not in control of the Trust	N/a	N/a	N/a	N/a
Senior representation secured at Gateshead Cares meetings					
Trust developed strong relationships with key stakeholders and can influence the agenda					
New strategy shared at Health and Wellbeing Board in September 2022 to help support alignment across Gateshead system.					

Increased capacity to develop strategic relationships at pace due to the appointment of the Medical Director of Operations freeing up capacity for the Medical Director to lead in this with the CEO						
Assurance (Level 1: Operational Oversight)		**Gaps in assurance and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
		To identify reports to include health outcomes to go to committee and Board	Medical Director	~~October 2022~~ ~~November 2022~~ August 2023	Working to include patient outcomes in the IOR. November 2022 is a more realistic target as this is a significant piece of work June 23 – J Halliwell agreed to revisit and provide an update at the next meeting	
Assurance (Level 2: Reports / metrics seen by Board / committee etc)						
Partnership working updates on cycle of business for SMT and EMT.						
Assurance (Level 3 – external)						

People and OD Committee BAF (SA2.1, SA2.2, SA2.3)

Strategic objective:	SA2.1 Caring for our people in order to achieve improved compliance to leading indicators by March 2024						
Executive Owner:	Executive Director of People and OD						
Board Committee Oversight:	People and OD Committee						
Date of Last Review:	July 2023 POD Committee						
Summary risk							
There is a risk that the Trust is unable to provide appropriate levels of support to staff from a health and wellbeing perspective due to resource and capacity constraints and an increase in activity as part of our operational recovery. This may result in increases in sickness, reductions in morale, reduced retention rates and ultimately impact negatively on our ability to deliver high quality care to our patients.	*Graph to be added once BAF has been considered for 2 months*	**CURRENT RISK SCORE**			**TARGET RISK SCORE**		
		Likelihood	Impact	Score	Likelihood	Impact	Score
		4	4	16	2	5	10
Links to risks on the ORR:	POD 2759 - Workforce health & Wellbeing - Risk of adverse impact to staff health and wellbeing due to internal and external pressures (12) POD 3095 - Risk of significant, unprecedented service disruption due to industrial action (20)						

Controls	**Gap in controls and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Health and wellbeing programme Board.	Delivery of the HWB Strategy.	AV	Mar 23	Complete and added to controls	**Complete**
Health and wellbeing team established (funding expires June 23).	Deliver a sustainable annual vaccination campaign that improves vaccination uptake, ensuring 85% of staff are vaccinated.	LF	January 24	July 23 – planning for this has commenced	**Ongoing**
Health and wellbeing conversations launched for all staff.	Reduction in sickness absence – training to be rolled out and new absence management approach embedded.	DB	Oct 23	Professional Absence Management training remains ongoing, robust absence management process	**Started with some risks to delivery**

					embedding, focused approach reviewed and well received by SMT, further focused approached required and to be reviewed in 6 months	
Partnership with Gateshead Citizen's Advice to provide additional support to staff.		Health and wellbeing team funding due to expire in June 23 and finance to extend not yet agreed. Charitable funds currently explored.	LF	Jun 23	Funding has been secured for a B7 Health & Wellbeing Manager role, which will go out to advert this month. Charitable Funds request submitted to fund B5 for another 12 months and work underway to scope options around B3 position. July 23 – B7 successfully appointed. Charitable Funds were secured to extend the Band 5 Health & Wellbeing Advisor position for a further 12 months. The B3 role has been extended for 3 months to cover a planned Occupational Health & Wellbeing Team restructure..	**Complete**
Listening Space now launched and in operation.		Implementation of rolling DBS programme to be completed.	DB	Timescale TBC	July 23 – this work has commenced	
Plans in place to prepare and mitigate risks as much as possible in respect of forthcoming industrial action.						

Flu and Covid vaccination programme delivered to colleagues.						
Health and Wellbeing ambassador network established.						
Improved catering provision in place, with medium term actions on track.						
Positive impact of focused sickness absence management approach from both management and POD teams.						
HWB strategy in place						
Planning in place for Covid, flu, whooping cough vaccinations						
Clear progress in reducing outstanding historic DBS						
Health and wellbeing funding secured for 23/24 in form of B7 role, 12m Band 5 and B3 for 3 months.						
Assurance (Level 1: Operational Oversight)		**Gaps in assurance and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
POD Quality Meeting, Management Meeting and People Portfolio Board.		Compliance with health and wellbeing conversations unknown.	DJ	Dec 22 To be reviewed Feb 23	Reportable from ESR from appraisals completed since November 22	**Complete**
Assurance (Level 2: Reports / metrics seen by Board / committee etc)						
Health and wellbeing metrics reported to POD Committee, including vaccination uptake and actions to support financial wellbeing						
Health and wellbeing metrics reported in IOR at Board.						
Strategic objective update reported for Q1						
Assurance (Level 3 – external)						
Staff feedback on HWB in 2022 survey results.						

International recruitment team has been awarded the NHS Pastoral Care Quality Award - recognises commitment to providing high-quality pastoral care and the positive impact this has on staff wellbeing.						

Strategic objective:	SA2.2 Growing and developing our people in order to improve patient outcomes and reduce reliance on high cost agency staff by March 2024						
Executive Owner:	Executive Director of People and OD						
Board Committee Oversight:	People and OD Committee						
Date of Last Review:	July 2023 POD Committee						
Summary risk							
Risk of not having the right people in the right place at the right time with the right skills due to lack of workforce capacity, resources and expertise across the organisation, ultimately impacting negatively on our patient outcomes and financial outcomes.	*Graph to be added once BAF has been considered for 2 months*	**CURRENT RISK SCORE**			**TARGET RISK SCORE**		
		Likelihood	Impact	Score	Likelihood	Impact	Score
		4	4	16	2	5	10
Links to risks on the ORR:	2764 - Risk of not having the right people in right place at the right time with the right skills (16) POD 3095 - Risk of significant, unprecedented service disruption due to industrial action (20)						

Controls	**Gap in controls and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Task and finish group well established and phase 1 of work complete. Phase 2 implemented to coordinate recruitment and retention activity, inc reporting and agency controls.	People Strategy has been developed and is due to be presented at March Board.	AV	~~Dec 22~~ New approved timescale – March 23	People Strategy timeline in Trac. Jan 23 – People Strategy to be presented at 9 Feb Board strategy day with ratification planned for March Board. April 23 - People Strategy signed off and agreed at March 2023 Board. Verbal update to be given and final version shared at PODC in May 2023.	**Complete**
International recruitment – programme well established.	Further development of people metrics; nursing dashboard further developed, medical staffing and AHP designed and tested.	LH	Feb 23	April 23 - AHP dashboard developed and updated monthly.	**Complete**

	People Analyst to look to triangulate bank and agency spend, sickness absence and vacancy rates and include in the narrative.			Initial Medical Dashboard developed – pending feedback from Medical Workforce Group. Nursing Dashboard not yet developed and reached a position where it was agreed with the Head of Nursing that the Nursing workforce information (whilst in various places) was sufficient. Bank, agency, sickness and vacancy rates triangulated via the inpatient workforce report summary with has been developed.	
Recruitment process streamlined (RPIW).	Comprehensive Workforce Plans – paper to be brought back to May Committee, writing up work to date, next actions and potential risks.	NB	Mar 23	Meetings scheduled throughout January 2023 with Business units and The Whole System Partnership to gather intelligence to support workforce planning looking at skill requirements. April 23 - Paper listed to be presented at PODC in May 2023.	**Complete**
Managing Well and Leading Well programmes fully operational.	E-Rostering for Medical Workforce.	BO	~~Mar 23~~ Revised to Sept 23	Zebra Project manager in post regular meetings in diary with Medical Staffing Manager.	**On track with some risk**

				Implementation plan under review.	
New absence management policy in place.	Securing funding to progress the RDN apprenticeship programme.	SN	~~May 23~~ Proposed new date June 23	Presented to SMT but further work required. April 23 - Agreed in principle at SMT with planning to commence. As investment needed exceeds £1m in total, this requires board approval. July 23 – on July 23 Board agenda for decision	**Overdue**
People analyst in post and initial reports developed; nursing dashboard in place with benchmarking and trajectories.	Exit interview process to be embedded and work to be undertaken to increase completion rates	NB	~~Mar 23~~ ~~Proposed new date July 23~~ New date – Sept 23	April 23 - Exit interview process reviewed and revisions suggested, however still requires roll out, comms and embedding. July 23 – agreed to review as part of wider retention work – to be considered at Sept POD Committee.	**On track**
Retention initiatives in place to support and encourage colleagues to remain with the Trust.	NHS Long Term Workforce Plan released – internal scoping for the Trust and wider ICS to be undertaken	AV / GR	Jan 24		
School and local community supply initiatives in place to attract the Trust's future workforce.					
Agency group in place to provide greater controls over the usage of agency staff.					
Healthcare Academy Approach in Development supporting Health Care Careers across Gateshead.					
KPI report developed around Theatre's initiatives and progress reports provided.					

Workforce plan in place					
People Strategy 2023-25 in place					
Planning and co-ordination process in place for industrial action					
Assurance (Level 1: Operational Oversight)	**Gaps in assurance and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Staffing Task and Finish Group.	BU Dashboard.	LH	~~Feb 23~~ Proposed new date July 23	April 23 - Business unit level workforce information is available via BI reporting but is currently being redeveloped by the BI team, co-ordinated by the People & Information Systems Manager.	**On track with some risk**
Nursing Workforce Group (People Portfolio Board approach).	Medical Staffing Dashboard.	LH	Feb 23	April 23 - Initial Medical Dashboard developed – pending feedback from Medical Workforce Group.	**Complete**
POD Management Meeting and SMT.	Further POD metrics being developed.	LH	Mar 23	April 23 - our People Analyst is always looking at ways to analyse and present current metrics differently. Looking at change over time, variations and data points that stand out.	**Complete**
Medical staffing dashboard developed in draft					
Strategic objective update reported for Q1					
Assurance (Level 2: Reports / metrics seen by Board / committee etc)					
POD Metrics to POD Committee.					
POD Portfolio Board.					

Nurse/HCSW Dashboard now in place to monitor vacancies and presented to formal groups for assurance and review.						
Assurance (Level 3 – external)						
Returns to NHSE.						

Strategic objective:	SA2.3 Being a great place to work in order to improve staff survey outcomes and impact upon patient outcomes within 2 years.						
Executive Owner:	Executive Director of People and OD						
Board Committee Oversight:	People and OD Committee						
Date of Last Review:	July 2023 POD Committee						
Summary risk							
There is a risk that the Trust's culture does not reflect the organisational values due to resourcing pressures and a lack of focus on organisational development, training and development, resulting in reduced retention, vacancies, poor staff survey results and ultimately impacting on patient outcomes.	*Graph to be added once BAF has been considered for 2 months*	**CURRENT RISK SCORE**			**TARGET RISK SCORE**		
		Likelihood	Impact	Score	Likelihood	Impact	Score
		3	4	12	2	5	10
Links to risks on the ORR:	POD 2759 - Workforce health & Wellbeing - Risk of adverse impact to staff health and wellbeing due to internal and external pressures (12) POD 3095 - Risk of significant, unprecedented service disruption due to industrial action (20)						

Controls	**Gap in controls and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Trust-wide engagement programme that resulted in the launch of a new vision and behaviour framework.	Engagement approach for the culture programme not yet fully defined.	LF	~~March 23~~ June 2023	April 23 - Culture Programme launched w/c 24 April 2023, with initial communications underway. Culture Board to be established May 2023, with a programme scoping session to follow, when a full engagement approach will be agreed.	**On Track**
Trust values have been reviewed as part of the wider engagement programme and remain the same.	Culture Programme approach agreed, with a structure built around 6 workstream SRO's and supporting Programme Managers.	LF	March 2023	April 23 - 6 SROs and 6 Programme Managers confirmed.	**Complete**

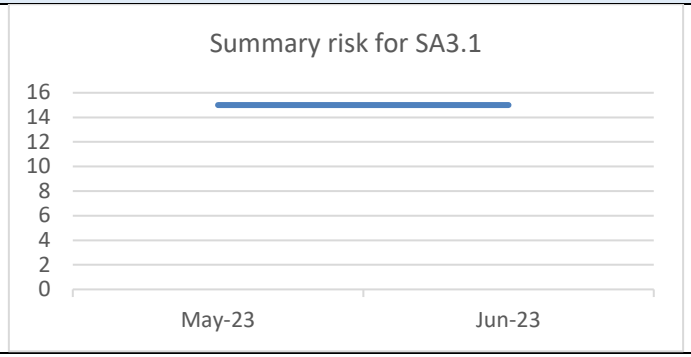
Culture Programme has been established overseen by the Transformation Board and sponsored by the CEO.	Engagement plan for EDS2.	KS	~~May 2023~~ Sept 23	April 23 - Verbal update to be given at PODC in May 2023. July 23 – written update requested for Sept 23	**On track with some risk**
Overarching Programme SRO agreed and confirmed.	Freedom to Speak Up – more information to be included on themes, trends and closing dates. People analyst to support future developments of the report.	GR	July 2023	April 23 – action plan in place to review Freedom to Speak Up more widely. Included in thematic review. June 23 – interviews scheduled for a dedicated FTSU Guardian role.	**On track with some risk**
Freedom to Speak Up report received for Q1	Low completion rates for Pulse survey – action to increase the Pulse survey rates in line with the leading indicator work	LF	Jan 24		
Existing team of Cultural Ambassadors that can support the programme.	Increase Board-level compliance for FTSU training	AV / SN / JB	Sept 23	July 23 – reminder sent to Board	
2022 Annual Staff Survey results received, analysed and communication campaign underway.	Develop zero-tolerance time to stop campaign	AV	Date TBC		
EDS2 update received.					
Culture programme resource and staffing now in place					
9 FTSU Champions and full-time Guardian appointed					
Corporate induction programme in place					
Anti-racism charter signed with Unison					
Assurance (Level 1: Operational Oversight)	**Gaps in assurance and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
POD Management Team.					
Assurance (Level 2: Reports / metrics seen by Board / committee etc)					
Transformation Board.					
POD Portfolio Board.					

POD Committee in place with regular reporting						
Corporate objective update for Q1 to POD						
Assurance (Level 3 – external)						
Staff survey provides good assurance (more detail to be added when embargo lifted).						

Finance and Performance Committee BAF (SA3.1, SA3.2, SA5.1)

Strategic objective:	SA3.1 Improve the productivity and efficiency of our operational services through the delivery of the New Operating Model transformation plans in order to meet required performance standards/recovery requirements by March 2024
Executive Owner:	Chief Operating Officer
Board Committee Oversight:	Finance and Performance Committee
Date of Last Review:	June 2023 – F&P Committee
Summary risk	

There is a risk that the Trust is unable to deliver the required productivity and efficiency to support the trust to meet the required performance standards, due to ongoing operational pressures and workforce gaps.



CURRENT RISK SCORE			TARGET RISK SCORE		
Likelihood	Impact	Score	Likelihood	Impact	Score
3	5	15	3	3	9

Links to risks on the ORR (as at July 23):	MEDIC 2982 – risk of delayed transfers of care and increased hospital lengths of stay (16) POD 2764 - Workforce - Risk of not having the right people in right place at the right time with the right skills. (16) COO 2868 - New Operating Model -Risk to the delivery of the new operating model resulting in adverse impact on performance & recovery plans (12) POD 3095 - Risk of significant, unprecedented service disruption due to industrial action (20) FIN 3128 - Risk that the capital cost of delivery of the new operating model continues to increase resulting in revenue implications. (9)

Controls	**Gap in controls and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
PMO team in place and supporting operational business units in the delivery of the transformation projects	Further work required to develop robust workforce plans to address vacancies in Business units	Executive Director of People and OD	March 2023	March 23 – business units engaged in the annual planning process to develop the workforce plans. May 23 – recruited to 95% of NOM plan. Workforce plan	**Complete**

					submitted as part of annual plan.	
as above		Clinically led estates strategy to be developed to inform 23-25 estates plans	QEF MD / Chief Operating Officer	~~December 22~~ Proposed: ~~March 22 May 2023~~ March 24	March 23 – recognition that this needs to be informed by the work to scope Bensham and the operational services review and therefore more work needs to be completed in due course May 23 – estates strategy work incorporated into the thematic review with deadline of 30/06 for initial assessment and 31/03/24 for overall delivery.	**On track**
New operating model (NOM) programme board in place to oversee the delivery and benefits realisation of the NOM delivery – receives updates from Elective and planned care project board and Unscheduled Care project board – The NOM board reports into the Trusts Transformation board and Executive Capital group		In respect of discharges there remains a gap in respect of LA capacity plans which are outstanding and the joint meeting scheduled for December was stood down. There are also issues in respect of digital capacity to deliver to required data. Collaborative work continues with the goal of presenting to the Board strategy session in February 2023.	Chief Operating Officer	February 23	COO and LA meeting is being scheduled. Digital issues escalated. March 23 – joint session delivered as part of Board strategy day. Work continues. May 23 – collaborative work will continue, but the specific work referenced here is complete. Discharges	**Complete**

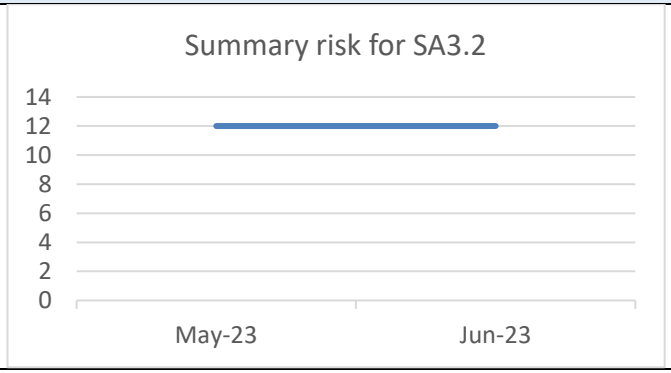
					currently within tolerable limits.	
Winter Plan in place and signed off by Board and submitted to ICB for winter 22/23		A need to develop a collective understanding of the sustainability, vulnerabilities and strengths of our service offering. The Trust Board has commissioned a review to inform this.	Executive Directors	September 2023	May 23 – incorporated into thematic review delivery plan. Engagement underway with full review expected to be completed by September 23.	**On track**
Estates plan for the New Operating Model in place and being delivered						
Productive relationship with local authority on discharges – collaboration will continue as business as usual						
Development of a focussed length of stay project to support a reduction in the duration of hospital stays						
Annual plan submitted for 23/24 covering operational delivery, finance and workforce						
Assurance (Level 1: Operational Oversight)		**Gaps in assurance and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Chief Operating Officer meets with senior team on a weekly basis to oversee performance delivery		NO workforce or Quality data in the IOR that enables triangulation with performance information	~~Chief Operating Officer~~ Group Director of Finance and Digital	March 23	March 23 – work being undertaken to refine the IOR with exception reporting at Board and increased granularity at operational tiers May 23 – this work is now complete and changes have been made to the IOR.	**Complete**

Escalation into BU monthly monitoring outcome of Q2 QOM re: Assurance Framework.		Benefits realisation process for elective and scheduled care transformation programmes not clear. Outcomes to be clearly defined so that they can be measured.	Chief Operating Officer	~~December 2022~~ April 2023	March 23 – action reopened to reflect benefits realisation exercise reporting to April F&P Committee. May 23 – paper was presented to April's meeting in line with timescale. Follow-up paper presented to the May 23 meeting. Action considered complete.	**Complete**
Elective and Planned Care Recovery project Board in place to monitor delivery of the transformation programme		Committee not sighted on the themes and trends from the weekly performance clinics – identified as a gap in assurance. Agreed to bring a summary back to the Committee along with the impact on the activity trajectory	Deputy Director of Planning and Performance	July 2023		
Unscheduled Care Programme Board in place to monitor oversight and delivery of the transformation programme		Gap in assurance relating to understanding the impact of the New Operating Model. A further report to come back to Committee to articulate performance metrics and mitigations.	Group Director of Finance / Deputy Director of Planning and Performance	July 2023	July 23 – on agenda	
Weekly performance clinics in place						
Assurance (Level 2: Reports / metrics seen by Board / committee etc)						
Quarterly Oversight Meetings in place -Executive led to meet on performance of all business units chaired by the CEO						
Integrated Oversight Report reviewed at Board and Board						

committees, and undertaking deep dives where required for extra assurance e.g. discharges.	[redacted]					
Transformation Board meets monthly with a suite of project update reports to provide assurance over key related workstreams feed into F&P Committee	[redacted]					
Operational Business Unit governance review completed and shared with the OBUs and Chief Operating Officer. Model documents developed to aid implementation.	[redacted]					
Quarterly Oversight meeting outputs on F&P cycle of business to provide assurance bi-monthly	[redacted]					
IOR contains quality and workforce data to support triangulation with operational performance	[redacted]					
Assurance (Level 3 – external)	[redacted]					
External review of discharges underway – outcome not yet available	[redacted]					
ECIST review undertaken – confirmed all transformation plans appropriate and identified areas of good practice	[redacted]					
External review of waiting list integrity provided good assurance	[redacted]					
Monthly regional performance report – benchmarking provided as part of IOR	[redacted]					
	[redacted]					

Strategic objective:	SA3.2 Achieve financial sustainability by in-year delivery of Trust CRP plan and development of robust sustainability plan for delivery within 3-years
Executive Owner:	Group Director of Finance and Digital
Board Committee Oversight:	Finance and Performance Committee
Date of Last Review:	June 2023 F&P Committee
Summary risk	

There is a risk that the Trust does not achieve its financial and capital plans due to the challenging level of CRP, rising costs of living and under-delivery of activity trajectories impacting upon the future ability of the Trust to deliver high quality services and innovation for our patients.



CURRENT RISK SCORE			TARGET RISK SCORE		
Likelihood	Impact	Score	Likelihood	Impact	Score
3	4	12	2	4	8

Links to risks on the ORR:	FIN 3128 - Risk that the capital cost of delivery of the new operating model continues to increase resulting in revenue implications. (9) FIN 3103 - operational pressures result in non-achievement of CRP (16) FIN 3127 - There is a considerable risk that the Trust is unable to meet the financial projections included in its plan. (12)

Controls	**Gap in controls and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Agreed budgets in place for each business unit reconciled to balanced position and agreed financial plan, inclusive of CRP targets	Finance team not yet fully established and therefore support is prioritised to 'core business' – recruitment underway	Group Director of Finance	~~December 2022~~ March 2023	March 23 – the team are now more established and no longer focussed on core business only. Two key posts will be recruited to in late March 2023.	**Complete**

					May 23 – new structures are now in place and all core roles recruited to.	
Financial accountability framework in place		SFIs and scheme of delegation require updating to reflect changes in the governance structure and decision-making	Group Director of Finance / Company Secretary	2023/24	March 23 – note this work will now take place in 23/24. May 23 – Deloitte review due for completion end of June with delivery plan to be agreed once findings known July 23 – Deloitte report anticipated by the end of the month	**On track**
Regular meetings with ICS to discuss system position, required actions and inflationary pressures						
New business case process launched in April 22.						
Oversight meetings in place with each business unit to hold to account, CRP and accountability framework key item						
Capital plan in place with monthly reporting to F&P						
Close monitoring of the Elective recovery programme to ensure delivery of ERF						
CRP framework in place for 23/24						
Core finance roles recruited to, strengthening the capability and capacity of the team						

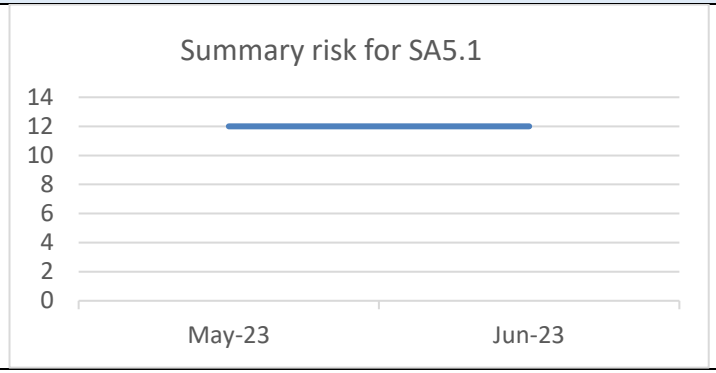
Assurance (Level 1: Operational Oversight)		Gaps in assurance and corrective action	Owner	Timescale	Update	Action status
Month end finance closure and related procedures		System Oversight Framework external monitoring and assurance arrangements not yet defined	Group Director of Finance	March 23	Dependent upon external developments – will be kept under review Jan – the forecasting protocol document has previously been presented to committee. SOF reporting and monitoring still to be confirmed. Feb 23 – no change March 23 – monitoring by NHSE has not yet restarted. The monitoring arrangements for 23/24 are yet to be communicated. May 23 – ICB meeting held to confirm SOF rating with further meeting in June. June 23 – meeting arranged for 21 June.	**Complete**
Monthly budget meetings held between business units and assigned financial management support leads						
Oversight / hold to account meetings						
Regional DoF ICS meetings now happening 4 times per month, accompanied by a monthly triangulation meeting between the Trust, the ICB and NHSE.						

SMT planning sessions held to develop a robust and realistic CRP plan for 23/24						
Assurance (Level 2: Reports / metrics seen by Board / committee etc)						
Achievement against revenue and capital plan reviewed for assurance at Finance and Performance Committee, including agency spend, CRP detail and forecasting.						
Revenue and capital report received for assurance at Board of Directors						
HFMA action plan in place and presented to the Committee.						
Assurance paper received on CRP plans and delivery						
CRP reporting and assurance defined as via SMT, Transformation Board and then Finance and Performance Committee.						
Supply and Procurement Committee oversight routinely reported to Finance and Performance Committee						
QEF Finance Report routinely presented to Finance and Performance Committee for assurance						
Assurance (Level 3 – external)						
Internal audits provide assurance over financial systems and controls – accounts receivable (good), accounts payable (reasonable), capital planning and monitoring (good), waivers (reasonable).						
ICB oversight meetings in place						
Unqualified audit opinion issued for 22/23						

'Good' Head of Internal Audit opinion issued for 22/23 – provides external assurance over control environment	[redacted]					

Strategic objective:	SA5.1 We will look to utilise our skills and expertise beyond Gateshead in order to ensure organisational sustainability and contribute towards innovative care and provision within 23/24
Executive Owner:	QEF Managing Director
Board Committee Oversight:	Finance and Performance Committee
Date of Last Review:	June 2023 – F&P Committee
Summary risk	

There is a risk that the Group will miss opportunities to utilise skills and expertise to generate income for reinvestment in patient care and staff wellbeing, resulting in increased pressures on existing funding.



CURRENT RISK SCORE			TARGET RISK SCORE		
Likelihood	Impact	Score	Likelihood	Impact	Score
4	3	12	3	3	9

Links to risks on the ORR:	POD 2759 - Workforce health & wellbeing - Risk of adverse impact to staff health and wellbeing due to internal and external pressures (12)

Controls	**Gap in controls and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Regular meetings in place with external partners to discuss opportunities	Trust commercial strategy in development	QEF MD	~~October 2022~~ ~~Jan 2023~~ Dec 2023	March 23 – this work will now take place in 23/24 due to capacity May 23 – new strategic objective resets delivery date of Dec 23.	**On track**
Monthly strategy meeting in place in QEF to discuss opportunities	Lack of clarity re: QEF strategy and how this links to the Trust's overall strategy. Collaborative session with the Board and QEF colleagues planned for April.	Board of Directors	June 2023	May 23 – collaborative session held and work underway to review the governance to	**Complete**

				support delivery of the aims	
QEF commercial strategy in place	A need to ensure the appropriate governance structure is in place to support the delivery of the collective vision for QEF and provide assurances back to the Trust Board and F&P Committee. Independent governance review to be commissioned to inform this.	CEO	~~June 2023~~ July 2023	May 23 – review commenced and due to report at the end of June 23. June 23 – verbal feedback to be provided 28 June with the written report to follow in July 23.	**On track**
Strategy session between the Board and QEF held – shared vision now in place.					
Assurance (Level 1: Operational Oversight)	**Gaps in assurance and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Weekly senior management meetings in QEF with reporting to QEF Board					
Commercial divisions within QEF report to QEF Board on progress made					
Assurance (Level 2: Reports / metrics seen by Board / committee etc)					
QEF quarterly reporting to F&P Committee					
QEF reporting to Board twice per year					
Assurance (Level 3 – external)					

Digital Committee (SA1.3)

Strategic objective:	SA1.3 Ensure that there is a Digital first and data led approach to transformation and improvement across all domains of activity in order to contribute to delivery of the key indicators by March 2024						
Executive Owner:	Group Director of Finance and Digital						
Board Committee Oversight:	Digital Committee						
Date of Last Review:	June 23 Digital Committee						
Summary risk							
There is a risk that the Trust is not able to access / utilise digital technologies to greatest effect, impacting upon the ability to drive improvements in service provision and deliver against the leading indicators as well as increasing the risk of critical system failure.	*Graph to be populated once the Committee has reviewed the BAF twice*	**CURRENT RISK SCORE**			**TARGET RISK SCORE**		
		Likelihood	Impact	Score	Likelihood	Impact	Score
		3	5	15	2	5	10
Links to risks on the ORR (as at June 23):	COO 2945 - Risk of ineffective and inefficient management of services due to availability and access to appropriate and timely BI. (12) Digital 1797 - Risk of failure to review appropriate information across multiple sources of clinical records stored in both system and paper format leading to potential patient harm. (16)						

Controls	**Gap in controls and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Digital re-prioritisation and engagement exercise completed to ensure digital delivery plan is realistic based on current resource.	Digital Strategy delivery plan to be developed.	Nick Black, CIO	Sep 23	Gap assessment underway.	**Started and on track**
Digital Transformation and Digital Assurance Groups in place.	Agree OBC for Electronic Patient Record system	Nick Black, CIO	Oct 23	OBC for EPR agreed by Execs in February 23. Asked to be re-validated following market engagement.	**Started and on track**
Significant stakeholder engagement to seek views on digital aspirations and	Agree FBC for Electronic Patient Record system	Nick Black, CIO	Oct 24	Follows OBC review	**Not Started**

challenges within the Trust to inform future developments.					
Engagement of Channel 3 Consulting to lead options appraisal, outline business case development and requirements specification work on the electronic patient record (EPR) plan.	Implementation of additional layer of project governance to provide control, ownership and assurance on the delivery of digital programmes.	Adam Charlton	Jun 23		**Started and on track**
Systems management audit programme.					
Structured project management and change control procedures					
Clinical Safety resource in place to oversee and manage best practice process.					
Board approved Digital strategy in place					
Qualified Cyber security specialist in place					
Prioritisation matrix in place to support the management of risks to the digital delivery plan					

Assurance (Level 1: Operational Oversight)	**Gaps in assurance and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Approval to proceed with development of Electronic Patient Record FBC – Feb 23.	Identification of EPR solution in place, but its method of procurement has changed. This modification has been communicated with Clinical Stakeholders who participated in the Channel 3 option appraisal work. Source of funding for the EPR project unclear. Full business case including fully costed benefits for the identified EPR solution is required to ensure the Trust is ready to benefit from funding should / when it becomes available.	Group Director of Finance & Digital/ Chief Digital Information Officer	~~Oct 22~~ *Dec 23*	Apr 23 Update – Approval given at Feb Exec, Digital Committee and CSG to move to FBC. Draft procurement proposal on requirements/procurement approach received from Channel 3 and is currently with key stakeholders for review. Meeting held with CEO and Group Director of Finance & Digital to verify approach 4th May	**Behind**

					Next steps - develop RFI/market engagement document and have a showcasing day to view the possibilities of the suppliers on the patch (ICS/national requirement) It has been confirmed regionally that no known funding is available. June 23 – EPR outline business case approval now anticipated for Nov 23 following clinical review.	
Assurance (Level 2: Reports / metrics seen by Board / committee etc)						
Digital delivery plan reviewed by Digital Committee at each meeting		Committee identified that greater assurance over data quality would be beneficial to see at Digital Committee. Work is being progressed through the Digital Assurance Group to expand the data quality reporting and will be reported to Digital Committee following this.	Chief Digital Information Officer	Jun 23	Apr 23 - ongoing	On track
Digital & Data Strategic objectives update report reviewed by Digital Committee		KPIs: Committee requests further assurance in the form of narrative explanations for the items RAG-rated as red in the Digital Service KPI report	Chief Digital Information Officer	Feb 23	Apr 23 – this remains a work in progress, linked to action below regarding 'leading indicators'	**Overdue**
Digital & Data KPIs reported to Digital Committee		KPIs: Risk Management Programme with IAOs at 22% compliance vs 100% target. Improvement plan and interim targets requested.	SIRO	Jun 23	Apr 23 – compliance routinely reported to SMT for management action. June 23 – issue identified by the Committee for Board escalation	**Overdue**
AuditOne outstanding actions – progress report presented to Digital Committee		KPIs: Review of digital KPIs is taking place with high level indicators to be developed and aligned to the emerging 'leading' indicators.	Head of Digital Transformation and Assurance	Jun 23	Apr 23 – commenced June 23 – lack of progress on delivery of some KPIs to be escalated to Board.	**Overdue**

Digital workforce capacity tracker reviewed at Digital Transformation Group						
Digital Committee receives tracking report on open audit actions to monitor implementation						
Assurance (Level 3 – external)						
AuditOne reports – Docstore IT General Controls (reasonable), Cyber Incident Response Planning (reasonable), Health Information Exchange (good), Outpatient Digital Programme (substantial), DSP Toolkit follow-up (moderate), IT Change Management (limited), IT Asset Management (limited)		Complete Peer Review and submit National Digital Maturity Assessment return	Chief Digital Information Officer	Jun 23	June 23 – peer review was completed in May 23 and submitted to NHSE. The results will be considered in a follow-up piece of work to understand development opportunities.	**Complete**
Global Digital Exemplar Fast Follower accreditation						
Digital Maturity Assessment and peer review completed						

Board of Directors

Gateshead Health NHS Foundation Trust

Agenda Item: 10iii

Report Title:	Organisational Risk Register (ORR)			
Name of Meeting:	Board of Directors			
Date of Meeting:	26th July 2023			
Author:	Marie Malone, Corporate and Clinical Risk Lead.			
Executive Sponsor:	Gill Findley, Chief Nurse and Professional Lead for Midwifery and Allied Health Professionals/Deputy CEO			
Report presented by:	Gill Findley, Chief Nurse and Professional Lead for Midwifery and Allied Health Professionals/Deputy CEO			
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 (ERMG) 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 at the Executive Risk Management Group meeting every month.			
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*	Following ERMG meetings in June and July. The following risks have been added to the ORR: Financial risks added: • **3127** There is a considerable risk that the trust will not be able to meet the planned trajectory of £12.588m adjusted deficit (12)			

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

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This is an overarching risk with 2 sub risks as follows:

- **3102** Activity is not delivered in line with planned trajectories, resulting in the Trust having reduced access to core funding. (16)
- **3103** Efficiency requirements cannot be achieved due to ongoing operational pressures resulting from COVID and demand on unscheduled care. (16)

Two further risks added with current score of 16:

- **3212 (POD)** Historical DBS clearances have not been fully recorded on ESR resulting in an inability to provide assurance as to compliance with DBS and NHS employment standards

- **3255 (CEO)** number of reports and incidents due to report in the public domain over the next few months. There is a potential for these reports to have an impact on our reputation across the ICS.

1 risk has increased and 3 risks have reduced. 0 risks have been removed from the ORR or closed. All risks have associated actions assigned. 8 actions have been completed in period.

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Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper

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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.
- Be clearly sited on the top 3 risks for the organisation.

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Trust Strategic Aims that the report relates to:

</td><td>**Aim 1** ☒</td><td colspan="5">We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>**Aim 2** ☒</td><td colspan="5">We will be a great organisation with a highly engaged workforce</td></tr>
<tr><td>**Aim 3** ☒</td><td colspan="5">We will enhance our productivity and efficiency to make the best use of resources</td></tr>
<tr><td>**Aim 4** ☒</td><td colspan="5">We will be an effective partner and be ambitious in our commitment to improving health outcomes</td></tr>
<tr><td>**Aim 5** ☒</td><td colspan="5">We will develop and expand our services within and beyond Gateshead</td></tr>
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Trust corporate objectives that the report relates to:

</td><td colspan="6">Each risk is linked to a corporate objective, see report.</td></tr>
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Links to CQC KLOE

</td><td>Caring ☐</td><td>Responsive ☐</td><td>Well-led ☒</td><td>Effective ☒</td><td colspan="2">Safe ☐</td></tr>
</table>

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

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 (ERMG) 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.

Following ERMG in June 2023, it was agreed that a standing agenda item will be added to the meeting to collectively agree our top 3 organisational risks.

This report covers the period 16th May- 16th July 2023 (extraction date for this report).

Organisational Risk Register – Movements

Following ERMG meetings in June and July 2023, there have been 4 additions to the ORR, although 1 risk has been increased, and 3 reduced.

There are currently 21 risks on the ORR, one with a score of 20, and eight with a score of 16 agreed by the group.

The following risks has been added to the ORR:

- **3255 (CEO)** A number of reports and incidents due to report in the public domain over the next few months. There is a potential for these reports to have an impact on our reputation across the ICS. (16)

- **3127 (Finance)** There is a considerable risk that the trust will not be able to meet the planned trajectory of £12.588m adjusted deficit (12)

This is an overarching risk with 2 sub risks as follows:

- **3102** Activity is not delivered in line with planned trajectories, resulting in the Trust having reduced access to core funding. (16)
- **3103** Efficiency requirements cannot be achieved due to ongoing operational pressures resulting from COVID and demand on unscheduled care. (16)

Risks escalated in score:

One risk escalated and added:

- **3212 (POD)** Historical DBS clearances have not been fully recorded on ESR resulting in an inability to provide assurance as to compliance with DBS and NHS employment standards. (16). Previous score of 12.

Risks reduced in period:

There were 3 risks reduced:

- **3128 (Finance)** Risk that the capital cost of delivery of the new operating model continues to increase resulting in revenue implications (9). Reduced from 12.

- **3103 (Finance)** Risk that efficiency requirements are not met. (16)
  Reduced from 20.

- **1797 (Digital)** Multiple sources of clinical records stored in systems and paper format leading to potential patient harm (12). Reduced from 16

Risks closed in period:

There were no risks closed or removed from the ORR.

Top 3 category of risks agreed at ERMG in July are:

Workforce/People risks- particularly around staffing gaps in all levels within the organisation.
Finance risks- overarching other finance risks on the ORR.
Reputation/Performance risks- Waiting times and access to various patient services.

1. **People:**

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

3095 (POD) Risk to quality of care due to Industrial Action of various trade unions across various sectors affecting staffing levels and potential impact on patient care, safety and quality (20)

There are workforce gaps within all levels of the organisation which have the potential for people and reputational harm.

2. **Finance:**

3127 (Finance) There is a considerable risk that the trust will not be able to meet the planned trajectory of £12.588m adjusted deficit. (12)

With 4 financial risks on the ORR, there is significant emphasis on financial implications as an organisation.

3. Reputation:

2945 (CEO) Risk of ineffective and inefficient management of services due to availability and access to appropriate and timely business intelligence to deliver and improve service. (12)
There has been a significant increase in waiting times and access to various patient services, with potential for reputational damage.

Current compliance

Risk and action review compliance is currently at 67% and 85 % consecutively. All risks have associated actions assigned.
Support with reviews continues to be offered by Corporate and Clinical Risk Lead where able.

Recommendations

The Board are asked to:

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

Organisational Risk Register Report

Reporting Period: 16-May-2023 to 16-Jul-2023

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

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

Digital - 1

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

Finance - 4

FIN 3102 - Activity is not deliverved in line with planned trajectories, leading to reduction in income (16)

FIN 3103 - Risk that efficiency requirements are not met. (16)

FIN 3127 - There is a considerable risk that the Trust is unable to meet the financial projections included in its plan. (12)

FIN 3128 - Risk that the capital cost of delivery of the new operating model continues to increase resulting in revenue implications. (9)

Information Governance - 1

IMT 1490 - Risk of inappropriate access/use/disclosure of data (15)

Reputation - 1

CEOL2 3255 - Potential reputational damage to the organisation (16)

Delivery of Objectives - 1

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

Effectiveness - 2

IMT 1797 - Multiple sources of clinical records stored in systems and paper format leading to potential patient harm (12)

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

Safety - 4

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

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

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

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

Compliance - 3

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

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

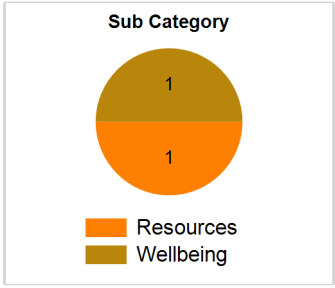
POD 3212 - Historical DBS clearances have not been fully recorded on ESR resulting in an inability to provide compliance assurance (16)

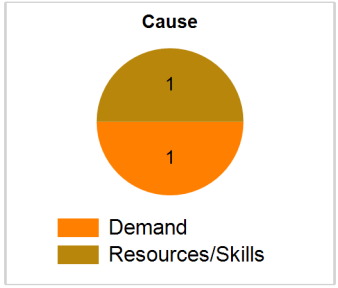
Organisational Risk Register Report

Reporting Period: 16-May-2023 to 16-Jul-2023

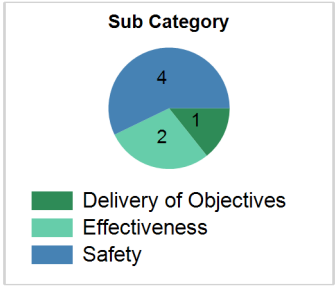
Gateshead Health NHS Foundation Trust

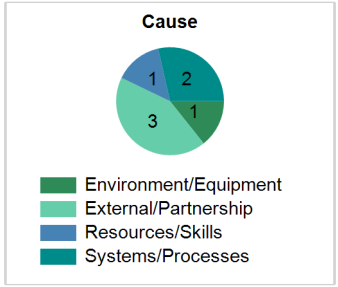
People & Resources



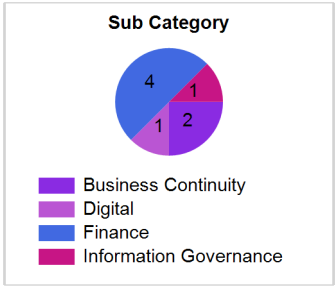


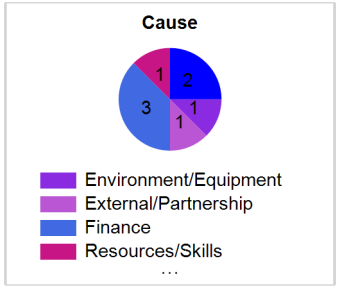
Quality Outcomes





Finance & Efficiency





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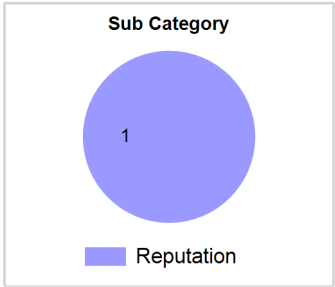

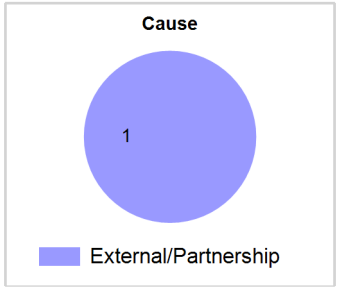

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Business Intelligence

Organisational Risk Register Report

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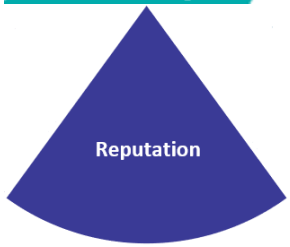

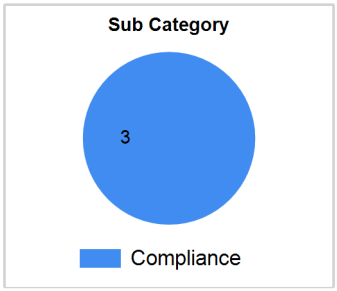

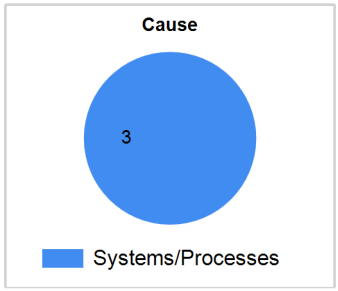

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3095 26/07/2022 Amanda Venner People and OD Workforce Development 22/07/2023 BU_DIR EPRR ORG HRC QGC SA1.2 Continuous Quality improvement plan, SA2.1 Protect and understand the health and well-being of our staff by looking after our workforce, SA2.2 Growing and developing our workforce	Risk to quality of care due to Industrial Action of various trade unions across various sectors affecting staffing levels and potential impact on patient care, safety and quality.	25	Industrial action working group established and meeting regularly. Focussed planning sessions have taken place to explore the planning, response and recovery elements of industrial action with reasonable worse case scenarios considered. A detailed work plan has been produced with a number of actions, lead officers and timescales citrep position updated daily Business continuity planning command and control structure will recommence in the event of industrial action Current mitigation is closer partnership working and regular local discussions with staff-side and respective trade union representatives (including RCN) as part of the IA Internal Working Group and the Sub-group of the JCC set up of command and control and coordination 12th decemner local strike committee in place from friday 9th may 23 Cancellation of some elective services to reduce need for junior medical staff. consideration of utilisation of other staffing sources- consultants and/or specialist nurses and pharmacy support review of on call teams	20	Support industrial action task and finish group Implementation of JCC sub- group on industrial action	Amanda Venner 30/07/2023 Amanda Venner (Completed 21/06/2023)	9	Update added by ead of risk following recirt of written update from AV which states Review of scores and due to ongoing industrial action no changes at this stage. Potential consultant strikes mean that even though the existing measures are robust, this will be a new cohort of staff to plan for.

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2764 17/11/2020 Natasha Botto People and OD Human Resources 19/07/2023 BAF ORG HRC QGC SA1.1 Continue to improve our maternity services in line with the wider learning from the Ockenden review, SA1.2 Continuous Quality improvement plan, SA2.2 Growing and developing our workforce	Risk of not having the right people in the right place at the right time with the right skills across the organisation. Noting regional and national supply pressures, resulting in failure to deliver current and future services that are fit for purpose.	20	Staffing Reporting Task and finish group established. International recruitment on track. Domestic recruitment actively pursued and monitored. Over recruiting to HCSW positions. Recruitment process streamlined (RPIW). SMT discussions on longer term strategic supply pipelines for Registered Nurses have commenced, inc Registered Nurse degree apprentices and Trainee Nurse Associates. Absence Management - Refreshed policy, roll out of training, enhanced support from POD team. Local pay arangements for hotspot and winter working. People analyst in post and initial reports developed. Retention initiatives in place to support and encourage colleagues to remain with the Trust. School and local community supply initiatives in place to attract the Trust's future workforce. Healthcare Academy Approach in Development supporting Health Care Careers across Gateshead. Approach to strategic workforce planning work with external partner, Whole Systems Partnership complete and is currently being written up. People Strategy has been developed. Workforce plan submitted as part of the Operating Plan for 2023-24.	16	Transfer Window	Dean Bosworth 04/06/2023	8	Risk reviewed and action dates altered due to delays following a recent period of absence.
					Workforce planning to be scoped and future resource/ways of working identified.	Natasha Botto 31/07/2023		
					Robust Exit Interview process	Natasha Botto 31/07/2023		
					Health and Care Academy internal development opportunities scoped	Sarah Neilson 01/09/2023		
					Clinical Strategy	Andrew Beeby (Completed 24/05/2023)		

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2779 01/07/2020 Andrew Rayner Nursing, Midwifery & Quality Quality Governance 22/07/2023 BAF BU_DIR FPC ORG QGC SA1.2 Continuous Quality improvement plan	The Trust fails to meet the CQC Fundamental Standards resulting in potential regulatory action, harm to patients, decline in ratings, and resulting reputational damage.	16	CQC three phased monitoring approach CQC Action plan T&F Group Exec Complinance Group Inspection action plans Nursing Strategy and Safe Staffing planning & delivery Governance Framework Risk Management systems and processes Health & Safety Governance and processes NICE guidance governance processes Learning Disability Support processes Cancer Services delivery plans Scheduled audits of operational safety elements.	16	Develop a route map to Outstanding Ensure any areas of improvement from last inspection are in place	Andrew Rayner 21/07/2023 Andrew Rayner 30/07/2023	6	Action transfered to AR due to JC secondment- Update- current action plan under full reviewed and refresh to fully reflect the work completed

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

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2982 06/12/2021 Mark Dale Medical Services Medical Services - Divisional Management 19/07/2023 BAF BU_DIR COO FPC ORG SA3.1 Improve the productivity and efficiency of our operational services through the delivery of the New Operating Model and associated transformation plans, SA4.2 Work collaboratively as part of Gateshead Cares system to improve health and care outcomes to the Gateshead population	Risk of delay in transfer to community due to lack of social care provision and intermediate care beds, due to increased numbers of patients awaiting POC up to 30 patients in medical wards. This delay adds significant pressures to acute bed availability, escalation beds being required and significant risk of problems with flow through hospital impacting A&E breach standards and risk of patients being delayed within ambulances. This could result in patients remaining in hospital when medically optimised creating risk to these patients as well as other patients as bed capacity not able to meet demand. There is also a risk of patients deconditioning, resulting in failed discharge secondary to this. This could lead to increased pressures on nursing teams as well as poor patient experience and quality.	20	Daily meeting with LA to examine capacity in out of hospital system and match with demand for discharges. Target discharges of 40 per week to keep pace with demand. Monitoring of Delayed transfers of care twice weekly meeting Escalation of delays of care to the community BU and social services at twice weekly meetings. Monitoring of any levels of harm - Datix incidents. Monitoring of Breach levels and times. Monitoring of Ambulance delays. Monitoring increased LOS of medically optimised patients. Escalation of patients requiring social services support raised weekly at Discharge Systems group which includes Social services management and CCG representative. Medically Optimised meeting 2x week, passed to IPC/CCG ECIST work Pilot on 2 wards re improving discharges. Further social care provision for discharge purchased and in place from beginning of June 2022	16	System leadership post for discharge created and to be recruited to	Joanna Clark (Completed 09/05/2023)	9	Risk remains. Site continues to be in esculation

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2993 28/01/2022 Kirsty Roberton Chief Executive Office Corporate Services & Transformation 24/06/2023 BAF BU_DIR ORG QGC SA1.2 Continuous Quality improvement plan	Risk of potential non-compliance with current legislation and guidance as a result of policies not being up to date, resulting in potential safety events and legislation and compliance breaches which may result in external scrutiny and reputational harm.	16	Policies in place for all key areas of legislation Overall policy management sat with CS&T Department (gap in leads for this work for a period) Policy system (pandora) maintained to manage and publish policies for staff to access Policy for Policies in place to provide clear direction and requirements for policy management Policies have lead 'author' and lead 'executive' Policy Review Group (PRG) in place (from Jan 22) to streamline process and target current backlog Policies include details of legislation and guidance they relate to, and information as to how compliance is monitored. Febraury 2023- starting to Monitor compliance against policies.	16	Begin to address overdue policy backlog Establish process for gaining assurance over policy compliance and embed	Kirsty Roberton 31/08/2023 Kirsty Roberton 31/08/2023	3	actions updated and score reviewed. to remain the same at present. Compliance is now presented at PRG as part of COB
3102 22/08/2022 Kris MacKenzie Finance Finance 16/06/2023 BU_DIR FPC ORG SA3.2 Achieving financial sustainability	Activity is not delivered in line with planned trajectories, resulting in the Trust having reduced access to core funding.	20	Active and in depth monitoring of activity information underway. Review of business units plans to deliver activity trajectories reviewed as part of monthly oveersight meetings. Activity achievement to be reviewed fortnightly at performance focussed SMT meeting. CRP project in development to strengthen counting and coding.	16	Timley and detailed reporting information Counting and Coding Review	Jane Fay 31/03/2024 Nick Black 31/03/2024	6	formal agreement to add to ORR following D/W KMac

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3103 22/08/2022 Kris MacKenzie Finance Finance 16/06/2023 BU_DIR COO ORG FPC SA3.2 Achieving financial sustainability	Efficiency requirements are not achieved.	20	Efficiency delivery closely monitored as part of month end reporting. Weekly CRP working group in place to ensure traction, delivery and ongoing engagement. SMT meeting to focus on performance on a fortnightly basis.	16	Regular CRP planning and monitoring workshops	Kris MacKenzie (Completed 16/05/2023)	9	

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3212 16/03/2023 Dean Bosworth People and OD Human Resources 29/07/2023 BU_DIR ORG HRC	Historical DBS clearances have not been fully recorded on ESR resulting in an inability to provide assurance as to compliance with DBS and NHS employment standards for the Group.	**20**	Reviewing the DBS policy and approach within the organisation including any requirement to recheck during employment (for example a rolling programme) Subsequently EMT - Reviewed options appraisal for continual DBS checks to occur within employment. The outcome of such was to request employees who require DBS check to sign up to the DBS update service to enable a regular check. Discussions with Staffside to commence. Identifying POD capacity to review employment records and transfer any clearances into ESR and subsequently Implemented a robust system of work setting up a DBS Clinic to support staff to obtain a new DBS. Business Units and Line managers have given clear briefings to staff to support their actions around this piece of work. Any DBS Clearances remaining outstanding employees have had a supportive follow up letter. Risk Assessment SOP implemented for the DBS Project. Disciplinary Panels being set up with standard panel approach to case management. Initial Panels set up for end of July 2023.	**16**	Ensure there is consistent application of appropriate levels of DBS checks for all employees,	Dean Bosworth 31/08/2023	**8**	Risk score reduced to 16 agreed with Deputy CEO, Interim Exec Director of POD, Head of People Services

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3255 27/06/2023 Gillian Findley Chief Executive Office Chief Executive Office 27/07/2023 BU_DIR ORG QGC	A number of reports and incidents due to report in the public domain over the next few months. There is a potential for these reports to have an impact on our reputation across the ICS.	20	ICB have been notified and a risk escalation meeting was enacted. The Trust has included these concerns in a thematic review and a delivery plan has been developed.	16	monitor implementation of thematic review delivery plan	Gillian Findley 31/07/2023	8	added to ORR following fomal agreement at ERMG 3/7/23
1490 11/03/2014 Digital Digital Transformation and Assurance 22/07/2023 BAF BU_DIR DIGC ORG SA1.2 Continuous Quality improvement plan, SA1.3 Digital where it makes a difference	Risk of inappropriate access/use/disclosure of data. Due to failure to manage the information assets by IAOs across business units and corporate services. Resulting in patient harm, adverse publicity, failure to comply with National standards and contractual requirements.	25	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 Digital Transformation Group Audit programme underway, focussed on critical systems	15	Bring resource in to support services to complete IARs Getting IAOs to take ownership of their information assets Ensure IAOs complete their Information Risk Management responsibilities	Dianne Ridsdale 31/07/2023 Nick Black 31/03/2024 Kris MacKenzie (Completed 27/06/2023)	3	Risk reassessed based on IG training levels, improved LRMP returns and communications shared

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2398 28/12/2018 Kate Hewitson Surgical Services Obstetrics 01/08/2023 BAF BU_DIR COO ORG QGC SA1.1 Continue to improve our maternity services in line with the wider learning from the Ockenden review, SA1.2 Continuous Quality improvement plan	There is a risk of delayed treatment due to maternity estate being a separate building resulting in the potential for severe harm to mothers and babies. This was highlighted by recent HSIB reports reflecting delayed attendance times of emergency multi disciplinary teams to obstetric emergencies. Rising acuity of maternity patients and more frequent use of CCU, theatre staff and Paediatric teams creates additional likelihood of the need for these teams to attend the maternity department and delays to be incurred.	20	Pre-assessment - Women deemed likely to require critical care after elective procedures have their operation in main theatre to allow swift access to critical care. This only applies to elective patients and not emergency procedures or those in spontaneous labour. Any incidents are investigated to identify potential learning.	15	2861 action re looking into estate options	Kate Hewitson 03/06/2024	5	6 litre PPH patient that required attendance of theatre teams and transfer to CCU in May 20 week STOP for maternal health carried out in main theatre in May using main theatre staff who were not familiar with the procedure due to requirement to be close to CCU for support.
1797 19/01/2016 Mark Smith Digital Health Records 06/07/2023 BAF BU_DIR DIGC ORG SA1.3 Digital where it makes a difference	Risk of failure to review appropriate information across multiple sources of clinical records stored in both system and paper format leading to potential patient harm. The trust has distributed data across a large number of systems and paper. The staff won't know where to look for information on the patient they are treating or won't look everywhere where there may be information [also impact for processes such as SARs/legal Services] The consequence of this is potential patient harm due clinical decisions being made on incomplete data, and the resulting financial effects + non compliance of legislative requirements	25	Systems management audit programme. Structured project management and change control procedures Standard operating procedures for each system	12	Map out current health record sources	Mark Smith 31/03/2024	8	Risk level reviewed, whilst the impact remains a 4, the likelihood has been moved to a 3. There are SOPs for each system, clinicians know where data could be held - so the risk has been accessed as might happen or recur occasionally.
					Implement single Document Store	Adam Charlton 30/09/2024		
					Develop FBC for Clinical System	Nick Black 30/09/2024		

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

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2868 27/04/2021 Jo Halliwell Chief Operating Officer Planning & Performance 29/07/2023 BAF COO EPRR FPC ORG QGC SA1.1 Continue to improve our maternity services in line with the wider learning from the Ockenden review, SA3.1 Improve the productivity and efficiency of our operational services through the delivery of the New Operating Model and associated transformation plans	New Operating Model - Risk to the delivery of the new operating model and associated transformation plans due to the increase in activity and reduced workforce capacity, resulting in an adverse impact on key performance and recovery plans.	20	EPRR incident response and OPEL plans in place to manage increase in demand Bed modelling completed and associated workforce plans developed winter plan developed, signed off by Board and in place Workforce management plans in place and monitoring of staff absences available Annual review and establishment of safe nursing staffing levels. Safe staffing report (nursing)produced and forecasting robust. Workforce bank in place (see linked risk) Expanded Agency usage (process for approval) Critical staff payment offer approved and in place. Workforce absence etc captured via ESR/ healthroster New operating model aligns staffing requirements to activity and service plans. Volunteers - recruitment and use Deployment Hub to improve use of available resources transformation plans in place to reduce admissions, LOS and improve discharge	12	active recruitment to vacanices	Amanda Venner 30/09/2022	6	risk transferred to JH as per agreement at ERMG 3/7/23
					international recruitment programme	Amanda Venner 30/09/2022		
					complete capital programme to enable delivery of model	Jo Halliwell 29/09/2023		
					a revised focus on reducing overall LOS in medicine	Jo Halliwell 29/02/2024		

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2945 14/09/2021 Debbie Renwick Chief Operating Officer Planning & Performance 05/08/2023 BU_DIR ORG SA3.1 Improve the productivity and efficiency of our operational services through the delivery of the New Operating Model and associated transformation plans	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 project groups established and PID developed and plans developed for delivery Improve data quality by working with teams and provide resilience to teams doing the RTT etc	Debbie Renwick 31/10/2023 David Thompson (Completed 26/06/2023) Debbie Renwick (Completed 05/07/2023)	3	no change to risk following consultation with DR. actions updated. programme of work stalled due to limitations of yellow fin. Trust purchased Power BI as an alternative solution. Action is to now move to Power BI to support Trust-wide Business aims. Overarching Strategy and Detailed Plans Leadership & Ownership between / in teams Roles to be assigned Capacity, resource & Capability investment Cultural work / alignment of teams
3089 25/07/2022 Gillian Findley Nursing, Midwifery & Quality Quality Governance 22/07/2023 BAF BU_DIR ORG QGC SA1.2 Continuous Quality improvement plan	Quality - There is a risk of quality failures in patient care (patient safety, patient experience and effectiveness) due to external causes such as delayed discharges and pressures from other Trusts resulting in patient harm, regulatory action, and reputational impact	15	Daily report provided detailing all delayed discharges within the Trust. regular meetings now established with social care. Discharge liaison staff available to support wards and facilitate earlier discharge.	12	improve flow through hospital	Rebecca Railton 15/08/2023	6	No change to risk or control- full review commisioned via AR in view of flow work and bed closures ongoing.

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3127 17/10/2022 Kris MacKenzie Finance Finance 16/06/2023 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 planned trajectory of £12.588m adjusted deficit. Contributory risks include delivery of planned elective activity limiting access to income, delivery of CRP, impact of inflation, realisation of mitigations and cost of ongoing service pressures resulting from unscheduled care activity and further periods of industrial action.	20	Financial performance being managed in line with the financial accountability framework. Accountability for performance part of the divisional oversight meetings discussions.	12	Delivery of financial mitigations inherent in plan	Jane Fay 31/03/2024	4	agreement at ERMG to add to ORR
					Monitoring and modelling of impact of industrial action	Jane Fay 31/03/2024		
					Comprehensive cost analysis	Jane Fay 31/03/2024		
3148 06/12/2022 Jo Halliwell Chief Operating Officer EPRR & Site Resilience 23/04/2023 BAF BU_DIR COO FPC MDMG ORG QGC SA1.2 Continuous Quality improvement plan, SA2.2 Growing and developing our workforce	There is a risk that the organisation is unable to release staff for mandatory training and medical devices training due to operational pressures and current vacancies in both medical and nurse staffing. This could result in possible patient safety incidents.	20	Receive database from QEF, take training to ward areas promotion of training in the clinical environments	12	Support clinical environment in accessing the learning management system on site	Michael Crowe (Completed 29/06/2023)	9	risk transferred to J halliwell as agreed at ERMG. improvement demonstrated with mandatory training aspect of training and therefore potential to reduce risk at next review. to D/W J halliwell

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

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR	Latest Progress Note
3186 07/02/2023 Philip Glasgow Chief Operating Officer 04/08/2023 BAF BU_DIR COO FPC ORG SA3.1 Improve the productivity and efficiency of our operational services through the delivery of the New Operating Model and associated transformation plans, SA3.2 Achieving financial sustainability	There is a risk to maintaining business continuity of services and recovery plans due to the estate infrastructure, age and backlog maintenance requirements which exceed the Trusts capital allocation	16	Clinically led estates strategy developed and prioritsied on priority versus affordability	12	commission full estates review as part of Bensham retraction programme	Anthony Pratt 31/07/2023	6	£2.1m of funding has been requested for backlog maintenance on estates as part of the 2023-24 capital budget allocation. This is due to go to Trust board in July for sign off. Further work continuing on the clinically led estates strategy.

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

Organisational Risk Register Report

Reporting Period: 16-May-2023 to 16-Jul-2023

Gateshead Health NHS Foundation Trust

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

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register / Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR	Latest Progress Note
1636 10/11/2014 Dianne Ridsdale Digital Digital Transformation and Assurance 11/07/2023 BU_DIR DIGC MDMG ORG	UCRF R01/R03/R20/R23 Malware such as Ransomware Compromising Unpatched Endpoints, Servers, Equipment or due to Lack of Hardened Build Standards. There is a risk of potential exposure to published critical cyber vulnerabilities. Laptops, workstations and medical devices compromised by ransomware or botnets, due to endpoints being susceptible to compromise through the use of obsolete, old, or unpatched operating systems and third party software, including Java. Endpoints often not monitored for patch status. Endpoints compromised more easily through dangerous browser plugins (such as Java, Flash), or unsupported browsers. Servers compromised by ransomware, due to servers susceptible to compromise through the use of obsolete, old, or unpatched operating systems and software. Servers often not monitored for patch status. Due to failure to maintain all Digital assets, including installing Operating system patches, AV patches or other software and hardware updates across the IT estate, including network equipment and medical devices. Resulting in potential harm to patients, data leaks, impacts on service delivery.	**25**	AV on all end points AV up to date ATP in place site wide NHSD & Microsoft group policy templates Ongoing updates routinely planned as they are released Patching regime Network fully supported and maintained	**10**	Review trust asset register for EOL hardware/Software Review trust asset register for EOL hardware/Software	David Thompson 01/08/2023 Mark Bell 31/08/2023	**5**	IG have reviewed Actions reviewed and extension applied to align with May DAG
3128 17/10/2022 Kris MacKenzie Finance Finance 16/08/2023 BAF BU_DIR FPC ORG SA3.2 Achieving financial sustainability	There is a Risk that the capital cost of delivery of the new operating model continues to increase resulting in revenue implications.	**12**	Detailed scrutiny of wider capital programme undertaken to ensure robust forecasting	**9**	Review of in-year costs with contractor	Paul Swansbury 31/01/2023	**9**	Risk remains.

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Organisational Risk Register Report

Reporting Period: 16-May-2023 to 16-Jul-2023

Gateshead Health NHS Foundation Trust

Changes to CRR in Period - Current/Managed Risks

**If a risk has changed CRR multiple times within the period, it will appear more than once*

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 Digital Digital Transformation and Assurance 22/07/2023 BAF BU_DIR DIGC ORG SA1.2 Continuous Quality improvement plan, SA1.3 Digital where it makes a difference	Risk of inappropriate access/use/disclosure of data	25	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 Digital Transformation Group Audit programme underway, focussed on critical systems	15	Bring resource in to support services to complete IARs	Dianne Ridsdale 31/07/2023	3	Risk reassessed based on IG training levels, improved LRMP returns and communications shared	15 12
					Getting IAOs to take ownership of their information assets	Nick Black 31/03/2024			
					Ensure IAOs complete their Information Risk Management responsibilities	Kris MacKenzie (Completed 27/06/2023)			

Organisational Risk Register Report

Reporting Period: 16-May-2023 to 16-Jul-2023

Gateshead Health NHS Foundation Trust

Changes to CRR in Period - Current/Managed Risks

**If a risk has changed CRR multiple times within the period, it will appear more than once*

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
1797 19/01/2016 Mark Smith Digital Health Records 06/07/2023 BAF BU_DIR DIGC ORG SA1.3 Digital where it makes a difference	Multiple sources of clinical records stored in systems and paper format leading to potential patient harm	25	Systems management audit programme. Structured project management and change control procedures Standard operating procedures for each system	12	Map out current health record sources	Mark Smith 31/03/2024	8	Risk level reviewed, whilst the impact remains a 4, the likelihood has been moved to a 3. There are SOPs for each system, clinicians know where data could be held - so the risk has been accessed as might happen or recur occasionally.	16
					Implement single Document Store	Adam Charlton 30/09/2024			
					Develop FBC for Clinical System	Nick Black 30/09/2024			
3103 22/08/2022 Kris MacKenzie Finance Finance 16/06/2023 BU_DIR COO ORG FPC SA3.2 Achieving financial sustainability	Risk that efficiency requirements are not met.	20	Efficiency delivery closely monitored as part of month end reporting. Weekly CRP working group in place to ensure traction, delivery and ongoing engagement. SMT meeting to focus on performance on a fortnightly basis.	16	Regular CRP planning and monitoring workshops	Kris MacKenzie (Completed 16/05/2023)	9		20
3127 17/10/2022 Kris MacKenzie Finance Finance 16/06/2023 BAF BU_DIR FPC ORG SA3.2 Achieving financial sustainability	There is a considerable risk that the Trust is unable to meet the financial projections included in its plan.	20	Financial performance being managed in line with the financial accountability framework. Accountability for performance part of the divisional oversight meetings discussions.	12	Delivery of financial mitigations inherent in plan	Jane Fay 31/03/2024	4	agreement at ERMG to add to ORR	6
					Monitoring and modelling of impact of industrial action	Jane Fay 31/03/2024			
					Comprehensive cost analysis	Jane Fay 31/03/2024			

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

Organisational Risk Register Report

Reporting Period: 16-May-2023 to 16-Jul-2023

Gateshead Health NHS Foundation Trust

Changes to CRR in Period - Current/Managed Risks

**If a risk has changed CRR multiple times within the period, it will appear more than once*

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
3128 17/10/2022 Kris MacKenzie Finance Finance 16/08/2023 BAF BU_DIR FPC ORG SA3.2 Achieving financial sustainability	Risk that the capital cost of delivery of the new operating model continues to increase resulting in revenue implications.	**12**	Detailed scrutiny of wider capital programme undertaken to ensure robust forecasting	**9**	Review of in-year costs with contractor Paul Swansbury 31/01/2023	**9**	Risk remains.	**12**

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

Organisational Risk Register Report

Reporting Period: 16-May-2023 to 16-Jul-2023

Business Intelligence

Gateshead Health NHS Foundation Trust

Handler BU Service Line Next Review Date BAF / Risk Register Objectives						Action Due			
3212 16/03/2023 Dean Bosworth People and OD Human Resources 29/07/2023 BU_DIR ORG HRC	Historical DBS clearances have not been fully recorded on ESR resulting in an inability to provide compliance assurance	20	Reviewing the DBS policy and approach within the organisation including any requirement to recheck during employment (for example a rolling programme) Subsequently EMT - Reviewed options appraisal for continual DBS checks to occur within employment. The outcome of such was to request employees who require DBS check to sign up to the DBS update service to enable a regular check. Discussions with Staffside to commence. Identifying POD capacity to review employment records and transfer any clearances into ESR and subsequently Implemented a robust system of work setting up a DBS Clinic to support staff to obtain a new DBS. Business Units and Line managers have given clear briefings to staff to support their actions around this piece of work. Any DBS Clearances remaining outstanding employees have had a supportive follow up letter. Risk Assessment SOP implemented for the DBS Project. Disciplinary Panels being set up with standard panel approach to case management. Initial Panels set up for end of July 2023.	16	Ensure there is consistent application of appropriate levels of DBS checks for all employees,	Dean Bosworth 31/08/2023	8	Risk score reduced to 16 agreed with Deputy CEO, Interim Exec Director of POD, Head of People Services	12 20

Organisational Risk Register Report

Reporting Period: 16-May-2023 to 16-Jul-2023

Gateshead Health NHS Foundation Trust

6

Risks Moved to Managed in Period

Risk ID / Date Identified	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR
Handler BU Service Line Next Review Date BAF / Risk Register Objectives							

0

Risks Closed in Period

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

0

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

Organisational Risk Register Report

Reporting Period: 16-May-2023 to 16-Jul-2023

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
3102 22/08/2022 Kris MacKenzie Finance Finance 16/06/2023 BU_DIR FPC ORG SA3.2 Achieving financial sustainability	Activity is not delivered in line with planned trajectories, resulting in the Trust having reduced access to core funding.	20	Active and in depth monitoring of activity information underway. Review of business units plans to deliver activity trajectories reviewed as part of monthly oveersight meetings. Activity achievement to be reviewed fortnightly at performance focussed SMT meeting. CRP project in development to strengthen counting and coding.	16	Timley and detailed reporting information Counting and Coding Review	Jane Fay 31/03/2024 Nick Black 31/03/2024	6	formal agreement to add to ORR following D/W KMac 16-06-2023

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

Organisational Risk Register Report

Reporting Period: 16-May-2023 to 16-Jul-2023

Business Intelligence

Gateshead Health NHS Foundation Trust

Handler BU Service Line Next Review Date BAF / Risk Register Objectives						Action Due		Date Added to ORR
3212 16/03/2023 Dean Bosworth People and OD Human Resources 29/07/2023 BU_DIR ORG HRC	Historical DBS clearances have not been fully recorded on ESR resulting in an inability to provide assurance as to compliance with DBS and NHS employment standards for the Group.	**20**	Reviewing the DBS policy and approach within the organisation including any requirement to recheck during employment (for example a rolling programme) Subsequently EMT - Reviewed options appraisal for continual DBS checks to occur within employment. The outcome of such was to request employees who require DBS check to sign up to the DBS update service to enable a regular check. Discussions with Staffside to commence. Identifying POD capacity to review employment records and transfer any clearances into ESR and subsequently Implemented a robust system of work setting up a DBS Clinic to support staff to obtain a new DBS. Business Units and Line managers have given clear briefings to staff to support their actions around this piece of work. Any DBS Clearances remaining outstanding employees have had a supportive follow up letter. Risk Assessment SOP implemented for the DBS Project. Disciplinary Panels being set up with standard panel approach to case management. Initial Panels set up for end of July 2023.	**16**	Ensure there is consistent application of appropriate levels of DBS checks for all employees,	Dean Bosworth 31/08/2023	**8**	Risk score reduced to 16 agreed with Deputy CEO, Interim Exec Director of POD, Head of People Services 06-06-2023

Organisational Risk Register Report

Reporting Period: 16-May-2023 to 16-Jul-2023

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
3255 27/06/2023 Gillian Findley Chief Executive Office Chief Executive Office 27/07/2023 BU_DIR ORG QGC	A number of reports and incidents due to report in the public domain over the next few months. There is a potential for these reports to have an impact on our reputation across the ICS.	20	ICB have been notified and a risk escalation meeting was enacted. The Trust has included these concerns in a thematic review and a delivery plan has been developed.	16	monitor implementation of thematic review delivery plan	Gillian Findley 31/07/2023	8	added to ORR following fomal agreement at ERMG 3/7/23 03-07-2023
3127 17/10/2022 Kris MacKenzie Finance Finance 16/06/2023 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 planned trajectory of £12.588m adjusted deficit. Contributory risks include delivery of planned elective activity limiting access to income, delivery of CRP, impact of inflation, realisation of mitigations and cost of ongoing service pressures resulting from unscheduled care activity and further periods of industrial action.	20	Financial performance being managed in line with the financial accountability framework. Accountability for performance part of the divisional oversight meetings discussions.	12	Delivery of financial mitigations inherent in plan	Jane Fay 31/03/2024	4	agreement at ERMG to add to ORR 06-06-2023
					Monitoring and modelling of impact of industrial action	Jane Fay 31/03/2024		
					Comprehensive cost analysis	Jane Fay 31/03/2024		
								4

Risks Removed in Period

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

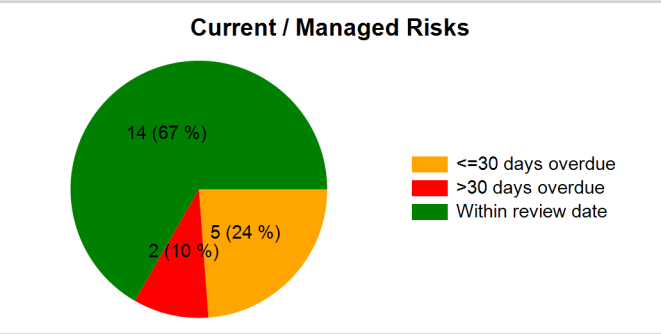
Key: **CRR** - Current Risk Rating **PRR** - Previous Risk Rating **IRR** - Initial Risk Rating **TRR** - Target Risk Rating

Organisational Risk Register Report

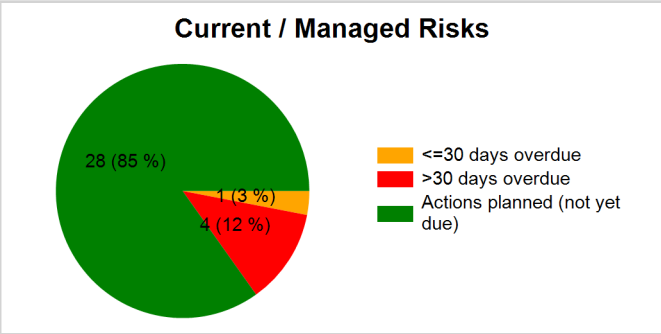
Reporting Period: 16-May-2023 to 16-Jul-2023

Gateshead Health NHS Foundation Trust

Risk Review Compliance



Risk Action Compliance



Movements in CRR

				CRR		
BU	Service Line	ID	Risk Description	May-2023	Jun-2023	Today
Chief Executive Office	Chief Executive Office	3255	Potential reputational damage to the organisation		16	16
	Corporate Services & Transformation	2993	Risk of potential non-compliance with current legislation and guidance as a result of policies not being up to date.	16	16	16
Chief Operating Officer		3186	There is a risk to ongoing business continuity of service provision due to ageing trust estate	12	12	12
	EPRR & Site Resilience	3148	Mandatory training- (including medical devices) compliance	12	12	12
	Planning & Performance	2868	New Operating Model -Risk to the delivery of the new operating model resulting in adverse impact on performance & recovery plans	12	12	12
		2945	Risk of ineffective and inefficient management of services due to availability and access to appropriate and timely BI.	12	12	12
Digital	Digital Transformation and Assurance	1490	Risk of inappropriate access/use/disclosure of data	15	15	15

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

Organisational Risk Register Report

Reporting Period: 16-May-2023 to 16-Jul-2023

Gateshead Health NHS Foundation Trust

Movements in CRR

				CRR		
BU	Service Line	ID	Risk Description	May-2023	Jun-2023	Today
Digital	Digital Transformation and Assur	1636	UCRF R01/R03/R20/R23 - Malware such as Ransomware Compromising Unpatched Endpoints, Servers and Equipment	10	10	10
	Health Records	1797	Multiple sources of clinical records stored in systems and paper format leading to potential patient harm	16	12	12
Finance	Finance	3102	Activity is not deliverved in line with planned trajectories, leading to reduction in income	16	16	16
		3103	Risk that efficiency requirements are not met.	16	16	16
		3127	There is a considerable risk that the Trust is unable to meet the financial projections included in its plan.	12	12	12
		3128	Risk that the capital cost of delivery of the new operating model continues to increase resulting in revenue implications.	9	9	9
Medical Services	Medical Services - Divisional Management	2982	Risk of delayed transfers of care and increased hospital lengths of stay	16	16	16
Nursing, Midwifery & Quality	Quality Governance	2779	The Trust fails to meet the CQC Fundamental Standards.	16	16	16
		3089	Quality - Risk of quality failures in patient care due to external causes such as delayed discharges and external pressures.	12	12	12
People and OD	Human Resources	2764	Workforce - Risk of not having the right people in the right place at the right time with the right skills.	16	16	16
		3212	Historical DBS clearances have not been fully recorded on ESR resulting in an inability to provide compliance assurance	20	16	16
	Workforce Development	2759	Workforce health & Wellbeing - Risk of adverse impact to staff health and wellbeing due to internal and external pressures	12	12	12
		3095	Risk of Significant, unprecidented service disruption due to industrial action	20	20	20

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

Organisational Risk Register Report

Reporting Period: 16-May-2023 to 16-Jul-2023

Gateshead Health NHS Foundation Trust

Movements in CRR

				CRR		
BU	Service Line	ID	Risk Description	May-2023	Jun-2023	Today
Surgical Services	Obstetrics	2398	Risk that MDT are delayed to a maternity emergency/delayed CCU transfers for maternity patients due to separate buildings	15	15	15

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

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 11

Report Title:	**Finance Update**			
Name of Meeting:	Trust Board			
Date of Meeting:	26 July 2023			
Author:	Mrs Kris Mackenzie, Group Director of Finance & Digital			
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:** ☐
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☐ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	Finance and Performance Committee			
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 month 3 financial position demonstrates that the Trust is delivering as expected per submitted plan. Inherent risk include capacity to achieve required cost efficiencies and the sustained impact of industrial action on both income and direct costs. The presentation on sustainability is that which was shared with the ICB to provide reassurance that the Trust is focussed upon longer term financial sustainability. The outline financial strategy and internal governance being utilised to achieve this are outlined. The attached capital plan requires ratification by Trust Board. As part of the planning submission, delegated authority was given to the Executive Management Team to manage capital expenditure in line with the funding received. The proposed programme of work to be committed to exceeds the funding envelope available. As per previous years, the request is for Trust Board to sanction the proposed plan with the condition it is closely monitored during the year.			

Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	To receive month 3 financial position and note that financial performance is as per plan in both year to date and forecast terms. To receive the sustainability presentation and note the strengthened governance in respect of the internal delivery model. To ratify the proposed capital programme, noting it currently represents an overcommitment against funding.				
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)	3127 – There is considerable risk that the Trust will not be able to meet the planned trajectory of £12.88m adjusted deficit. Linked to 3102 (activity delivery) and 3103 (efficiency requirements)				
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒		

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 11

Report Title:	**Consolidated Finance Report – Part One**			
Name of Meeting:	Trust Board			
Date of Meeting:	26th July 2023			
Author:	Mrs Jane Fay, Deputy 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*	The Trust has an approved 2023-24 planned deficit of **£12.588m.** As at June 23 the Trust has reported an actual deficit of **£4.031** after adjustments for donated assets and gain & losses of asset disposal which is a favourable variance of **£0.079m** from its year-to-date target. As of June 23, the Trust is forecasting achievement of its planned deficit totalling **£12.588m** with identified risks outlined in the body of this report. The Trust's proposed 2023-2024 capital programme totals **£30.023m,** as this has not yet been ratified by the Trust Board performance as at the end of June 23 is reported against the original capital plan total of **£27.947m.** As at June 2023 the Trust has reported actual capital spend totalling **£2.199m**, and a reported under-spend of **£0.176m** against the year-to-date target.			

<table>
<tr><td>Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper.</td><td colspan="5">The recommendation to Board is to receive the report, discuss the potential implications and record partial assurance for the achievement of the forecast 2023-2024 planned deficit as a direct consequence of the reported year to date position and financial risks.

To note the summary of performance as of June 2023 (Month 3) for the Group (inclusive of Trust and QE Facilities, excluding Charitable Funds).</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">Achieving financial sustainability</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">3127 Overall risk of not meeting financial plan, with contributing risks relating to activity (3102), efficiency (3103) and cost of delivery of New Operating Model (3128).</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>

1. Introduction

1.1 The purpose of this report is to provide a summary of financial performance as of 30th June 2023 (month 3) for the Group (inclusive of the Trust and QE Facilities, excluding Charitable Funds).

1.2 Reporting for June is against the Trusts 2023-2024 financial plan which reports an adjusted annual deficit of £12.588m inclusive of the achievement of a £15.900m cost reduction target and achievement of elective recovery funding income (ERF) totalling £2.654m.

2 Income and Expenditure

2.1 The Trust has reported a deficit of £4.138m for the period April 23 to June 23 and £4.031m after the adjustment for donated assets, gains / loss on disposal of assets.

2.2 This is a favourable variance of £0.079m against the Trusts financial plan as detailed on the Trust Statement of Comprehensive Income (SOCI) as presented in Table 1.

2.3 For the month of June 23 the Trust has reported actual income of £30.395m and total year to date income of £92.031m. This is an adverse variance of £1.208m against the Trusts financial plan. The year-to-date variance mainly comprises of less income than planned for pathology pillar 1 covid testing totalling £0.947m, education & training income £0.132m and the impact of unachieved CRP £0.235m offset by more income than planned for £0.355m pass through drugs & devices and £0.198m across other income categories.

2.4 For the month of June 23 the Trust has reported actual operating expenditure of £31.372m and total year to date operating expenditure of £95.349m. This is an adverse variance of £2.254m against the Trusts internal financial plan. The year-to-date variance comprises of an overspend on pay budgets totalling £2.132m and non-pay of £0.122m.

2.5 A detailed analysis of performance against all income and expenditure categories is detailed in Table 1.

June 23-24	NHSE APRIL - MARCH 24 FINAL PLAN		VARIANCE
	Plan to Date £000's	Actual to Date £000's	Variance (Actual - Plan) £000's
Operating			
Operating Income from Patient Care activities			
Income From NHS Care Contracts	(83,531)	(83,880)	(350)
Income From Local Authority Care Contracts	(26)	(44)	(17)
Private Patient Revenue	(184)	(214)	(30)
Injury Cost Recovery	(125)	(37)	88
Other non-NHS clinical revenue	(129)	(152)	(23)
Total Operating Income From Patient Care activities	**(83,995)**	**(84,327)**	**(333)**
Other Operating Income			
Education and Training Income	(2,574)	(2,442)	132
R&D Income	(217)	(245)	(28)
Funding outside of System Envelope	(977)	(30)	947
Other Income	(5,184)	(4,987)	198
Donations & Grants Received	(57)	0	57
Cost Improvement Programme - Income	(235)	0	235
Total Other Operating Income	**(9,244)**	**(7,704)**	**1,540**
Total Operating Income	**(93,239)**	**(92,031)**	**1,208**
Operating Expenses			
Employee Expenses - Substantive	61,634	60,385	(1,249)
Employee Expenses - Bank	110	1,958	1,848
Employee Expenses - Agency	553	1,620	1,067
Employee Expenses - Other	291	412	120
Cost Improvement Programme - Pay	(345)	0	345
Total Employee Expenses	**62,243**	**64,375**	**2,132**
Purchase of Healthcare - NHS bodies	2,009	1,876	(134)
Purchase of Healthcare - Non NHS bodies	937	1,005	68
Purchase of Social Care	0	0	0
NED's	47	44	(3)
Supplies & Services - Clinical	8,832	9,406	574
Supplies & Services - General	756	287	(469)
Drugs	5,631	5,625	(6)
Research & Development expenses	3	10	7
Education & Training expenses	404	398	(6)
Consultancy costs	86	89	2
Establishment expenses	919	873	(46)
Premises	4,771	4,907	137
Transport	455	370	(85)
Clinical Negligence	1,833	1,833	0
Operating Leases	46	205	159
Other Operating expenses	1,517	1,221	(297)
Cost Improvement Programme - Non Pay	(801)	0	801
Reserves	(0)	0	0
Operating Expenses included in EBITDA	**89,687**	**92,521**	**2,834**
Depreciation & Amortisation - Purchased / Constructed	2,019	2,063	44
Depreciation & Amortisation - Donated / Granted	86	107	21
Depreciation & Amortisation - Finance Leases	1,278	795	(483)
Impairment & Revaluation	25	(137)	(162)
Operating Expenses excluded from EBITDA	**3,408**	**2,828**	**(580)**
Total Operating Expenses	**93,095**	**95,349**	**2,254**
(Profit)/Loss from Operations	**(144)**	**3,318**	**3,462**
Non Operating			
Non-Operating Income			
Finance Income	(469)	(543)	(75)
Total Non-Operating Income	**(469)**	**(543)**	**(75)**
Non-Operating Expenses			
Finance Costs	121	117	(4)
Gains / (Losses) on Disposal of Assets	0	0	0
PDC dividend expense	971	971	0
Total Finance Costs (for non-financial activities)	**1,092**	**1,088**	**(4)**
Other Non-Operating Expenses			
Misc. Other Non-Operating expenses	0	0	0
Total Non-Operating Expenses	**1,092**	**1,088**	**(4)**
(Surplus) / Deficit Before Tax	**480**	**3,863**	**3,383**
Corporation Tax	63	275	212
(Surplus) / Deficit After Tax	**543**	**4,137**	**3,595**
Balancing Adjustment to NHSE Plan	3,597		(3,597)
(Surplus) / Deficit After Tax from Continuing Operations	**4,140**	**4,137**	**(2)**
Remove capital donations / grants I&E impact	(30)	(107)	(77)
Adjusted Financial Performance (Surplus) / Deficit	**4,110**	**4,031**	**(79)**

Table 1: Trust Statement of Comprehensive Income

3 Cost Reduction Programme (CRP)

3.1 Included in the Trusts 2023-24 financial plans is an annual CRP requirement of £15.900m of which the Trust achieved £1.307m as of June 23 and £1.953m for the financial year. This equates to 12.3% of the annual target.

Business Unit	23-24 Annual Target £000	23-24 YTD Target £000	23-24 YTD Achieved £000	23-24 YTD Variance £000	23-24 Annual Achieved £000	23-24 Annual Variance £000	23-24 Annual Achieved %
Chief Executive	(0.012)	(0.002)	(0.007)	0.005	(0.010)	(0.002)	79.3%
Chief Operating Officer	(0.111)	(0.016)	0.000	(0.016)	0.000	(0.111)	0.0%
Clinical Support & Screening	(3.479)	(0.522)	(0.293)	(0.228)	(0.508)	(2.971)	14.6%
Community	(1.211)	(0.182)	(0.017)	(0.165)	(0.068)	(1.143)	5.6%
Director Of Nursing	(0.186)	(0.028)	0.000	(0.028)	0.000	(0.186)	0.0%
Estates & Facilities	(0.195)	(0.029)	0.000	(0.029)	0.000	(0.195)	0.0%
Finance & Information	(0.566)	(0.085)	(0.033)	(0.052)	(0.070)	(0.496)	12.4%
Medical Director	(0.025)	(0.004)	0.000	(0.004)	0.000	(0.025)	0.0%
Medicine & Elderly	(3.129)	(0.469)	0.000	(0.469)	0.000	(3.129)	0.0%
People & Organisational Development	(0.202)	(0.030)	0.000	(0.030)	0.000	(0.202)	0.0%
Surgical Services	(3.284)	(0.493)	(0.173)	(0.320)	(0.211)	(3.073)	6.4%
Corporate Cost Reduction	(3.500)	(0.828)	(0.785)	(0.043)	(1.087)	(2.413)	31.0%
Total	**(15.900)**	**(2.688)**	**(1.307)**	**(1.381)**	**(1.953)**	**(13.946)**	**12.3%**

4 Cash and Working Balances

4.1 Group cash as of 1st April 23 totalled £49.335m. The cash position of £48.910m as of 30th June is equivalent to an estimated 48 days operating costs which represents no movement since May.

4.2 The liquidity metric has deteriorated by 1.50 days against May to +5.50 days, this is 6.11 days below plan (+11.61 days). This is due to a £6.254m decrease in working capital balance against estimate.

4.3 The balance sheet is presented in Table 2.

Statement of Position - June 2023

	2023/2024 May 2023 Group £000's	2023/2024 June 2023 Group £000's	Movement from Prior Month £000's	2023/2024 June 2023 QEF £000's	2023/2024 June 2023 FT £000's
Assets					
Non-Current Assets					
Investments	80	80	0	80	16,824
Property, Plant and Equipment, Net	142,502	143,321	819	1,234	142,087
Right of Use Assets	13,687	13,855	168	0	13,855
Trade and Other Receivables, Net	1,986	1,931	(55)	814	1,117
Finance Lease - Intragroup				41,326	0
Trade and Other Receivables - Intragroup Loan	0	0	0		7,403
Total Non Current Assets	158,256	159,187	931	43,453	181,287
Current Assets					
Inventories	4,827	4,988	161	2,846	2,141
Trade and Other Receivables - NHS	16,474	8,325	(8,150)	863	7,461
Trade and Other Receivables - Non NHS	6,295	4,384	(1,911)	1,459	2,925
Trade and Other Receivables - Other	0	0	0		0
Prepayments	7,787	5,850	(1,937)	570	5,280
Cash and Cash Equivalents	48,145	48,910	765	6,455	42,455
Other Financial Assets - PDC Dividend	6	6	0		6
Accrued Income	1,653	1,970	317	1,268	702
Finance Lease - Intragroup				543	0
Trade and Other Receivables - Intragroup Loan					3,213
Total Current Assets	85,189	74,433	(10,756)	14,005	64,184
Liabilities					
Current Liabilites					
Deferred Income	8,096	7,445	(652)	145	7,300
Provisions	3,509	3,433	(76)	579	2,854
Current Tax Payables	4,915	9,079	4,165	1,020	8,059
Trade and Other Payables - NHS	1,414	1,484	70	667	817
Trade and Other Payables - Other	12,461	11,899	(561)	2,334	9,565
Lease Liabilities	4,359	4,538	179	0	4,538
Trade and Other Payables - Capital	(657)	500	1,157	0.000	500
Other Financial Liabilities - Accruals	42,266	28,449	(13,816)	6,690.913	21,759
Other Financial Liabilities - Borrowings FTFF	999	999	0	0.000	999
Other Financial Liabilities - PDC Dividend	648	971	324	0.000	971
Other Financial Liabilities - Intragroup Borrowings	0	0		3,212.777	0
Finance Lease - Intragroup	0	0		0.000	543
Total Current Liabilities	78,008	68,798	(9,210)	14,650	57,904
NET CURRENT ASSETS (LIABILITIES)	7,180	5,634	(1,546)	(645)	6,279
Non-Current Liabilities					
Deferred Income	2,023	2,023	0	1,719	304
Provisions	2,280	2,280	0	0	2,280
Trade and Other Payables - Other	-	0	0	0	0
Lease Liabilities	9,643	10,025	382	0	10,025
Other Financial Liabilities - Accruals	0	0	0	0	0
Other Financial Liabilities - Intragroup Borrowings	0	0	0	7,403	0
Other Financial Liabilities - Borrowings FTFF	12,012	12,012	0	0	12,012
Finance Lease - Intragroup				0	41,326
Total Non-Current Liabilities	25,958	26,340	382	9,122	65,946
TOTAL ASSETS EMPLOYED	**139,479**	**138,482**	(996)	**33,687**	**121,619**
Tax Payers' and Others' Equity					
PDC	149,767	149,767	0	0	149,767
Taxpayers Equity	0	0	0	0	0
Share Capital	0	0	0	16,824	0
Retained Earnings (Accumulated Losses)	(20,183)	(21,179)	(996)	23,686	(44,865)
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	139,479	138,482	(996)	40,510	114,796
TOTAL ASSETS EMPLOYED	**139,479**	**138,482**	(996)	**40,510**	**114,796**

Table 2 – Statement of Position

5 Capital

5.1 The Trusts 23-24 CDEL limit has been set at £9.469m, which includes £1.792m of internal funding. The Board is committed to spend £1m above this CDEL allocation which will require a total commitment of £2.792m from cash reserves. PDC awards totalling £17.478m are expected to fund the CDC £14.376m; Digital Diagnostics £0.847m; and the MRI £2.255m. this increases the estimated capital funding to £27.947m.

Capital Funding	£000's	£000's
Net Depreciation*		7,677
Internal Cash		2,792
PDC Schemes		
CDC	14,376	
Digital Dignostics	847	
MRI	2,255	17,478
Total		27,947

* After Principal Loan Repayments

5.2 The Trust is currently awaiting final approved of a revised capital programme by the Trust Board, with delegated authority to spend up to the capital programme included in the 2023-2024 annual plan until an updated capital plan is approved.

5.3 Capital spend to 30th June totalled £2.199m and £0.176m less than the year-to-date plan. Expenditure in the year was in respect of the new operating model, community diagnostic centre and schemes carried forward from the 2022-2023 programme.

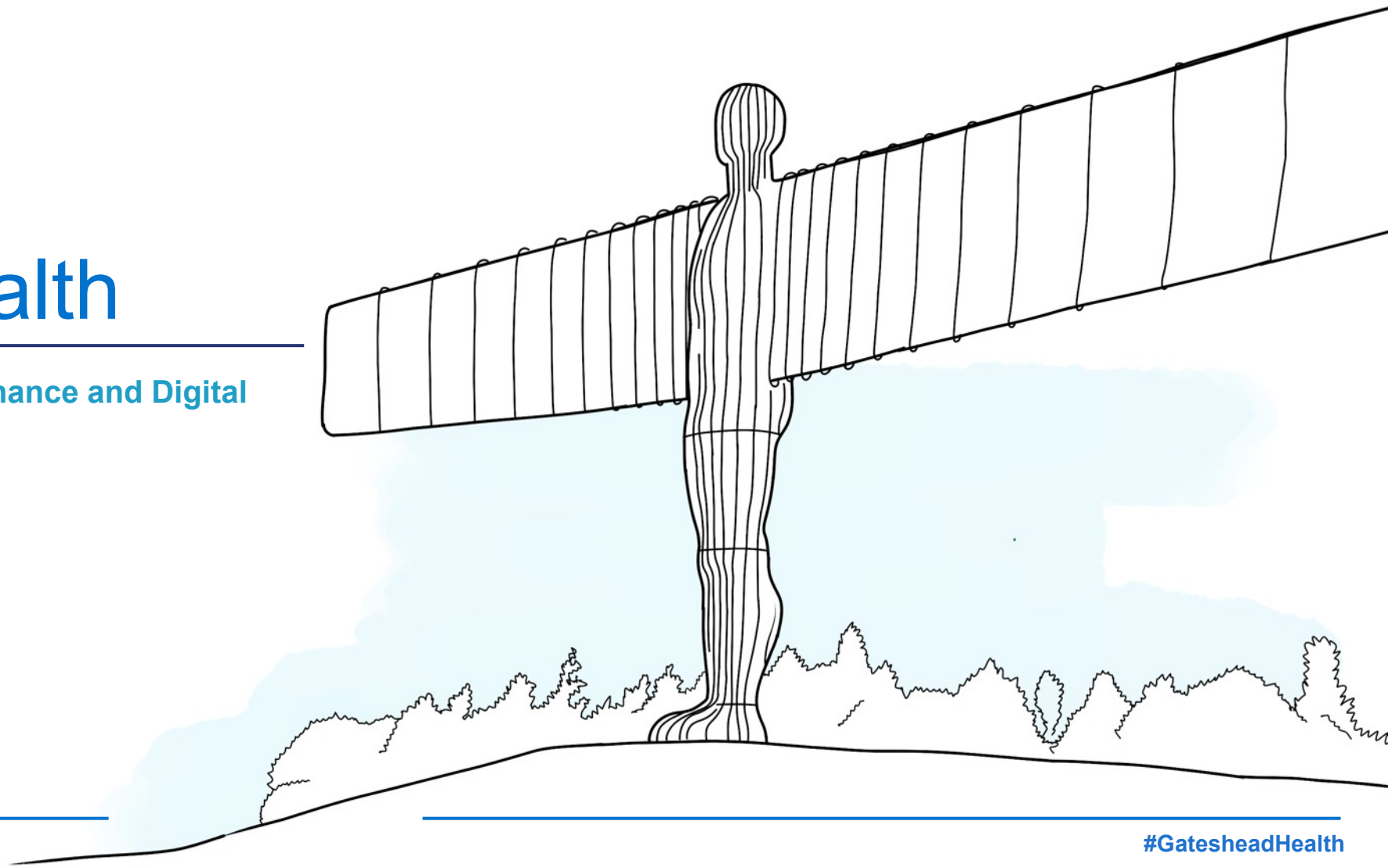
Kris Mackenzie, Group Director of Finance & Digital
July 2023

NHS
Gateshead Health
NHS Foundation Trust

Gateshead Health

Kris Mackenzie, Group Director of Finance and Digital

21st June 2023



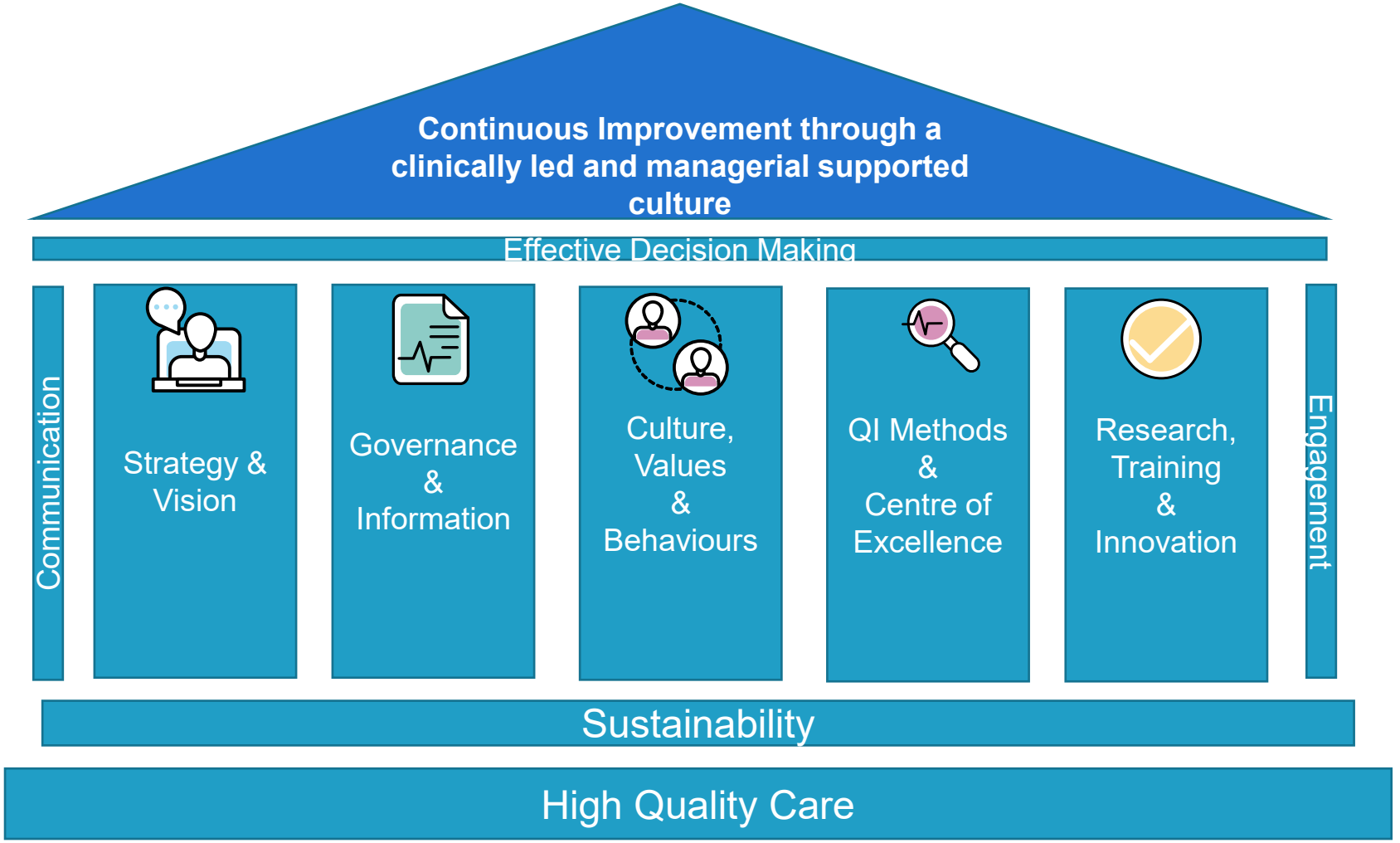
Financial Sustainability

Gateshead Health NHS Foundation Trust

To return the organisation to a balanced financial plan for the financial year of 2025/26.

Aim: *A Coordinated collection of strategic processes and decisions that together enable the most effective balance of organisational change and business as usual*

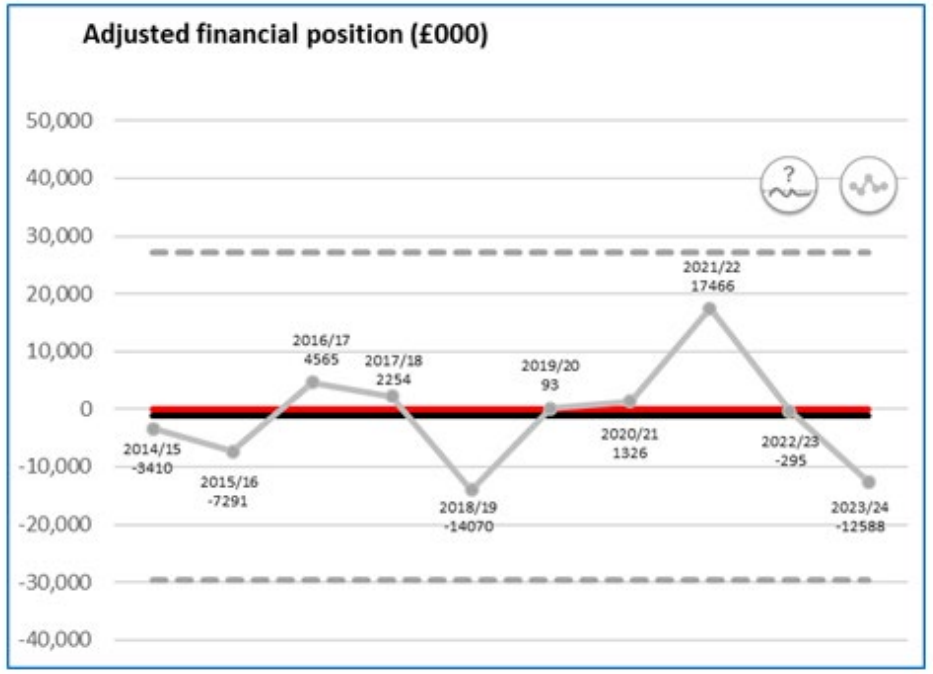
Gateshead Health NHS Foundation Trust



Historical Position

Gateshead Health NHS Foundation Trust

£000s	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Adjusted Financial Position	(3,410)	(7,291)	4,565	2,254	(14,070)	93	1,326	17,466	(295)	(12,588)



- Historic financial performance – reliance on non-recurrent income
- Analysis undertaken to understand cause of underlying deficit
- Historic CRP delivery – non-recurrent 60-70%
- Finance managed corporately not devolved
- Incremental growth in finance team in response to developments

2022/23 Year End

Gateshead Health NHS Foundation Trust

- Planned surplus of £1.6m vs actual deficit of £0.3m.
- Internal Audit
  - Head of Internal Audit Opinion – Good
- External Audit
  - Closure meeting on afternoon of Thursday 22 June 2023
  - Accounts to be presented to Audit Committee on Monday 26 June 2023
  - Accounts to be presented to Board on Wednesday 28 June 2023

2023/24 Headlines

Gateshead Health NHS Foundation Trust

- Projected deficit £13m (adjusted financial position)
  - Includes assumed CRP of £16m
  - Assumes delivery of activity trajectories
  - Assumes no growth in pay or non-pay costs
  - Loss of non-recurrent income

- April-May 2023
  - Planned deficit of £2.9m – on plan
  - CRP plan of £1.8m - £0.2m transacted
  - Capital spend of £1m on pre-approved schemes
  - Cash currently at £48m – reduction of £1m this year

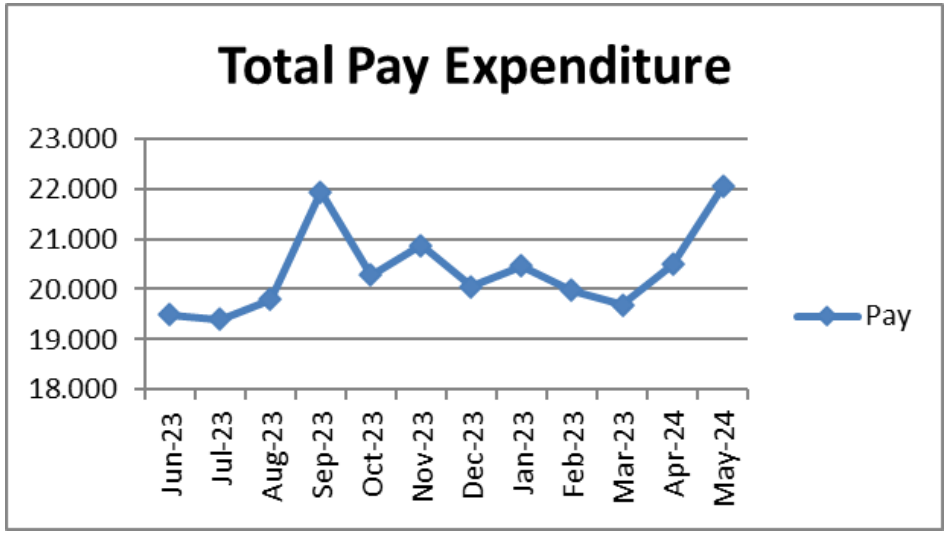
2023/24 – What are we doing differently?

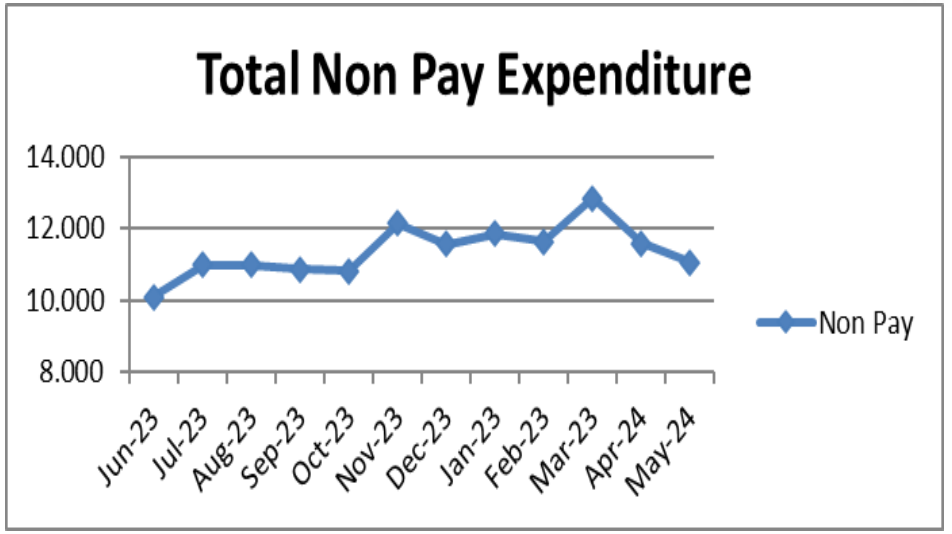
Gateshead Health NHS Foundation Trust

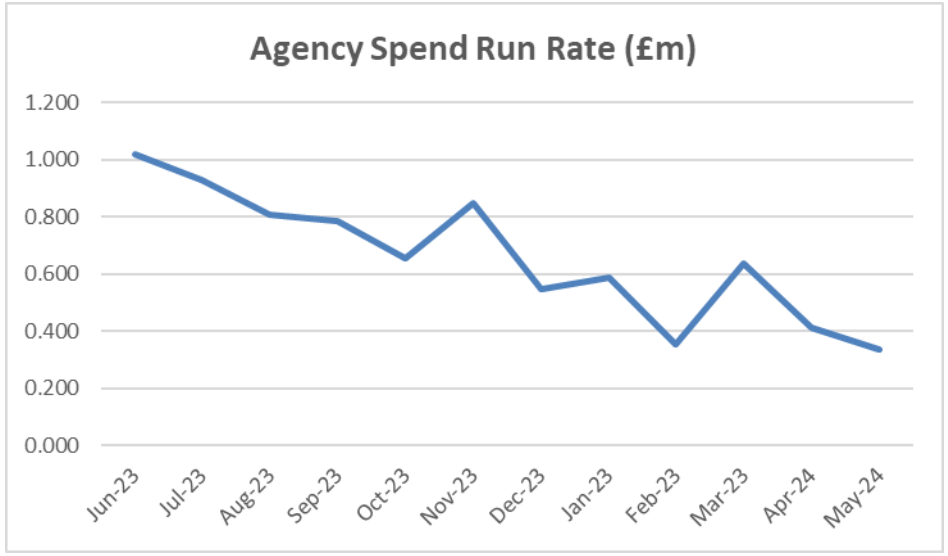
- Dual running:
  - Immediate Cost Containment
  - Underlying financial sustainability (return to financial balance)
- Immediate cost containment
  - Weekly CRP working group
    - Schemes identified for between £7m and £12m
    - Just finalising the EQIA outcomes of the proposed schemes
    - Reporting to Board level via Finance and Performance Committee
    - Focus on recurrent efficiencies
  - Grip and control checklist
  - HFMA financial sustainability – self assessment with internal audit review
  - Accountability framework and monthly oversight meetings
  - Assessment against and engagement with letter of 15 June 2023
  - Assessment against PWC financial reset – key questions for Board

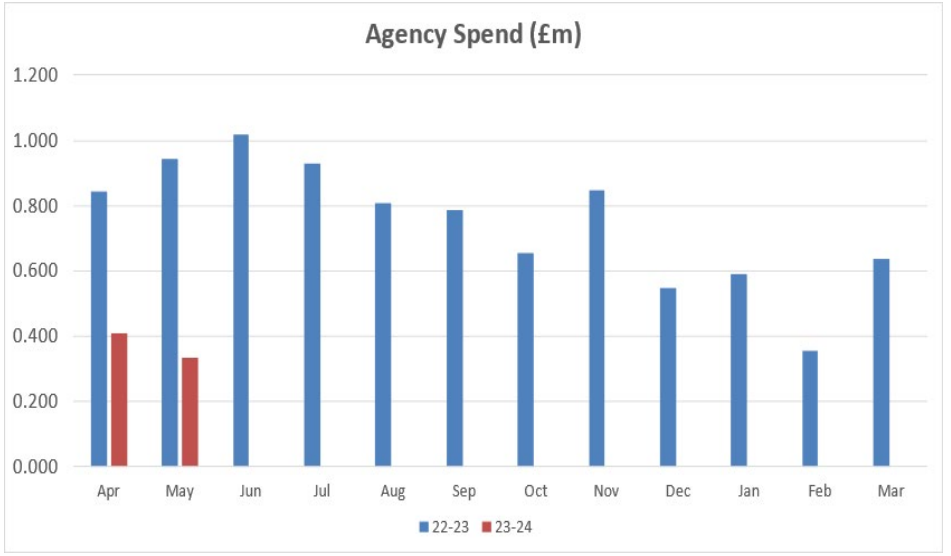
2023/24 –Impact

Gateshead Health NHS Foundation Trust









2023/24 – Risks

Gateshead Health NHS Foundation Trust

- Efficiency requirements
- Delivery of planned activity trajectories
- Increasing cost of capital
- Further inflationary pressures
- Community diagnostic centre
- Sufficiency of pay award funding
- Additional funding available during the year

Financial Sustainability

Gateshead Health NHS Foundation Trust

To return the organisation to a balanced financial plan for the financial year of 2025/26

Financial Strategy

#GatesheadHealth Finance Vision

Gateshead Health NHS Foundation Trust

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

Financial Strategy

Do we understand our financial drivers? National Context

Gateshead Health NHS Foundation Trust

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

Financial Strategy

Do we understand our financial drivers? Local Context

Gateshead Health NHS Foundation Trust

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

Financial Strategy

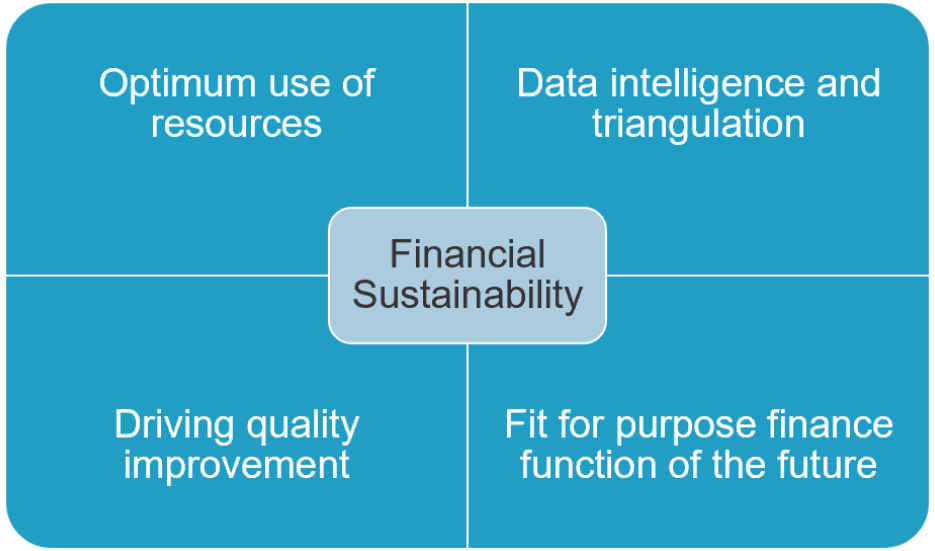
Finance as an enabling function

Gateshead Health NHS Foundation Trust

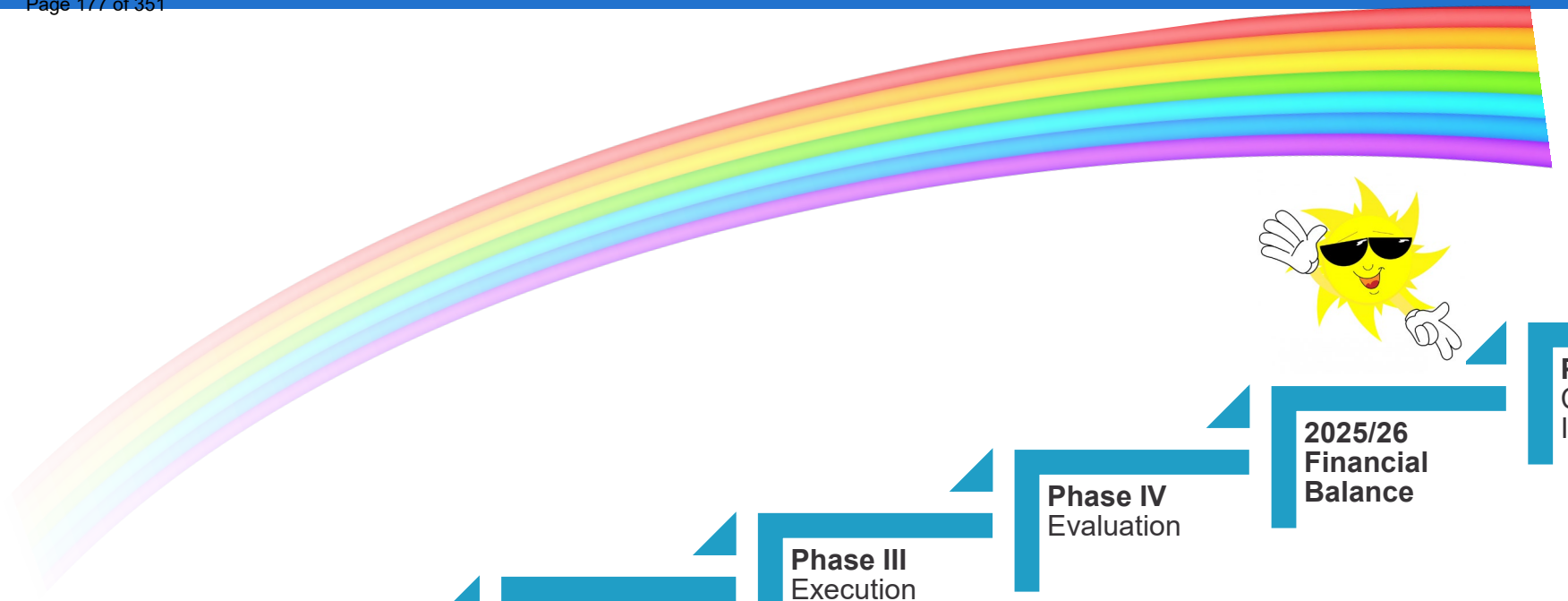
The #GatesheadHealth corporate strategy prioritises the need to:

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

This is underpinned by the Financial Strategy



Gateshead Health NHS Foundation Trust



Phase 0 – Immediate Actions

Phase I Understanding our Needs

Phase II Organisational Blueprint

Phase III Execution

Phase IV Evaluation

2025/26 Financial Balance

Phase V Continuous Improvement

- Optimum use of resources
- Data intelligence and triangulation
- Driving quality improvement
- Fit for purpose finance team of the future

Innovation + Caring + Openness + Respect + Engagement = ICORE

NHS Constitution

Phase 0 – Immediate actions

Gateshead Health NHS Foundation Trust

- Understand the nine building blocks advocated by HFMA
- Strengthen financial culture (use communications and engagement)
- Strengthen governance arrangements
- Appointment into strategic planning role
- Alignment of performance and information portfolio with digital and data
- Finance restructure and OD support
- True clinical engagement and leadership
- Effective deployment of internal audit
- Wider engagement – place/region/national
- Back to basics programme
- Subco commercial strategy

Phase I – Understand our needs

Gateshead Health NHS Foundation Trust

- Thematic review
- Self assessments
- Identify gaps
- Use of benchmarking tools
- Comprehensive analysis of underlying runrate
- Full review of contracting arrangements
- Identify critical enabling services
- Review of sustainable services
- Reduced data complexity
- Identify key cost drivers
- Capacity vs demand vs potential
- Review of processes e.g. business planning process
- Digital first where appropriate

Phase II – Roadmap activities/Phase III - Execution

Gateshead Health NHS Foundation Trust

- Thematic review delivery plan
- Leading indicators
- Sustainable services review
- Productivity focus
- Estates rationalisation
- Review of structures
- Data capture
- Reporting of information
- Organisation wide corporate transformation
- Outpatient transformation
- Financial modelling and projections
- Trust commercial strategy e.g. Northern Women's Centre of Excellence

Phase IV - Evaluation

Gateshead Health NHS Foundation Trust

- Financial modelling and projections
- Self-assessment tools
- Internal Audit
- Benchmarking
- Leading indicators
- Staff assessment

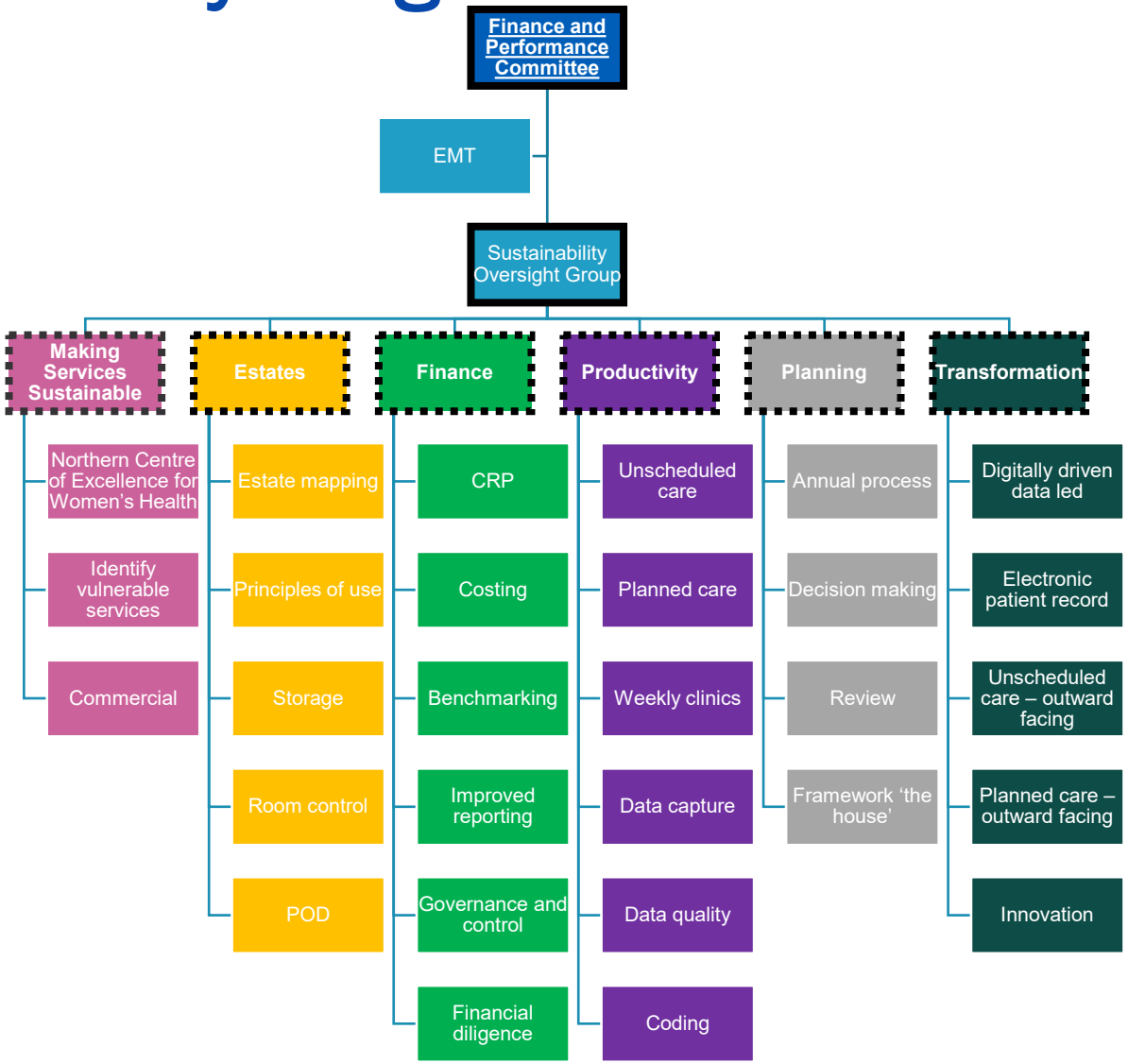
2025/26 – Financial Balance

Gateshead Health NHS Foundation Trust

- Sustainability programme – supported by Sustainability Oversight Group
- Clinically led managerially supported
- Collective understanding and ownership of the operational underlying financial position – increased organisational competence
- Effective and strong financial governance
- Fit for purpose finance function of the future – appropriate accreditation
- Organisation wide support to identify efficiencies
- Prioritised workforce
- Exploitation of digital technologies – digitally driven data led
- Balance short term priorities with medium term strategy
- System level approach to financial planning – collaborative partner at place – system asset beyond finance
- Embedded QI methods and centre of excellence
- Productive with best possible outcomes
- Happy staff happy patients

Sustainability Programme - Governance

Gateshead Health NHS Foundation Trust



Sustainability Programme - Governance

Gateshead Health NHS Foundation Trust

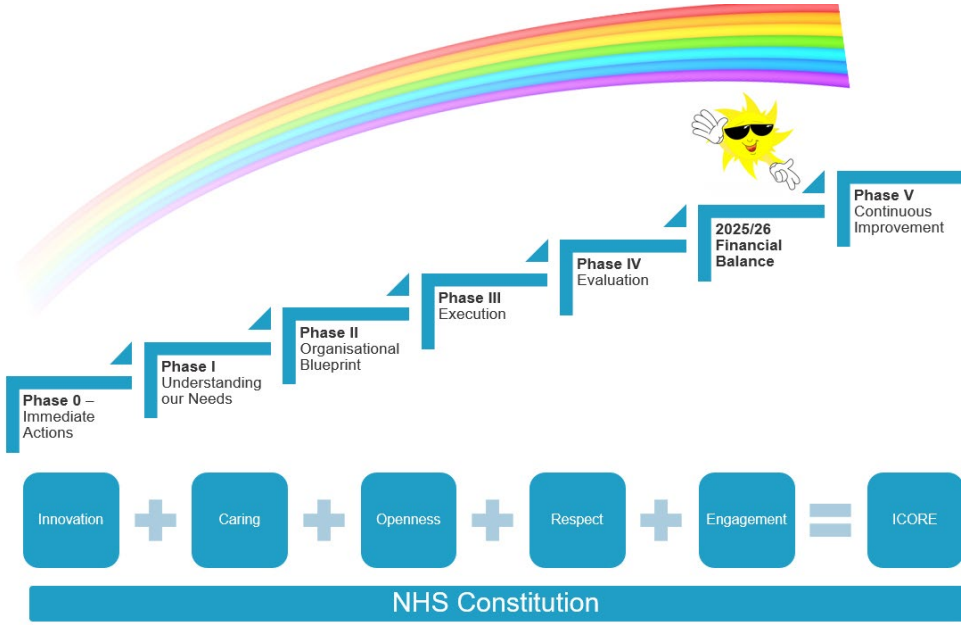
Sustainability Oversight Group:

Exec lead: Kris - Group Director of Finance, Digital and Performance

Director: Nicola – Director of Strategy, Planning and Partnerships

Members: Clinical, Managerial, Corporate colleagues

Methodology:



Phase V – Continuous Improvement

Gateshead Health NHS Foundation Trust

- Talent management within finance team
- Commercial strategy
- Digitisation and automation
- Exploit opportunities for growth
- Drive and embrace opportunities for appropriate collaboration
- Subsidiarity at place – effective use of the ‘Gateshead £’

Financial Sustainability

Gateshead Health NHS Foundation Trust

To return the organisation to a balanced financial plan for the financial year of 2025/26...**and beyond**

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 11

Report Title:	**2023/24 Capital Plan**			
Name of Meeting:	Trust Board			
Date of Meeting:	26 July 2023			
Author:	Mr Michael Smith, Assistant Director of Finance – Governance and Control			
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:** ☐
	To provide the Trust Board with the assurance that a full review of the 2023/24 capital position has been made and considered alongside the CDEL for 2023/24, before determining the recommended programme of work for the year.			
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*	Executive Team Meeting Finance and Performance Committee – June 2023			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	Capital Funding of £27.947m is now available to support the capital programme for 2023/34. The Executive Management Team have considered and are recommending to Finance and Performance Committee a capital programme of £29.792m, which exceeds the funding envelope by £1.845m. This is predicated on the historical trend for capital programmes to underspend due to slippage in timing of delivery, but also the increasing likelihood of last minute capital funding being made available during the financial year.			

	Trust Board has previously delegated authority to Executive Management Team to spend capital in line with the capital plan.				
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	To ratify the recommendation from Executive Management Team to approve the capital programme as outline in the paper. To note that Charitable Funds has yet to confirm funding for eligible schemes and is not included in this paper.				
Trust Strategic Aims that the report relates to:	**Aim 1** ☐	We will continuously improve the quality and safety of our services for our patients			
	Aim 2 ☐	We will be a great organisation with a highly engaged workforce			
	Aim 3 ☒	We will enhance our productivity and efficiency to make the best use of resources			
	Aim 4 ☐	We will be an effective partner and be ambitious in our commitment to improving health outcomes			
	Aim 5 ☐	We will develop and expand our services within and beyond Gateshead			
Trust corporate objectives that the report relates to:	*List corporate objective reference and headline – e.g. 1.4 Maximise the use of Nervecentre to improve patient care*				
Links to CQC KLOE	Caring ☐	Responsive ☐	Well-led ☒	Effective ☐	Safe ☐
Risks / implications from this report (positive or negative):					
Links to risks (identify significant risks and DATIX reference)					
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒		

1 Introduction

1.1 As part of the planning process the Trust Board delegated authority to the Executive Management Team to spend capital resources in line with the agreed capital plan. This paper is intended to present the recommended capital programme for 2023/24, confirming the funding available to support.

1.2 The paper does not include chartable fund projects as these are currently unconfirmed.

2 2023/24 Draft Capital Programme

2.1 The current capital funding for 2023/24 totals £27.947m; £10.469m of internal funding and £17.478m of external funding, as outlined in table 1. The current system allocation of CDEL totals £9.469m, which includes £1.792m of internal funding. The Board have previously committed to spend £1.000m above this CDEL allocation in respect of implementation of the 2nd MRI scanner, this will require a total commitment of £2.792m from cash reserves.

Capital Funding	£000's	£000's
Net Depreciation*		7,677
Internal Cash		2,792
PDC Schemes		
CDC	14,376	
Digital Dignostics	847	
MRI	2,255	17,478
Total		27,947

* After Principal Loan Repayments

Table 1: Draft Capital Funding 2023/24

2.2 The original funding included £1.136m in respect of digital diagnostics. This has been confirmed as £0.847m in 2023/24, with £0.536m available in financial year 2024/25.

2.3 Against this a plan totalling £29.792m is recommended as per table 2. Total capital bids are £1.845m in excess of available resources (£27.947m). The original draft programme considered by the Executive Team totalled £30.023m however the digital diagnostic PDC award has been revised down by £0.289m with commitments for schemes carry forward now estimated at £0.335m an increase of £0.058m. The programme has been approved in principle by the Executive Team for onward recommendation to the Finance and Performance Committee.

Capital Programme Schemes	£'000s	£'000s
Estates		
CDC	14,376	
New Operating Model	3,145	
MRI	3,255	
Equipment Replacement	1,200	
Digital Diagnostics	847	
Backlog Maintenance	1,100	
Air Handling Units	600	
Contingency	500	
Water Pipe Works - Pathology	500	
Bowel Screening	480	
Pathology Decant	442	
Carry Forward of Schemes 2022/23	335	
H&S Investment	100	
Energy Conservation Schemes	90	
Dementia Environment	60	
Sustainability Agenda	50	
Patient Experience Works	20	
Blaydon Fence	15	
Highways Works	10	
Bensham Garden Fence	10	
Water Supply Survey	7	27,142
I.T.		
Nutanix - storage	1,000	
Netapp for PACS/RIA/Vna	500	
Core Network (Year 1 of 2)	500	
Hardware Replacement	300	
Server 2012 Upgardes	250	
Winscribe Replacement	100	2,650
Total		**29,792**

Table 2: Draft 2023/24 Submitted Capital Programme

2.4 The CDC, MRI and Digital Diagnostics schemes each attract PDC funding in year. The MRI scheme bid is also inclusive of £1.000m of enabling works to allow full implementation.

2.5 The Trust previously approved funding of £7.1m in respect of the New Operating Model, to date £3.955m has been invested in financial years 2021/22 and 2022/23; with £3.145m remaining in 2023/24.

2.6 Building and engineering maintenance works. The Trust has previously provided £0.500m per annum to address priorities. However, the current number of high priority works required on site has resulted in the need for an additional allocation of £0.500m increasing the required budget to £1.100m in 2023/24.

2.7 The draft programme also includes a contingency of £0.500m to allow the Trust to respond to any emergency or priority works that may arise within the year.

2.8 Of the remaining estate scheme bids: -

- Air Handling Units for Theatres £0.600m. Replacement of the current Units is a high priority and risk due to their age and effectiveness. The units are regularly failing and when a unit fails this results in no airflow to two Theatres. There is also a health and safety risk to staff due to build-up of chemical and anaesthetic agents in the space which are not being dispersed/diluted by the ventilation system. Continued use of these Theatres is a patient safety risk and staff safety risk.
- A bid of £0.500m has been made for urgent water pipe works that are required for Pathology. The current plastic pipes feeding the analysers and valves are failing resulting in leaks and water pressure issues which disrupts critical service delivery and requires weekly repairs. The proposal would be to replace the existing plastic infrastructure with stainless steel pipework installed at high level around the lab then dropping down into the underfloor ducts.
- Bowel Cancer £0.480m. This is in respect of capital works required to facilitate the Bowel Cancer Screening Programme Age Expansion scheme.
- Pathology Decant £0.442m. This is required to allow the continuity of the Pathology service as the Laboratory is reconfigured.
- Several capital schemes were incomplete in 2022/23 and £0.335m of commitments remain.
- Costs included for H&S investment, energy conservation and dementia environment are recognisable as amounts warded to these schemes each year and are therefore consistent with recent years allocations for such works.
- A budget of £0.050m has been included to address the Sustainability Agenda.
- Small Scheme expenditure of £0.062m in respect of fencing, highways works, conversion of office space to enhance patient experience of and a water study are included.

2.8 I.T. Capital Bids. All of the I.T. bids are classified as high priority.

- Winscribe Replacement £0.100m. The current system expires in September 2023.

- Server 2012 Upgrades £0.250m. These are unsupported systems that require upgrade to protect against any potential Cyber-attack.
- Hardware Replacement £0.300m. This is required to provide the necessary contingency against system failure.
- Netapp for PACS/RIS/VNA £0.500m. Unsupported Hardware so risk of failure and therefore loss of image store.
- Nutanix Storage £1.000m. This storage systems maintenance expires in July 2023, with the support contract also expiring in January 2025. This scheme could be deferred into financial year 2024/25 but would require settlement early in the financial year.
- Core Network £0.500m. The risk of unsupported hardware and therefore hardware failure and potential loss of trust network. This scheme could be deferred into financial year 2024/25 but again would require settlement early in the financial year.

3 Charitable Funds

3.1 Charitable Funds has yet to confirm funding for specific schemes, which is outside the CDEL allocation.

4 Next steps

4.1 Backlog maintenance and equipment replacement programmes have both been informed by QEF expertise. The Trust was not engaged within the prioritisation exercise and therefore must assure itself as to the process that was undertaken and fully understand the level of risk inherent in not being able to fulfil all backlog maintenance and equipment replacement requests.

4.2 QEF estates team and the Trust digital team are required to formalise the timelines and phasing associated with the programme of works.

4 Summary

4.1 Against capital resources of £27.947m in 2023/24, the Trust has defined a capital programme totalling £29.792m; an over subscription of £1.845m.

5 Recommendation

5.1 That the Trust Board approve the 2023/24 capital programme as outlined in the paper.

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 12

Report Title:	Integrated Oversight Report			
Name of Meeting:	Board of Directors			
Date of Meeting:	26th July 2023			
Author:	Deborah Renwick & Jon Gaines and IOR Reporting Leads			
Executive Sponsor:	Kris Mackenzie			
Report presented by:	Kris Mackenzie			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☒	**Assurance:** ☒	**Information:** ☐
	To summarise performance in relation to strategic aims, key NHS standards, requirements and KLOE's to outline the risks and recovery plans associated with COVID -19. This report covers the reporting period May and June 2023			
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*	Following feedback from F&P Committee & GGI CQC Preparation- Rapid Diagnostic Report this overview report and the IOR continue to be reviewed and revised. The covering report does not seek to replicate all the detail in the IOR, rather give a high-level overview of the key themes and triangulate areas where appropriate. Detail for each area can be sourced from the IOR. **Points to note for July:** The average number of G&A beds open again reduced for the third month in June from 436 to 434, in line with NOM levels for the first time, and there was a further reduction in long stay patients 74.2. However average length of stay spells all increased slightly in June, having fallen for the previous 2 months. Attendances at A&E remain high, with June recording the third highest volume of A&E attendances since Covid, and the second highest volume of ambulance attendances seen in the past 12 months. However, UEC performance measures improved in June compared to May: • 4-hour A&E waiting times improved to 74.4% • There were zero 12-hour trolley breaches. • 46.6%% of Ambulance handovers were within 15 mins of arrival, 94.1% within 30-60 mins			

<table>
<tr><td></td><td colspan="2">Overall elective activity achieved was 113.4% of planned for levels in June. Individually day case and new outpatient activity was above planned for levels. Diagnostic activity was at 105.3%, exceeding planned for levels for the first time. Elective overnight activity continues to be the area at largest variance to planned for levels, achieving only 71.1% of planned for levels in June (75.0% year to date).

Key performance headlines are:

• RTT <18 weeks waiters' performance is at 70.7% (92% target)
• RTT waiting-list list increased by 344 patients (2.5%) to 13,381 (420 above plan)
• Diagnostic performance was 90.0% (95% target). Audiology continues to be the biggest long-term risk. Some challenges in Endoscopic modalities reported in previous months are starting to see improvements through the deployment of insourcing
• 3/8 cancer standards are achieving their targets latest validated month
• Patient waiting over 62 days reduced to 52 (below planned level of 64)

Workforce metrics continue to improve across the suite of indicators, with on-going efforts to improve staff engagement. Vacancy rates are below planned for levels. There was a sharp increase in Agency spend on Medical and Nursing staff in June, compared with May.

High-level financial summary indicates in June the Trust transacted £1,116m in CRP, £219k above planned for levels for the month. Pay spend was £401k over plan in M3. Non pay spend was £202k below plan in M3.</td></tr>
<tr><td>Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper</td><td colspan="2">This report seeks to provide assurance in respect of the strategic aims 1,2,3 and 4. The recommendations to the Committee are to receive this report, discuss the potential implications and note the improvements in key areas, noting the impact of IA in elective recovery and the impact on waiting times.</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:</td><td>Aim 1
☒</td><td>We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>Aim 2
☒</td><td>We will be a great organisation with a highly engaged workforce</td></tr>
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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>Trust corporate objectives that the report relates to:</td><td colspan="2">3) We will enhance our productivity and efficiency to make the best use of our resources.

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

	SA3.2 Achieving financial sustainability				
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)	• Activity levels & Elective Recovery • Continued growth in RTT waiting lists and the ability to reduce long waiters. • Growth in 2-week referral rates • Risk of patient flow and challenges to achieving all UEC performance measures • Workforce engagement • Impact of Industrial Action				
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒		

INTEGRATED OVERSIGHT REPORT – July COMMITTEES

1. Introduction

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

2. Key issues & findings

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

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

Caring Domain

2.2 **Patient Friends & Family Tests (FFT)**: Inpatient / day case services saw an increase in the percentage of patients reporting a positive experience to 97.1% from 95.5% in the previous month (96.3% average last 3 months). National Benchmarking data (which remain for February) shows we remain above the national average of 95%, with GH 97.6%. Response rates also slightly increased from 8.1% to 8.3% in June.

2.3 A&E services also demonstrated an increase in overall levels to 88.1% from 85.2% of patients reporting experiencing a positive experience (87.0% average last 3 months). Benchmarking data ((which remain for February) shows that we remain above the national average of 80% with performance at 81.9%. However, response rates reduced slightly from 5.7% to 5.4% in June.

2.4 Themes identified from patients who rated their experience as 'poor or very poor' include waits and delays, poor communication, busy staff contributing to perceived lack of attention and care and pain management.

2.5 Although increasing in the past 2 months the number of formal complaints volumes continue to be within the expected range, with verbal communications and clinical treatment complaints making up the majority of complaints received each month, distribution continues to be spread across a range of all clinical areas proportionately. The number of overdue complaints at the end of June continues to trigger special cause variation and demonstrates improvement, having more than halved since the high of November. However, at the end of June there were 27 overdue complaints, the same as at the end of May. Indications Mid July was there had been further progress and the figure had reduced to 16.

Safe Domain

2.6 Seven Serious Incidents (SI's) were reported to StEIS in June, all reported were categorised as resulting in severe harm. 4 of the incidents were related to falls, 1 discharge and two other listed as patient accident and post 72 hr Cdiff. The number

of reported SIs in the first 3 months of this year continue to be lower than the same period last year.

2.7 There were 571 patient safety incidents reported in June – 3.7% (21) were recorded as resulting in moderate, severe, or major harm, the highest proportion of any month since September last year. Over the past 12 months the average is 2.2% of incidents recorded as moderate, severe, or major so June is higher than the period average. Patient falls and Delay / failure to treat / monitor are consistently the top two reasons for incidents of this nature.

2.8 The HCAI 2023/24 national objective for Clostridioides difficile infection (C.Diff) is no more than 23 cases attributed to the Trust. The Trust has recorded 5 year to date. In June we had 1 Hospital Onset (HOHA), with zero were Community Onset (COCA). The trust is therefore reporting 5 cases against the annual allowance and is below trajectory for this point in the year.

2.9 Having fallen significantly in the previous months the Trust reported 6 COVID outbreaks in the month, up from 4 in May. And the incidence of nosocomial cases also increased slightly from 27 to 29, There are no outstanding safety alerts and there were no MRSA cases reported in April or May.

2.10 June has seen a notable increase in E.coli infections, reporting 12 Healthcare Associated E. coli during June 2023 and 20 Community associated. The rise in E. coli BSIs could be associated with seasonal variation, however the increase will continue to be monitored and investigated as required.

2.11 The number of inpatient deaths triggered special cause variation from December 2022 with the most recent seven consecutive months above the 18-month average. However assessing crude mortality (deaths / discharges) and considering a longer time series displays a return to common cause variation at more typical levels. Supporting indicators (HSMR and SHMI) and the review of all deaths by the ME service and mortality review do not highlight any cause for concern over recent months.

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

Effective Domain

2.12 HSMR and SHMI continue to show deaths with expected ranges, with the SHMI is showing lower than expected deaths. These Mortality review data for the last 12 months demonstrates that 99.1% of deaths reviewed were ‘Definitely not preventable’ with 95.6%% of cases reviewed identified as ‘Good practice’. 72 cases in the period required a review by the Mortality Council and/or the ward-based team.

2.13 General and Acute beds open in June averaged 434 for the month, for the first time in line with the planned NOM bed levels of 434. Bed occupancy remains consistently well above 92% threshold and the ICB average, however occupancy levels reduced to 94.4% from 95.6% in May, but daily levels peaked at 99.3% on the 20th June, so some days posed significant challenges.

2.14 There were on average 42 patients in beds each day in June, who no longer met the criteria to reside, down from 46 in May. This is against an ambition to reduce to 15-18 patients. But continues to be significantly lower than the highs of December 2022.

There was also a slight decrease in the days accrued between the patient becoming medically optimised (MO) to discharge, from 1,952 days to 1,851.

2.15 The number of patients in the hospital with spells of more than 7+, 14+ and 21+ days have continued to reduce, each month since January, and did again in June. Compared to may there was a 7.4% reduction in the average number of patients with spells of 7+ days, a 3.93% reduction with spells of 14+ days and a 1.38% with those with spells of 21+ days, from 75.5 to 74.2. However, having reduced for the past 2 months, average length of stay spells for elective, non-elective and total overall patients all increased slightly in June.

We will improve the productivity and efficiency of our operational services.

Responsive Domain

2.16 **ED and Ambulance attendances** - Attendances were again high in June, having increased sharply in May and stood at 9,830. June was the third highest daily attendance figure since the start of the Covid pandemic, and daily attendances averaged 6 per day more than June last year (representing an increase of 1.8%). April to June has consistently seen some of the highest number of Ambulance attendances in the past 12 months, averaging 1838 per month. June saw 1821 attendances, only slightly lower than the highest month of May when the figure was 1885.

2.17 **Ambulance handovers** times improved from last month with 46.6% of handovers within 15 mins of arrival and 94.1% within 30-60 mins. Trust data shows 96 patients waited between 30-60 minutes for handover (increase from 93 last month) and 52 patients waited longer than 60 mins (down from 77 last month) The Trust continues to benchmark fairly well across the ICS, in second for 30-60 minute handovers. The Trust supported 3 diverts in June, same as May. And requested support for 5 in June, down from 10 in May.

2.18 **Total waits in ED** – the proportion of patients waiting more than 12 hours in ED slightly increased to 4.02% in June, however the Trust reported Zero 12-hour DTA breaches in the month. Slightly more patients waited less than 4 four hours to be seen and treated, with performance improving to 74.4% in June and placing the Trust 39th out of 137 of Trusts, compared with 44th in May.

2.19 **Rapid response -** validated performance in May was above the 70% target again standing at 71.4%, and cumulatively since April the service stands at 78.4% for the two validated performance months. With activity also continuing to be higher. The targeted support and training continue to be undertaken within the service to improve data capture and reporting of performance.

2.20 **Diagnostic performance** improved slightly again in June to 90.0% from 89.5% of patients waiting less than 6 weeks. The latest benchmarking continues to place us better than the latest national average and ICS averages. Audiology is the single largest risk area in achieving the 95% standard for the Trust. Audiology performance fell slightly in June to 52.0% from 52.6% in May. The service has a number of challenges impacting on performance including staffing and are currently developing a recovery plan as part of the weekly Performance Clinics, which is expected to be discussed on the 21st July. Pressures around endoscopy continue but are improving further insourcing commenced at the start of July and will run to the end of August.

The 5th Endo room is also now operational providing additional capacity and flexibility. As a result, the number of endo long waiters has continued to reduce from 144 at the end of May, to 101 at the end of June.

2.21 **Cancer Waiting Times**: For the latest validated months, the Trust met the 31 days to treatment standard, the 31-day subsequent chemotherapy treatment and 62 days from screening to treatment standards. The 28 Day Faster Diagnosis target was not met in May for the first time since September 22; however, it has recovered based on the latest indicative data for June. The 2 week wait, 28-day screening and 62 days from GP referral to treatment continue to not meet their standards. Indicative positions for the current unvalidated month are also provided in the report with a similar pattern of performance observed, with the exception of the 28-day faster diagnosis standard which has improved. At the end of June, the number of long waiters reduced to 52 and was below planned for levels. Pressures remain in across most Tumour site and standards, but particular challenges are present in Gynae and two week waits.

2.22 **Referral to Treatment - 18 weeks**: Challenges remain in achieving planned for activity levels and continues to place pressures on the Trust. In June, the number of patients on the waiting list increased by 2.5% to 13,725 and the proportion of patients waiting less than 18 weeks fell slightly to 70.7% from 72.4% last month.

2.23 **Referral to Treatment – Long Waiters:** The number of patients on the RTT waiting list waiting more than 78 weeks remained at Zero, however the number of patients waiting more than 65 weeks increased to 14 (remained below planned for levels). Those waiting more than 52 weeks, as projected, continued to increase to 196 at the end of June (above planned for levels of 80). Paediatric, Pain and Trauma and Orthopaedic patients remain the biggest risk at present. Plans to mitigate these increases in Paediatrics: (which are exclusively children aged 0-4 awaiting an autism assessment) a proposal to revisit the Pathways for these children to align them to guidance is being discussed with Commissioners in July, which would potentially change the clock stop and therefore reduce long waiters significantly. Pain: locum capacity has been sought which commenced w/c 17/07 which will support in reducing these numbers, and new staff start in October which will provide further additional capacity, and work to address backlog. In T&O a business case to increase capacity through the use of LLP was supported by EMT and is currently being worked up.

We will be a great organisation with a highly engaged workforce.

Well Led Domain

2.24 While the number of staff in contracted posts increased slightly in June the gap between planned and contracted staffing levels also slightly increased in June compared with May, as a result the Trust vacancy rate was 3.4% as of Jun 23, a 0.8%, 35.3 WTE increase from May, but still below les than 5% target. While the overall vacancy rate appears positive, the IOR highlights how there are services across the Trust where rates are notably higher, for example Pathology. Turn over rates remain low, at 0.9% for June.

2.25 Sickness absence data continues to show a positive reduction in absence rates across the Group with both the Trust inline with the 5% target, QEF is now below. Core training continues to increase with a Group compliance figure of 87% in June, against the 85% target. In relation to appraisals, while there has been a sustained

improvement since May 2022, the Group remains below the 85% target, in June the figure stood at 81.3%.

2.26 Having been on a downward trajectory, Agency spend saw a sharp increase in June with spend on Nursing and Medical Staff rising sharply from the previous month, resulting an increase top around 2.5% of the pay bill in June, from around 1% in May. However, bank spend reduced in each of the groups in June compared with May.

We will achieve financial sustainability

2.27 **Finance -** Transacted CRP in M3 is above planned levels for the first time, non-pay spend was below planned for levels for the second month in a row and pay spend was above planned levels. YTD CRP variance reduced to £1.3m from £1.6m, but remains below plan. Non pay spend variance improved to -£764k (lower than plan). However, pay spend variance increased to +£2.2m (above plan).

NHS
Gateshead Health
NHS Foundation Trust

Integrated Oversight Report

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

JULY 23 COMMITTEES

THIS PACK IS BEST VIEWED ON SCREEN IN SLIDESHOW MODE

Contents	Pages	Reporting Period	Data Quality Signoff
Summary of KLOE	**3**		
Safe			
Serious Incidents reported to StEIS and Medication errors per 1000 FCEs	**4**	June 23	***
Datix - Patient Safety Incidents	**5**	June 23	***
Infection Prevention & Control	**6 – 7**	June 23	***
Effective			
Hospital Standardised Mortality Ratio and Summary Hospital Level Mortality Indicator	**8**	Nov 20 to Mar 23 / Oct 20 to Feb 22	***
Discharge & Delays	**10**	Jan 22 to June 23	*
Long Length of stay patients	**11**	June 23 CDS	***
Efficiency and Productivity – Theatres	**12**	June 23	***
Responsive			
Urgent & Emergency Care	**13**	June 23	***
Ambulance handovers	**14**	June 23	***
Community Waiting List and 2hr Rapid Response	**15**	WList June / RR May final / June unvalidated	***/ ***/ **
Elective Recovery	**16**	June 23	***
Diagnostics Activity and 6w Performance	**17 - 18**	June 23	***
RTT	**19**	June 23	***
Cancer	**20 – 23**	May / June (indicative)	**
Duty of Candour Verbal Compliance	**24**	June 23	***
Complaints	**25 - 26**	June 23	***
Well Led			
Sickness	**27**	June 23	***
Core Training	**28**	June 23	***
Appraisals	**29**	June 23	***
SIP and Vacancies	**30**	June 23	***
Agency and Bank Spend	**31**	June 23	***

NHS
Gateshead Health
NHS Foundation Trust

Key to Data Quality Signoff:

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

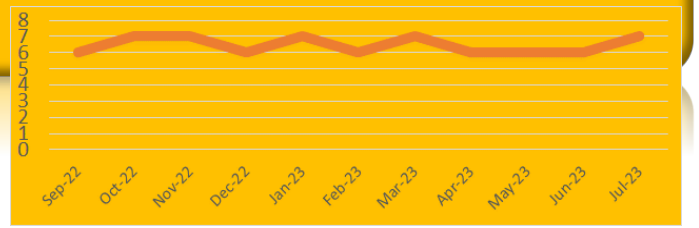
= New operating model measures

NOM

KLOE Summary: Indicators performing against target

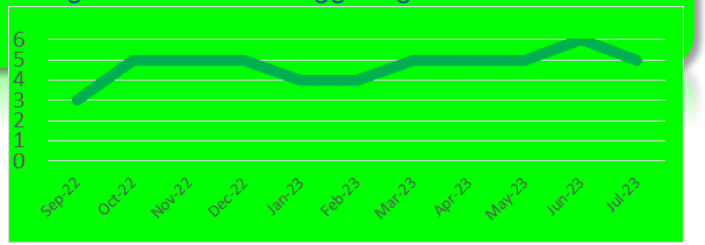
Safe
7 of 8 (88%)

applicable indicators are performing well and/or not triggering SPC or are achieving against targets



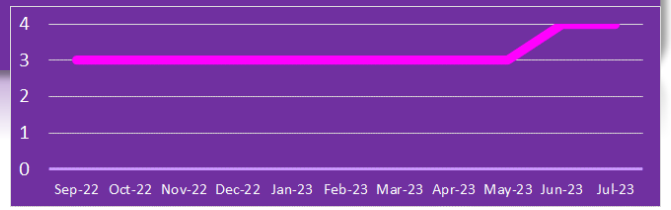
Effective
5 of 6 (83%)

applicable indicators are performing well and/or not triggering SPC or are achieving against targets



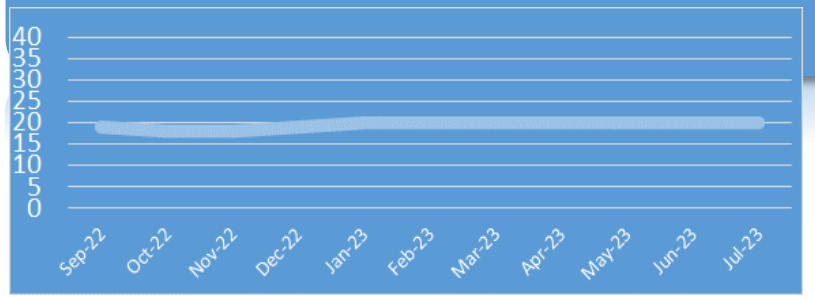
Caring
4 of 4 (100%)

applicable indicators are performing well and/or not triggering SPC or are achieving against targets



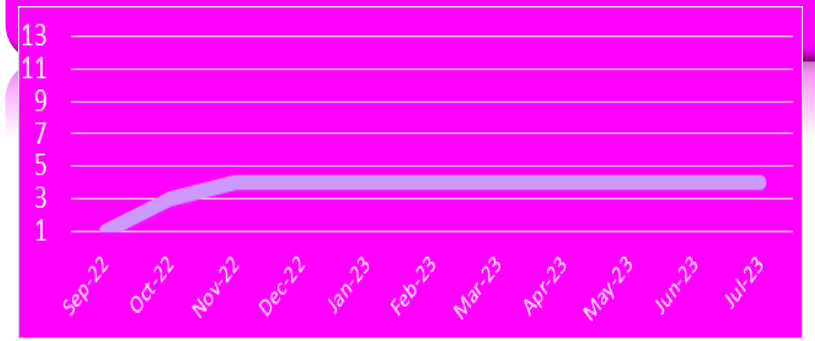
Responsive
20 of 41 (49%)

applicable indicators are performing well and/or not triggering SPC or are achieving against targets



Well Led
4 of 13 (31%)

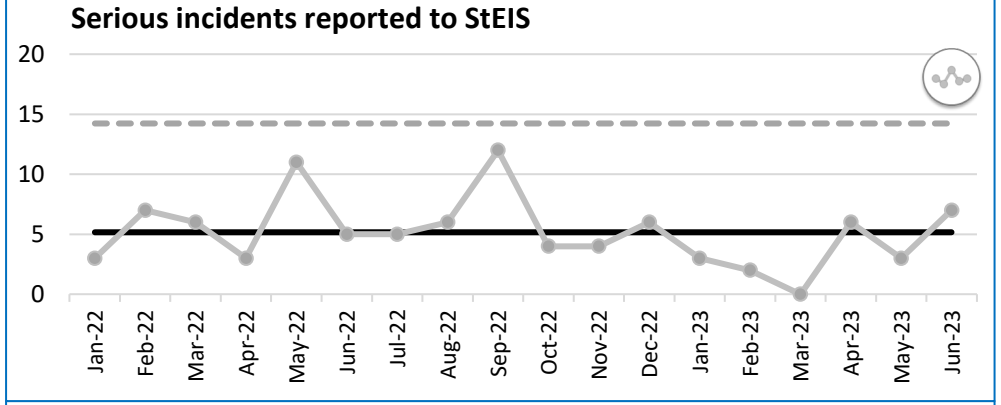
applicable indicators are performing well and/or not triggering SPC or are achieving against targets



Serious Incidents reported to StEIS and Medication errors per 1,000 FCEs

Safe

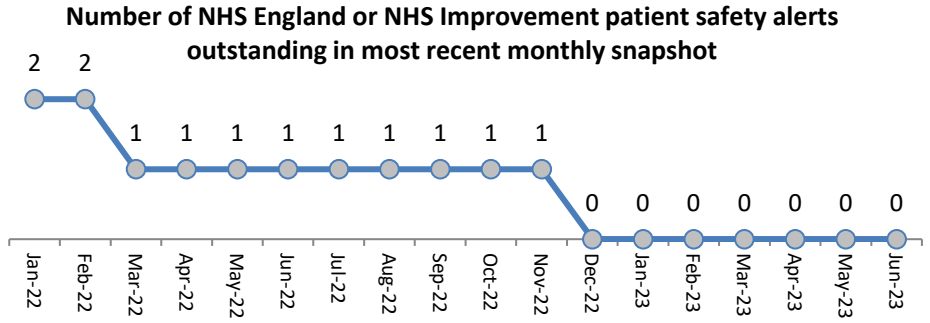
NHS Gateshead Health NHS Foundation Trust

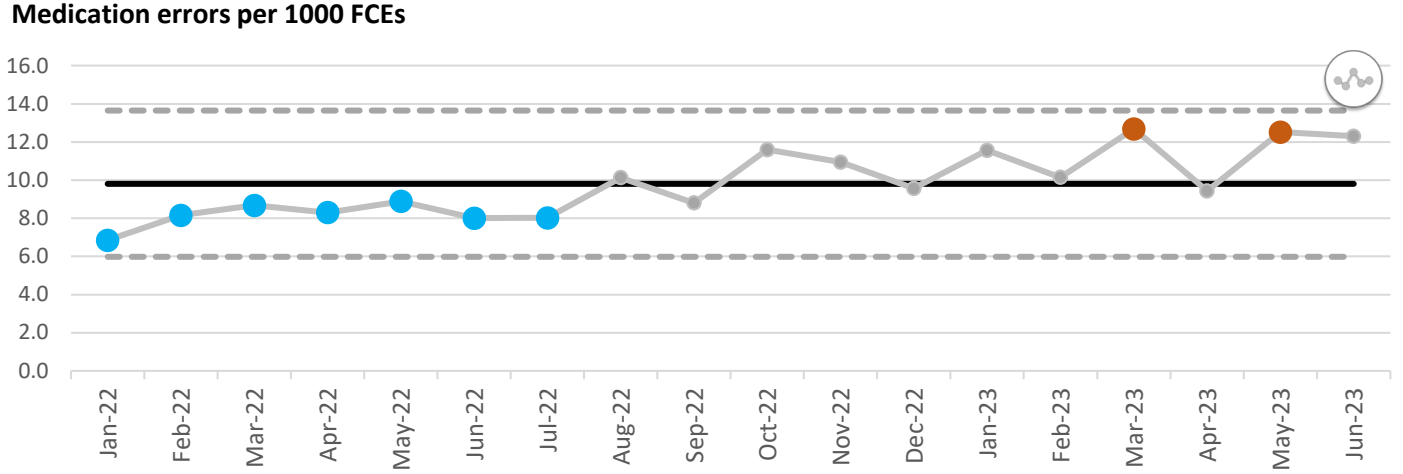


Serious Incidents reported to StEIS - There were 7 SI's declared in June 2023, all categorised as Severe harm linked to the following:

- 2 x Fall on same level - cause unknown
- 1 x Fall from height - bed
- 1 x Fall from height - chair
- 1 x Discharge - inappropriate
- 1 x Patient accident (non-fall) - Other
- 1 x Post-72 hour - C diff

National Patient Safety Alerts -There are currently no open National Patient Safety Alerts beyond the closed deadline date





Situation
Special cause variation in June 2023 with 12.3 medication events per 1000 finished consultant episodes (two of three point close to the limit).

Assessment
A shift in the medication errors rate is observed from October 2022 with most months above the 18 month mean. This increased reporting is predicted to be sustained and may increase further with the implementation of the new more accessible reporting system.

- A total of 93 medication events were observed in June
- 81 No harm, 10 low harm, 2 moderate harm, 0 severe harm.

Actions
Medication incidents are analysed quarterly by the Trust Medicines Safety Officer (MSO) for presentation and action at Medicines Governance Group. Identification of themes and action planning are outputs of this process.

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

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

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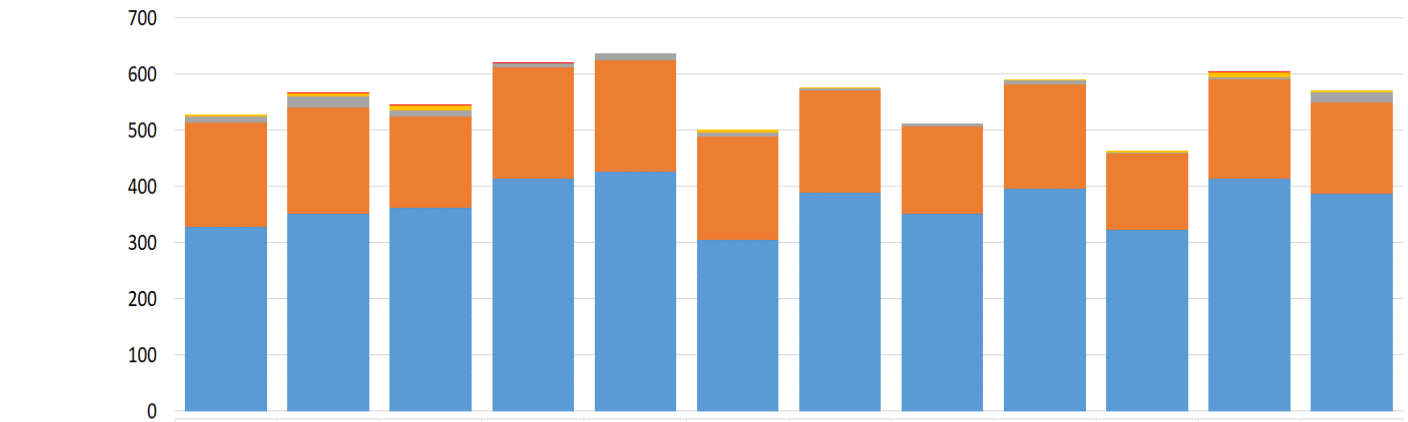
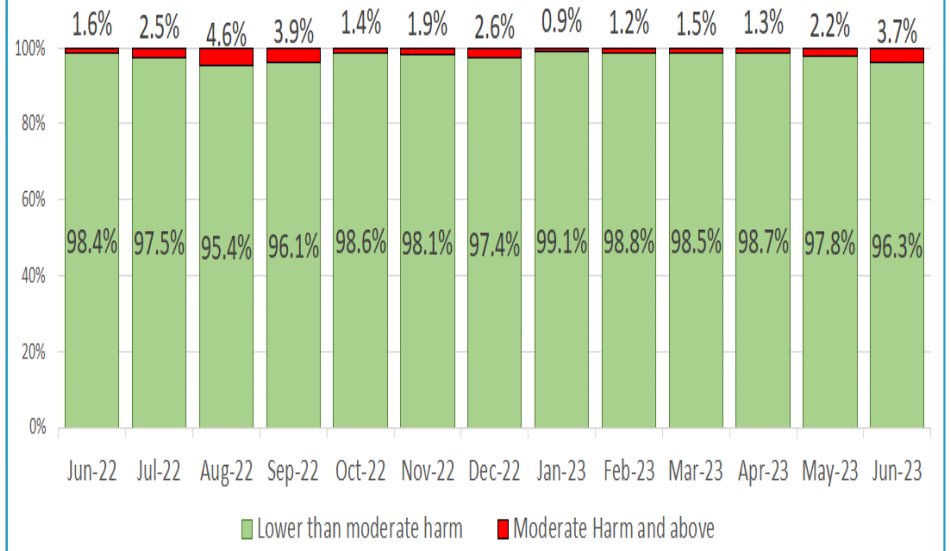


	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
Death / Catastrophic		1	1	1							1	
Severe / Major Harm	4	5	9			6	2		2	4	8	4
Moderate Harm	9	20	11	8	12	7	3	6	7	2	4	17
Low / Minor Harm	187	189	161	197	198	183	182	156	185	136	177	163
None/Negligible	328	352	363	415	427	306	390	351	397	323	414	387



Top 10 Reasons (all incidents) Jul22 to Jun23

1. Patient falls (1562)
2. Medication (944)
3. Pressure damage (645)
4. Delay / failure to treat / monitor (580)
5. Discharge or transfer issue (489)
6. Communication failure (478)
7. Violence, abuse and harassment (436)
8. Maternity / foetal / neonatal (336)
9. Equipment (165)
10. Pathology sample issues (189)

- The volume of Patient safety incident (DATIX) are provided for the rolling 12 months, by level of harm (top left).
- Over the past 12 months an average of 556 incidents have been logged each month, with monthly figures varying between 465 and 637.
- The chart shows severity continued to be consistently and predominantly recorded as 'No harm and Low harm'.
- Patient falls, Medication, and Pressure damage continue to be the top 3 incident types by volume, as they have been since this reporting began (bottom left).
- On average 2.2% of incidents each month have been recorded as moderate harm or above (top right), but months ranged from 0.9% to 4.6%. Monthly average of 12 incidents in actual numbers.
- Patient falls, Delay / failure to treat / monitor are typically the top two incident types the moderate and above group (bottom right), with Results / investigations issues, medication and discharge typically next.

Top Reasons (moderate & above) Jan23 to Jun23

1 . Patient falls (22)
2. Delay / failure to treat / monitor (9)
3. Medication (6)
4. Infection prevention & control (4)
5. Discharge or transfer issue (4)
6 . Results / investigations issues (3)
7. Maternity / foetal / neonatal (3)
8. Communication failure (3)

IPC – Healthcare Associated Infections

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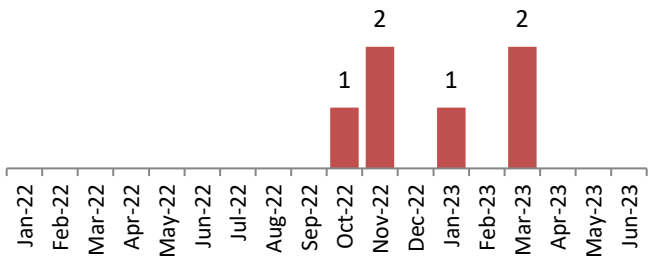
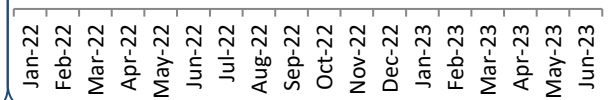
MRSA

The Trust adopts the national aspiration of a zero MRSA blood stream infections (BSI). The trust has had zero incidence of Healthcare Associated MRSA BSI in the preceding 18 months and zero community healthcare associated MRSA BSI's from April 2023 onwards.

MRSA -Community Associated



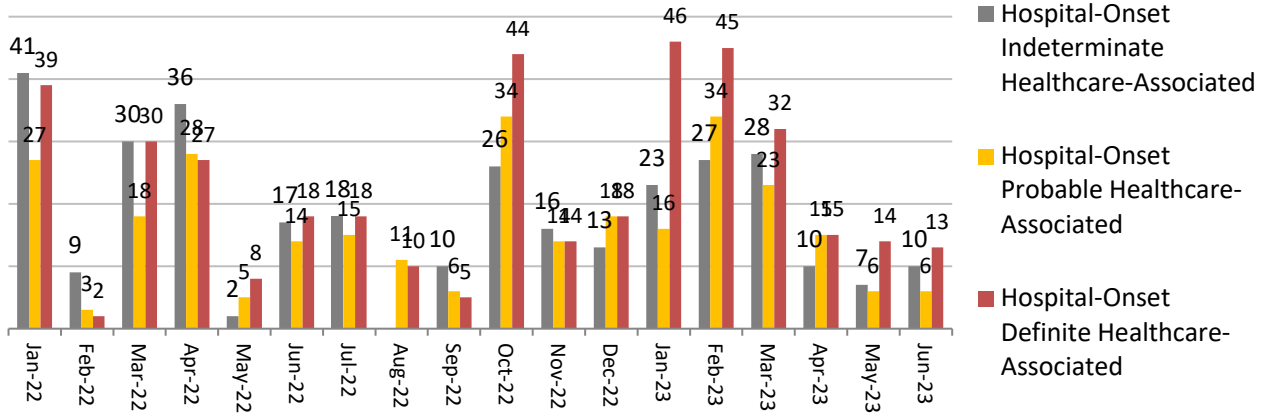
MRSA- Healthcare Associated



Nosocomial COVID 19 cases

All Healthcare associated COVID cases are reported and investigated through the DATIX system. 6 Outbreaks related to COVID were declared within the organisation in June, compared with 4 in May. The incidence of nosocomial cases in June continues to fall in line with local and national prevalence. The trust continue to operate a hybrid model to place patients if unable to isolate on their base ward in side rooms.

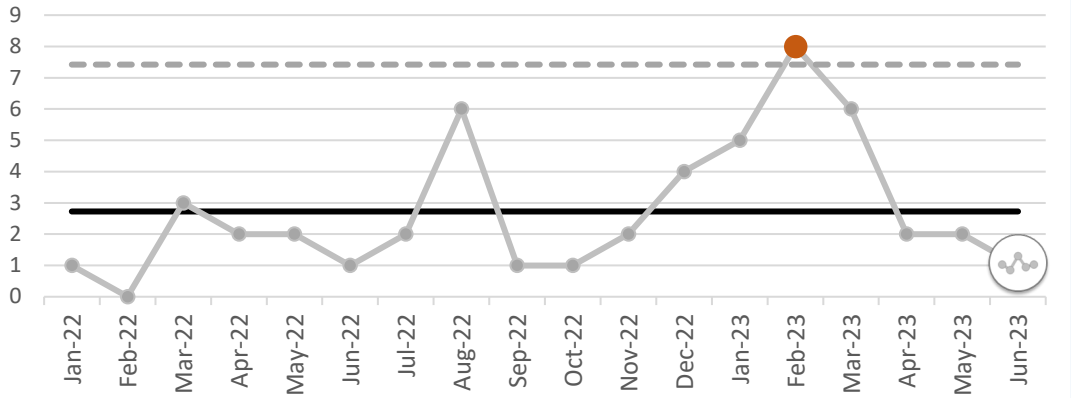
Nosocomial COVID-19



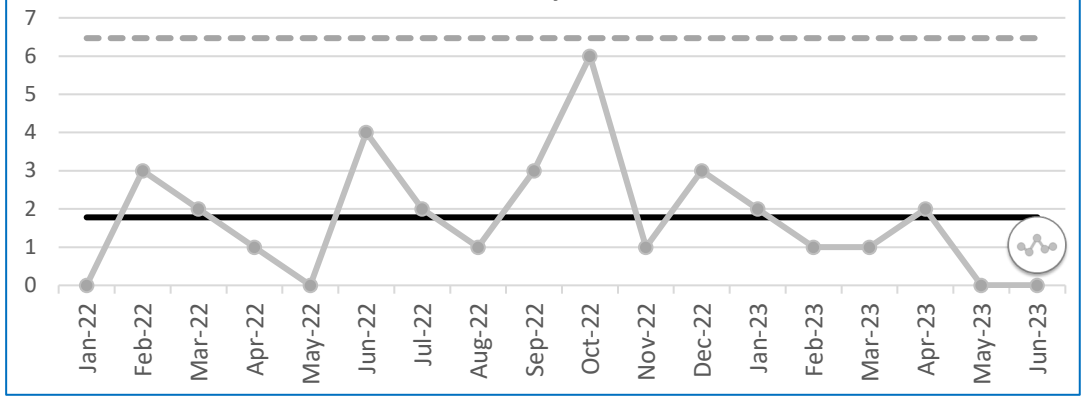
Clostridiodes Difficile Infection

- The Trust has a CDI threshold 23 for 2023/24 and has recorded 5 year to date.
- In June, the Trust reported 1 CDI, a Hospital Onset (HOHA) incident and 0 Community Onset (COCA).
- All Healthcare Associated Infections are investigated, and any learning shared with the relevant business units.

Clostridiodes difficile infection - Healthcare Associated



Clostridiodes difficile infection - Community Associated



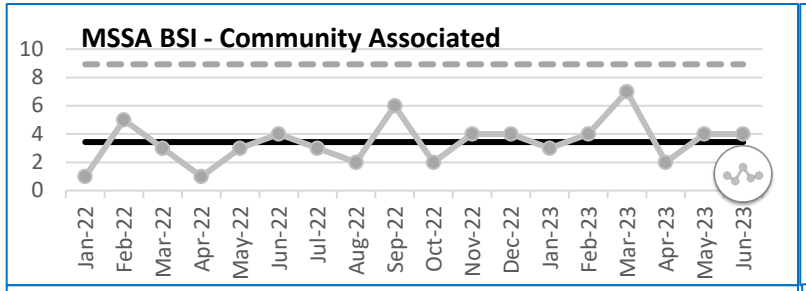
IPC – Healthcare Associated Infections

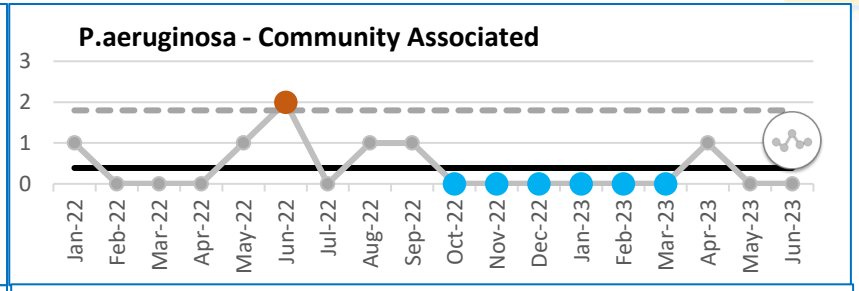
Safe

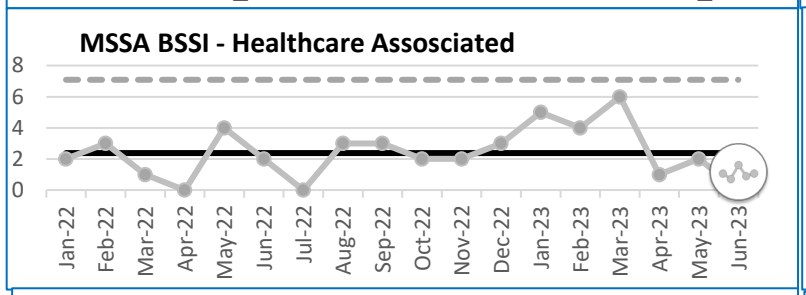
NHS Gateshead Health NHS Foundation Trust

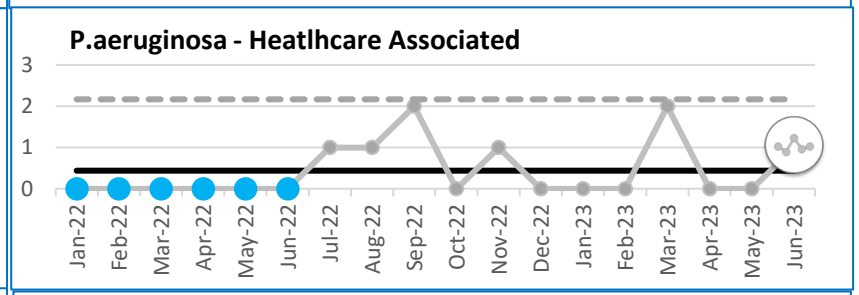
MSSA & E Coli

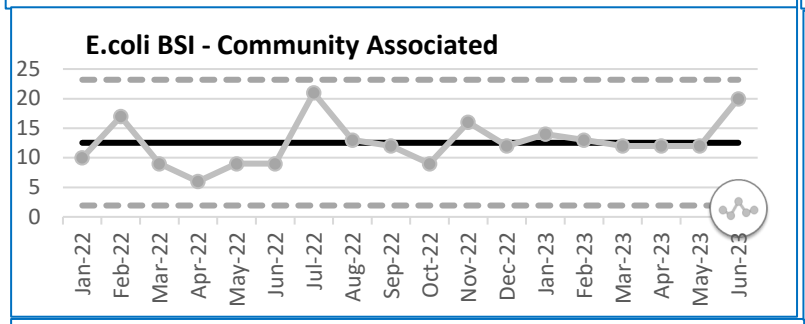
- All Healthcare associated BSI are reviewed and actions are initiated if necessary.
- NHS England has not set a Healthcare Associated MSSA BSI threshold for 2023/24
- In June the Trust has reported 0 Healthcare Associated and 4 Community Associated MSSA BSI
- The Trust has reported 12 Healthcare Associated E. coli during June 2023 – 5 HOHA's and 7 COHA's.
- It is also reported 20 Community associated (COCA's)
- The rise in E.coli BSI's could be associated with seasonal variation. The increase will continue to be monitored and investigated as required.

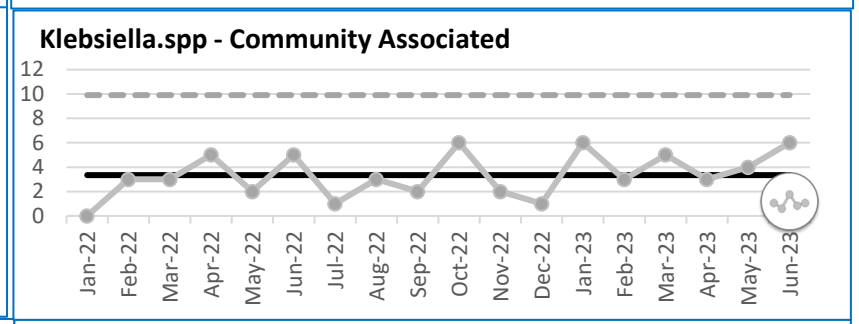


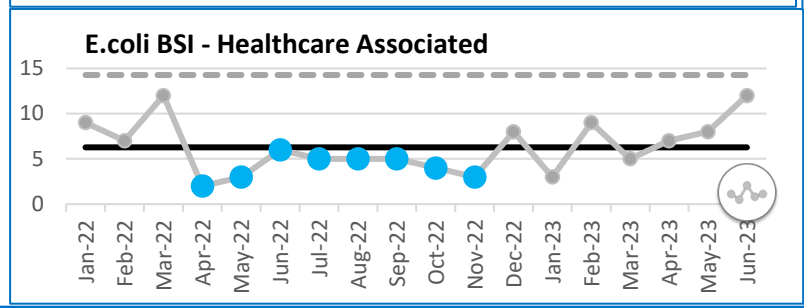


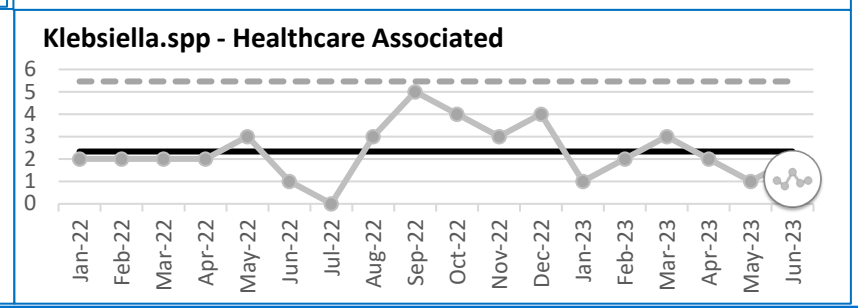












P. aeruginosa & Klebsiella spp

- All Healthcare associated BSI are reviewed, and learning are initiated, if necessary. Any BSI's are investigated and learning/themes fed back to the relevant BU's.

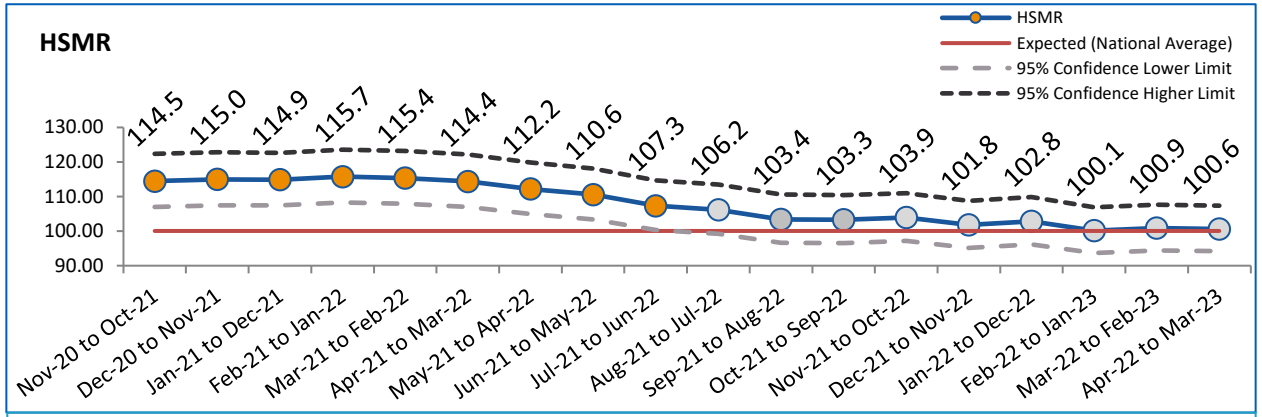
The Trust has reported:

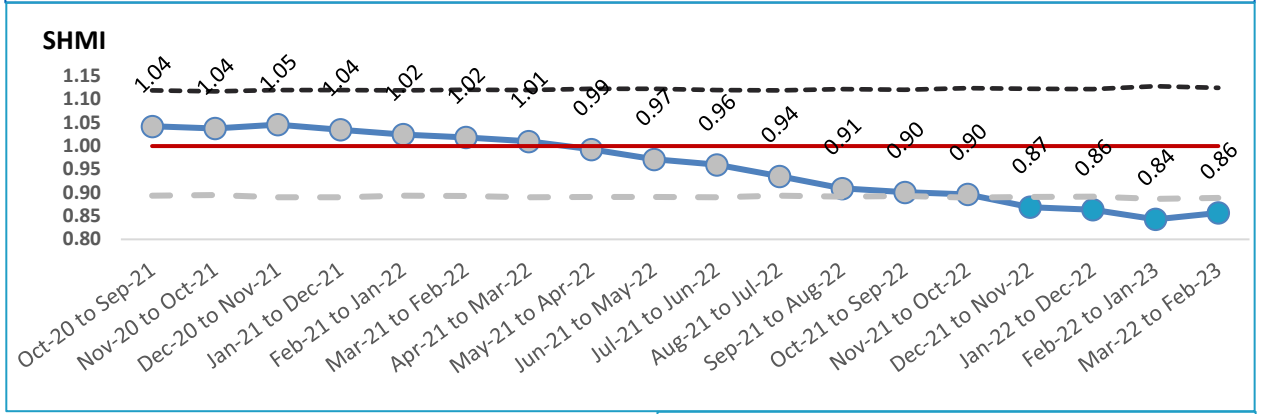
- P. aeruginosa x1 Healthcare associated BSI's
- Klebsiella spp x2 Healthcare associated and x6 Community associated BSI's in June.

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

Effective

Gateshead Health NHS Foundation Trust





Mortality Review Data Extracted 12/07/2023

Deaths 01/06/2022 to 31/05/2023

Deaths in period	Deaths reviewed by Medical Examiner		Hogan 1 - Definitely Not Preventable	NCEPOD Score 1 Good Practice
1239	1239		99.1%	95.6%
	100.0%			

Background

The HSMR and SHMI are measurement tools that consider observed hospital deaths (and deaths within 30 days of discharge for the SHMI) with 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.

Please note: SHMI remains unchanged from last month as there is a delay in the SHMI publication.

Assessment

- The HSMR is showing deaths 'As Expected' with a score of 100.6 against the national average figure of 100.
- The SHMI is showing lower than expected deaths with the latest figure of 0.86, below the national average of 1.00
- Mortality review data for the last 12 months demonstrates that 99.1% of deaths reviewed were 'Definitely not preventable' with 95.6% of cases reviewed identified as 'Good practice'.
- 72 cases in the period require a review by the Mortality Council and/or the ward-based team.

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

Actions

- The new mortality review process went live on the 10th October 2022 involving initial scrutiny and grading by the Medical Examiner's Office and subsequent referral where appropriate.
- The process for reviewing deaths were patients had a serious mental illness diagnosis. The process is embedded for those over 65, however the process to review under 65s relies on input from CNTW. The process has now been agreed with CNTW, they will review the backlog of cases and present at the Mortality Council in the next couple of months and do these when they arise going forward. To address the backlog of cases requiring Mortality Council review – 2 additional extended Mortality Councils took place in early July, 34 cases were reviewed in total.
- Outstanding surgical ward level reviews have been escalated to the SafeCare Lead and those requiring review in the Medical Business Unit are to be discussed with the Clinical Lead to agree a way forward.
- An advert to promote attendance by medical staff at the Mortality Council will feature in the staff newsletter week commencing 17th July and also the MD bulletin, this will hopefully decrease the occasions when the meeting cannot go ahead due to lack of representation.

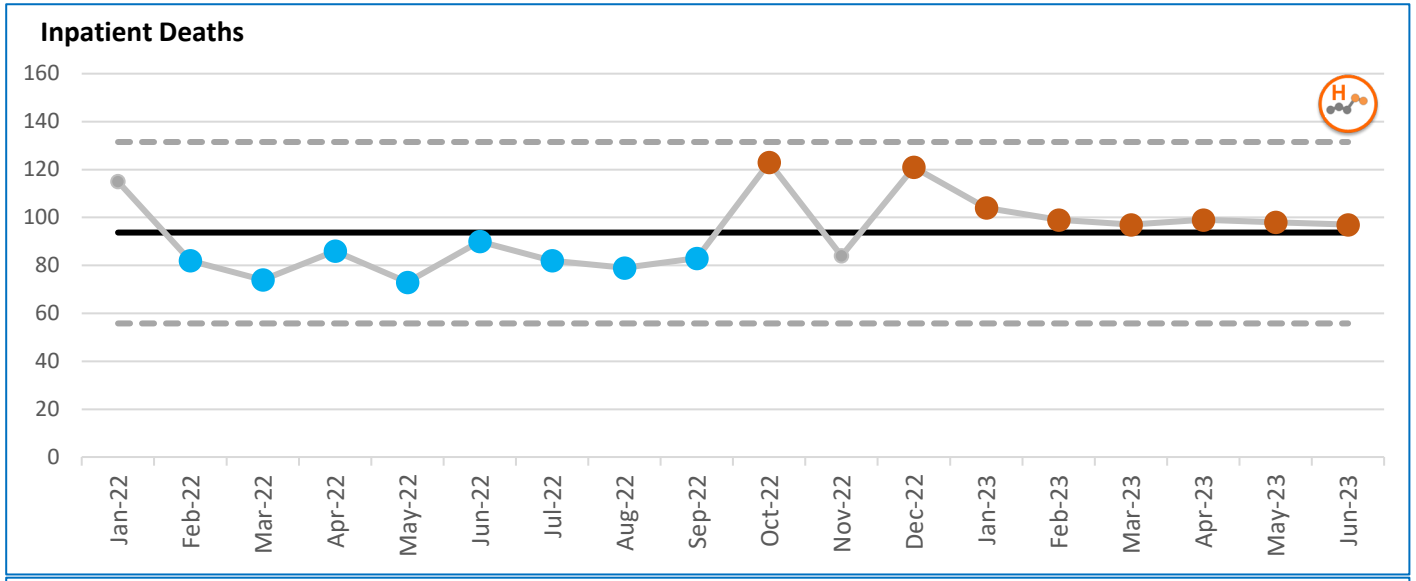
Recommendation - Continue to inform & note actions undertaken at Mortality and Morbidity steering group and Quality Governance Committee via the Integrated Oversight Report and Mortality Paper.

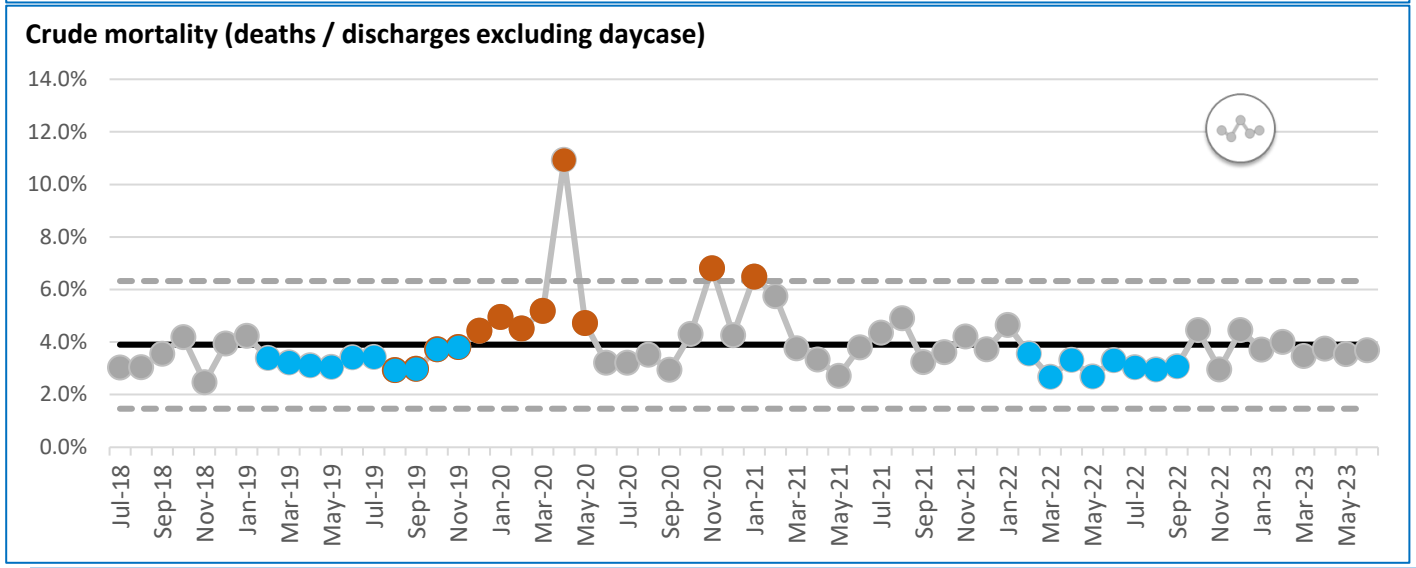
Report by exception: Inpatient Mortality

Detail on this measure is included as the number of inpatient deaths triggered special cause variation (concern) in recent months

Effective

NHS Gateshead Health NHS Foundation Trust





Background – The number of inpatient deaths is continually monitored and shared monthly at the Trusts Mortality and Morbidity Steering group. The number of inpatient deaths triggered special cause variation from December 2022 with the most recent seven consecutive months above the 18-month average.

Assessment .

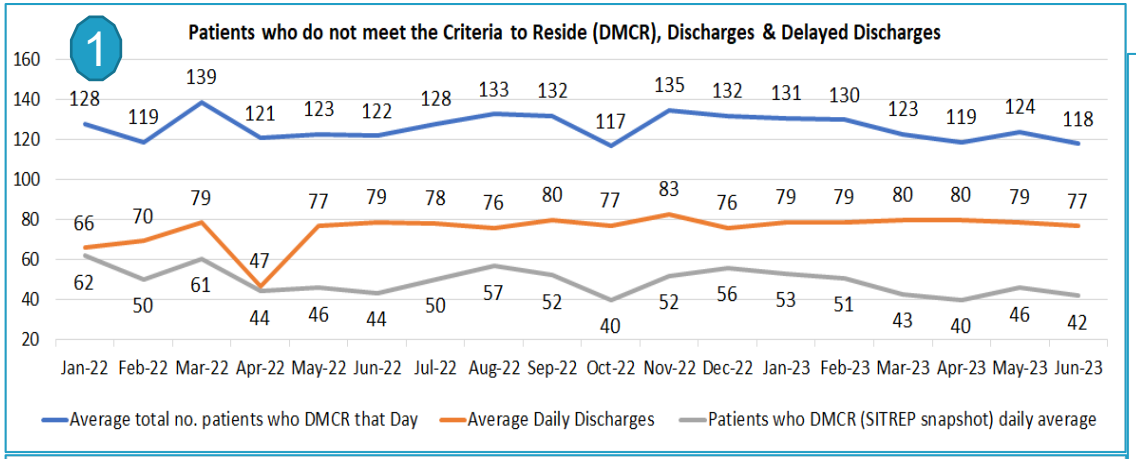
- Low volumes of inpatient deaths were identified between February and September 2022.Inpatient deaths have remained above the 18 month mean since December 2022 .
- Assessing crude mortality (deaths / discharges) and considering a longer time series also shows a low period of crude mortality February to September 2022, then displays a return to common cause variation at more typical levels.
- Supporting indicators (HSMR and SHMI) and the review of all deaths by the ME service and mortality review do not highlight any cause for concern over recent months (see previous page / lead indicator section).

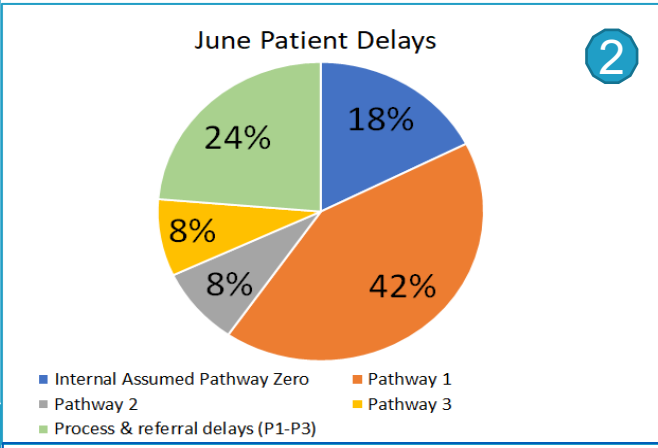
Actions

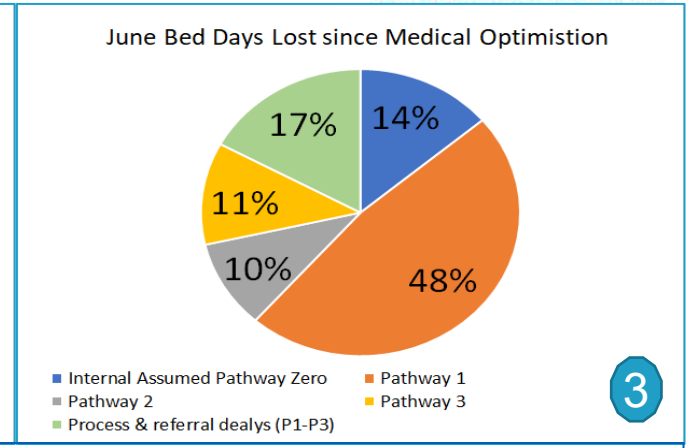
- Continue to monitor inpatient mortality.
- Present the figures and Mortality and Morbidity Steering group.

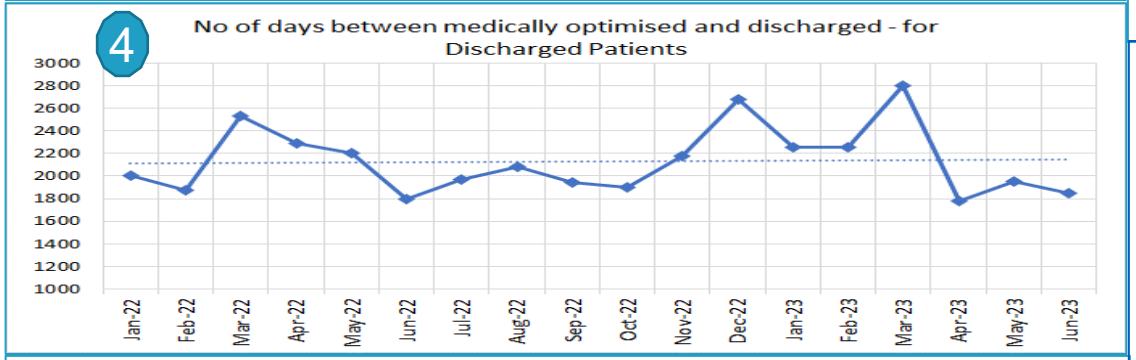
Discharge & Delays

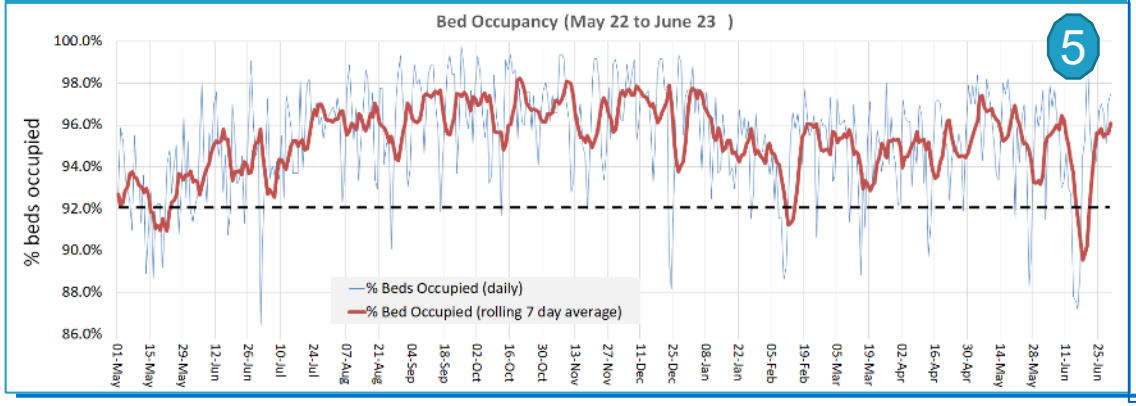
NOM











Discharge and Delay – Discharges Jan 22 to present

During the day (on average) 126 patients don't meet the criteria to reside. We discharge on average 77 of these patients per day (61%):

- 54% of the discharges occur before 5pm (circa 41 patients) (10% of these discharges occur before 12 noon (4 of the 41 patients)
- 46% of the discharges occur after 5pm (36 patients)
- 39% of the remaining patients continue to occupy a hospital bed (49)
- Figure 4 shows the total number bed days accrued since medical optimisation **for discharged patients**. Having reduced significantly in April, the figure has remained fairly stable, reducing slightly in June from May from 1952 to 1851 (-101 in actual numbers).

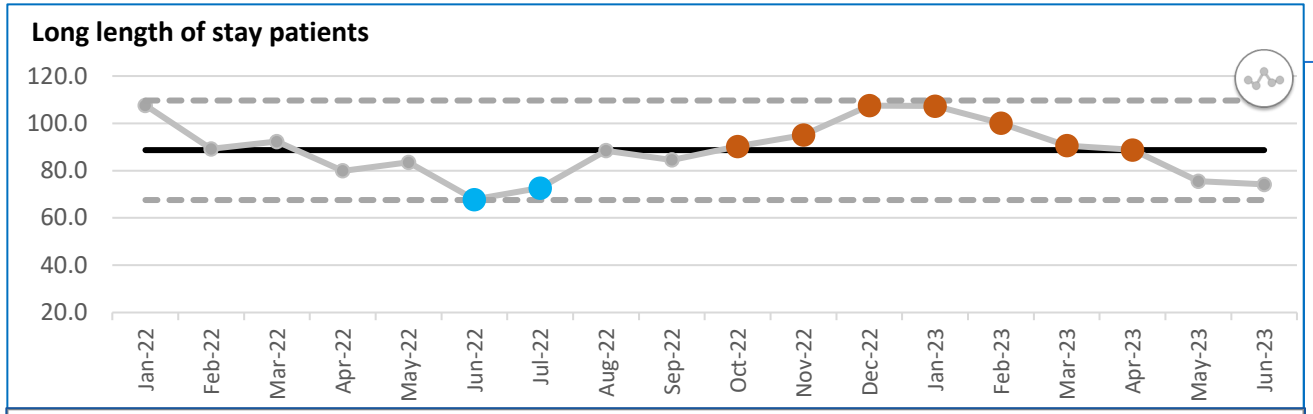
June Update:

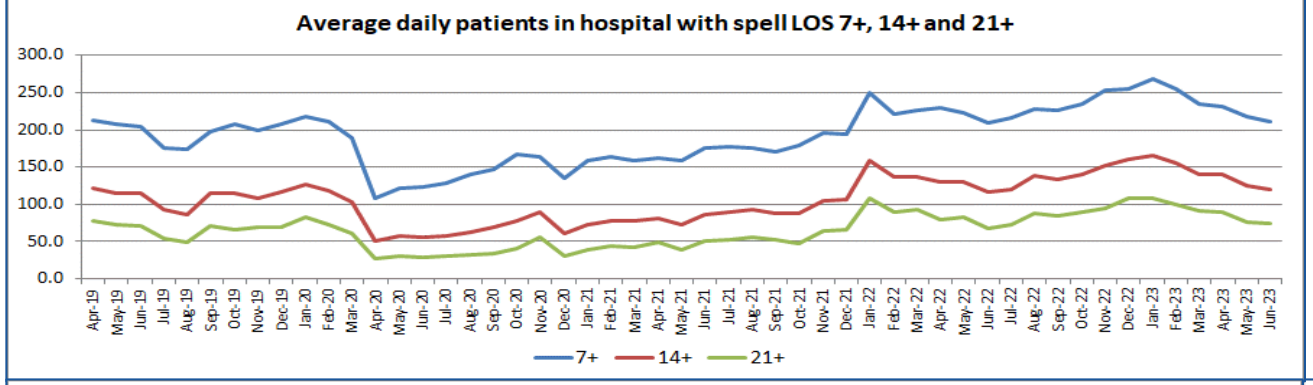
- Av. daily admissions: 91 per day (93 May) (range 61–115) / Average daily discharges: 88 per day (range 39-122) (90 May)
- CTR average daily patients – 118 per day, fall from 124 in May and 12.5% lower than November high of 135
- CTR average discharges - 77 per day (79 May)
- 60% of discharges occur before 5pm (58% May)
- Figures 2 & 3 demonstrate in June that Pathways 1-3 accounted for 58% of the patients and 69% bed day delays, Internal assumed pathways zero and process and referral delays account for 42% of the patients and 31% of the bed days delayed.
- Average daily number of patients who no longer meet the criteria to reside reduced in June to 41, which remains well below the December high of 56. Out of area patients continue to account for variable proportions of our Hub discharges (Sunderland and Durham).
- Trust has the highest bed occupancy levels in ICS since June 22. June bed occupancy average 94.4% a reduction from 95.6% in May (ICS average 89.0% June). Bed occupancy remains consistently well above 92% threshold, using 7 day rolling average basis, however mid June the chart shows a sustained period when occupancy was below the 92% level for the first time since February.

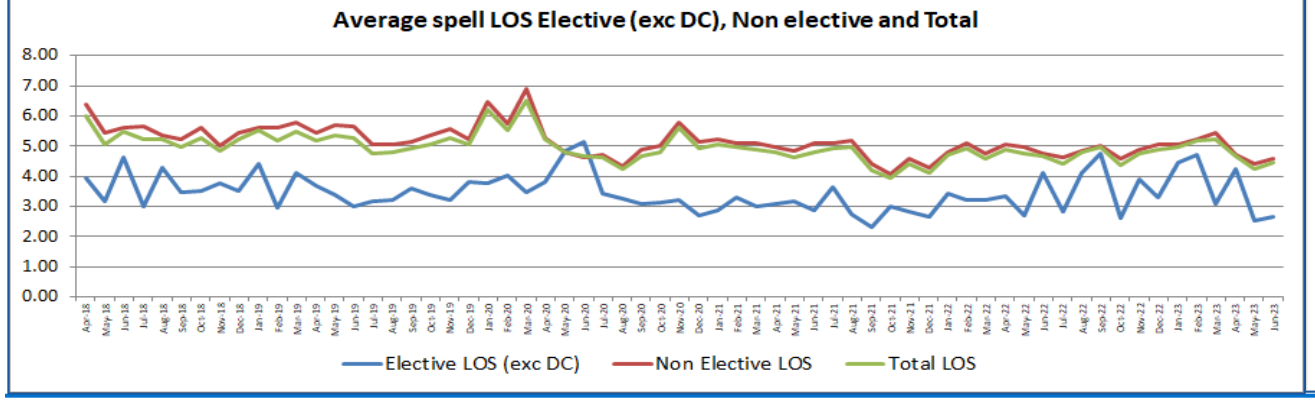
Report by exception: Long Length of Stay Patients

Effective

Gateshead Health NHS Foundation Trust







Situation

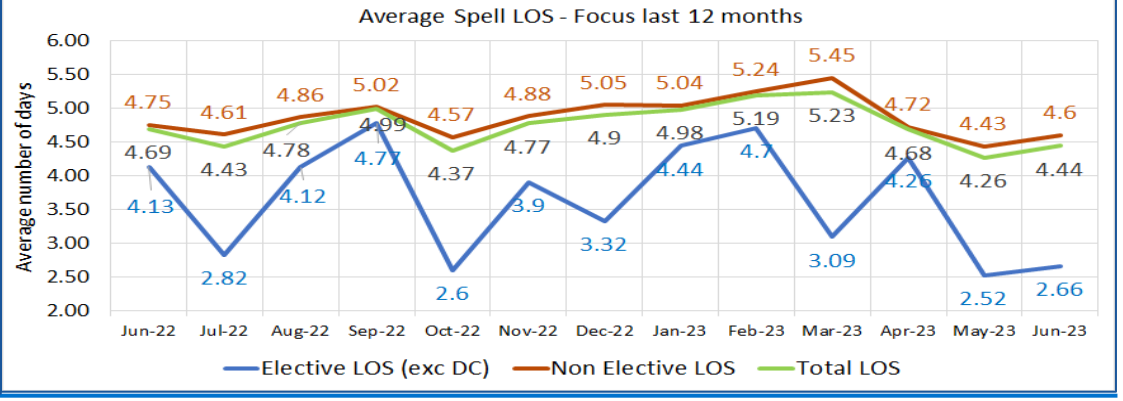
- The average number of patients in hospital with 21+ days LOS is currently showing common cause variation. An increase since June 2022 was observed but in the current calendar year 2023 this has improved.

Background

- An expectation that the daily average number of patients staying 21+ days would not exceed 59. The ECIST existing target of 59 is subject to either pass or fail based on common cause variation.
- The number of LLOS patients again decreased further to 74.2 in June from 75.5 in May. This is the 6th month in a row that has seen a reduction, following the peak in December.
- The number of patients in the hospital with spells of more than 7+, 14+ and 21+ days have continued to reduce, each month since January, and again in June
- In June there was a daily average 210.7 patients in the hospital with a spell of 7+ days, a 7.40% reduction from 218.1 in May
- A daily average of 120.2 patients in the hospital with a spell of 14+ days, a 3.93% reduction from 124.2 in May
- A daily average of 74.2 patients in the hospital with a spell of 21+ days, a 1.38% reduction from 75.5 in May
- Trust monthly data shows average length of stay of elective patients (excluding day cases) fluctuates each month, having fell sharply in May to 2.52, rose slightly to 2.66.
- Both total LOS and non-elective also rose slightly this month, having reduced for the past two.
- Total LOS increased from 4.26 in May to 4.44 in June, still well below the highs of March 23
- While non elective LOS increased from 4.43 to 4.6, also well below the highs of March 23

Recommendation

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



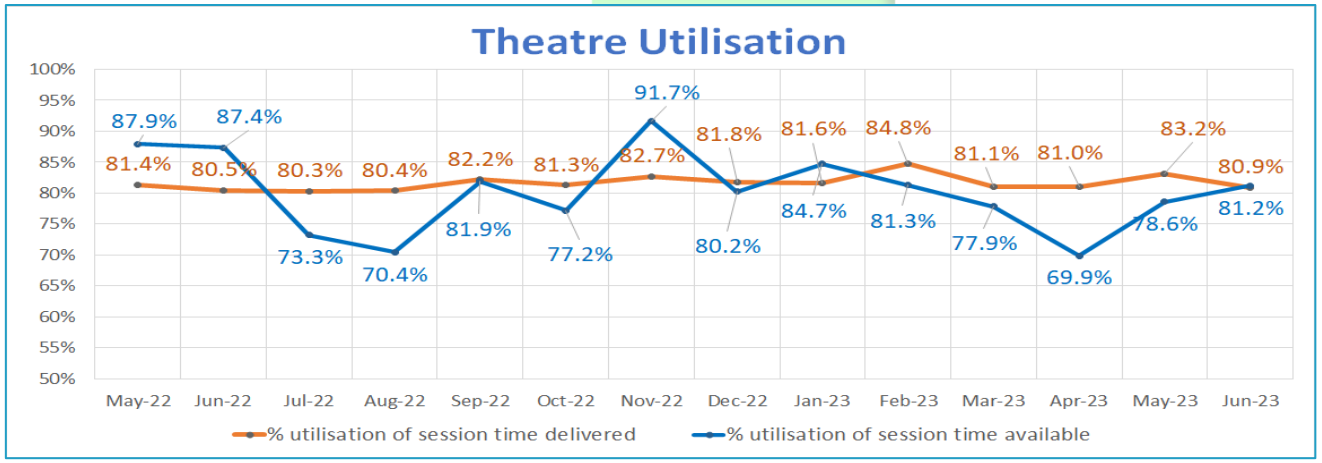
Efficiency and Productivity – Theatres

Effective

Gateshead Health NHS Foundation Trust

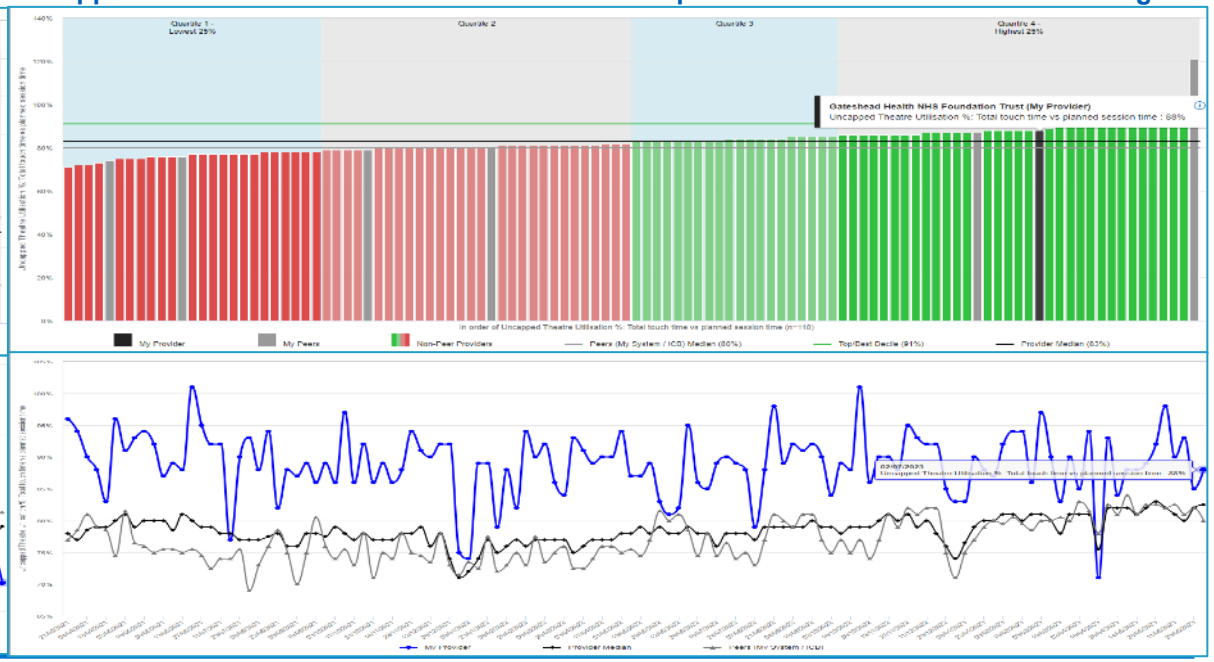
Improving theatre productivity to drive elective activity plays a crucial role in reducing our patient waiting times and eradicating our backlogs.

- Maximise our running theatre sessions > =85% with appropriate volumes of cases per list. At the end of June, the Trust continued to be below the threshold at 80.9%, a slight fall from 83.2% in May.
- Maximising the use of the theatre session time available is also an area of improvement. The chart right, now factors in funded capacity. This has changed the trend in relation to previous monthly performance outturns and show some significant shifts in performance across the year. Since a high of 91.7% in November the general overall monthly trend had been one of steady reduction. However, month on month, since April there has been an increase in performance from 69.9% in April to 81.2% in June.
- National data shows Uncapped theatre utilisation rate of 88% for touch time/planned which in line with the latest peer average (88%) and higher than the national average (83%). With Capped theatre utilisation rate of 85.7% for touch time/planned again higher then latest peer average (75.3%) and national average (77.3%).
- National data also benchmarks well in relation to additional capacity (%) including 5% on the day cancellation rate which stands at 4%, and continues to be in the best performing quartile, lower than the latest peer average (14%) and national average (12%).



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

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



UEC Measures

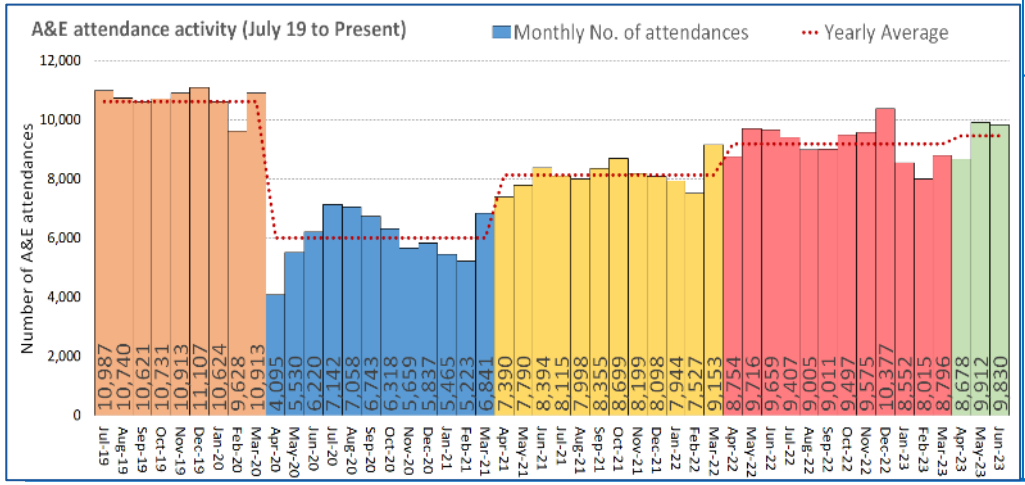
Responsive

Gateshead Health NHS Foundation Trust

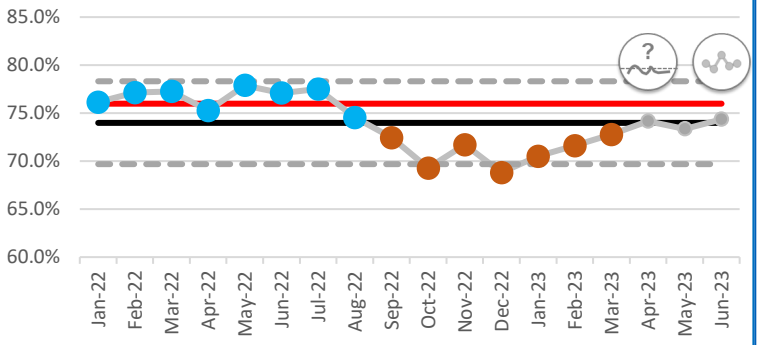
NHSI SOF Operational Performance & National Operational Standards

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

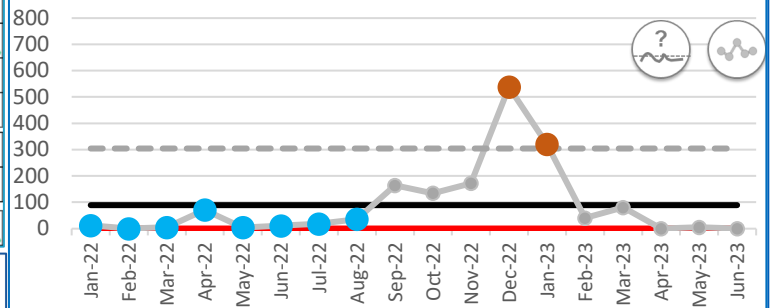
	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Monthly Trend
Attendances: Type 1	5950	5579	5796	6254	6220	7012	5500	5255	5940	5843	6499	6000	
Attendances: Type 3	3457	3427	3215	3243	3355	3365	3052	2760	2856	2835	3413	3830	
Total Attendances	9407	9006	9011	9497	9575	10377	8552	8015	8726	8678	9912	9830	
Total Breaches	2116	2292	2484	2918	2709	3237	2522	2275	2395	2243	2641	2520	
Trust Total - % seen in 4 hours	77.5%	74.6%	72.4%	69.3%	71.7%	68.8%	70.5%	71.6%	72.6%	74.2%	73.4%	74.4%	
National Rank (Accute trusts - Lower is better)	16	29	33	38	31	25	50	47	37	43	44	39	
12 hour trolley waits (DTA breaches)	18	36	164	134	172	538	320	40	80	0	5	0	
Volume in department > 12hours	213	318	703	731	738	1116	710	325	496	237	355	395	
A&E >12hour waits (target <2%)	2.26%	3.53%	7.80%	7.70%	7.71%	10.75%	8.30%	4.05%	5.68%	2.73%	3.58%	4.02%	
Peadiatric Type 1 Attendances (number)	1107	749	886	1070	1388	2030	977	946	1103	1003	1172	1014	
Peadiatric Type 1 Attendances (% of all attendances)	11.8%	8.3%	9.8%	11.3%	14.5%	19.6%	11.4%	11.8%	12.6%	11.6%	11.8%	10.3%	
Average bed occupancy	95.1%	96.0%	96.8%	96.7%	96.5%	96.6%	95.4%	94.4%	94.6%	94.9%	95.6%	94.4%	



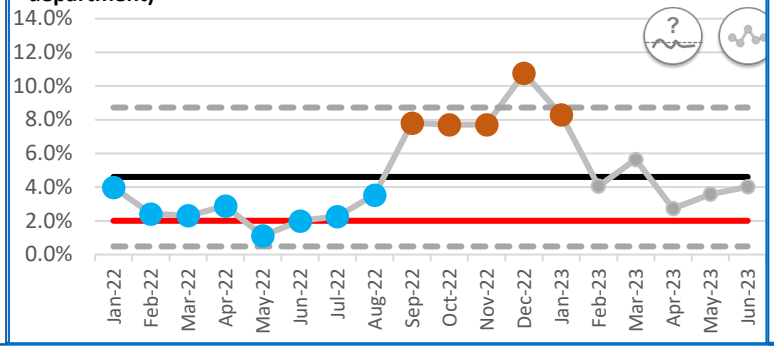
UEC 4 hour



12 hour trolley waits (from DTA to left department)



% of ED attendances > 12 hours in department (from registration to left department)



Situation

- Attendances increased in June fell very slightly to 9,830 from 9,912 in April, daily attendances averaged 6 per day more than June 2022 (representing an increase of 1.8%).
- 4hr performance was 74.4%, an increase on 73.4% in May. The Trust ranked 39th nationally in June, compared to 44th in May.
- Overall time in the department for non-admitted patients was 2 hours 47 minutes and admitted patients 7 hours 55 minutes (almost same as May)
- The target for 12 hr dept times of no more than 2% of all attendances has not been met since June 22, and increased again in June. In June the figure was 4.02% of attendances (395) were in the dept more than 12 hours.
- There were 0 12 hr DTAs in June, a fall from 5 in May. 2 of the 3 months of the year so far there have been 0 DTAs, at a time when attendances are high.
- Bed occupancy levels fell to 94.4% in June, an reduction 95.6% in May, with a daily peak of 99.3% on the 20th June.
- General and Acute beds open in May averaged 432 for the month, slightly below the planned NOM beds of 434, and a significant reduction from 466 in March.

Context:

- Urgent and Emergency Care remains under pressure however, with some of the highest monthly attendance numbers since Covid. However in a number of key areas there continues to be early performance improvements.
- Challenges remain however as a result of high bed occupancy, pressures on social care discharges, IPC bed closures other challenges in the managing and placing of patients.
- The Trust was at OPEL 2 throughout the whole of April, with exception of one day. However, the ratio changed in May with 23 out of 31 days spent at OPEL3 (74%), and 16/30 days in June (53%).

UEC Measures - Ambulance Handovers

Responsive

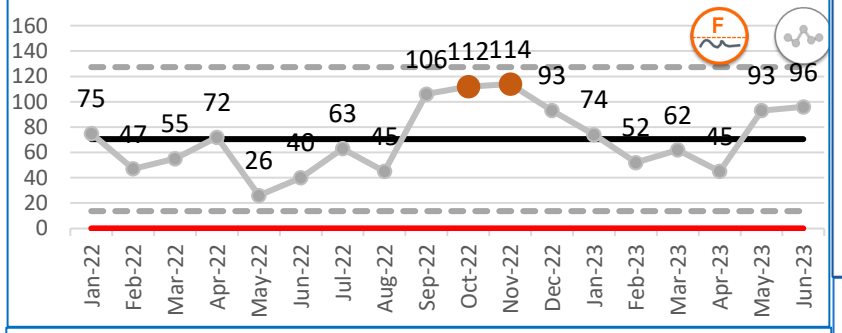
NHS Gateshead Health NHS Foundation Trust

NHSI SOF Operational Performance & National Operational Standards

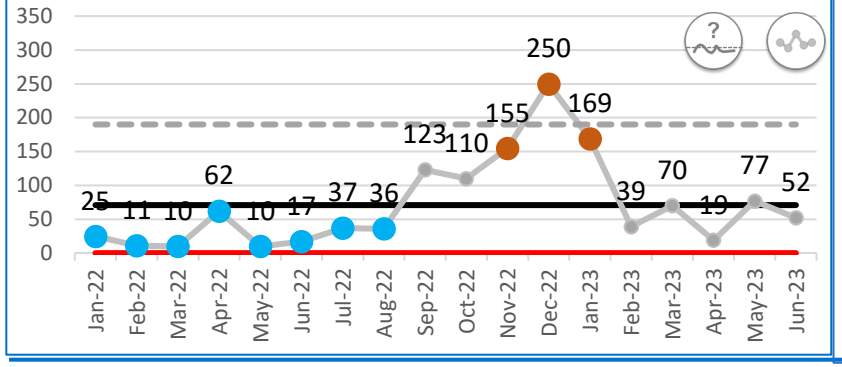
1. No. of ambulance delays
2. No. of ambulance diverts

Ambulance Arrivals and handover delays	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Monthly Trend
No. Patients arriving by Ambulance	1748	1760	1753	1708	1679	1563	1629	1597	1778	1809	1885	1821	
% of handovers <15 Minutes	42.5%	45.8%	38.2%	34.7%	33.6%	24.7%	39.5%	48.6%	48.0%	48.0%	40.3%	46.6%	
% of handovers 30-60 Minutes	95.9%	97.1%	93.0%	92.9%	92.2%	93.4%	94.9%	96.3%	95.9%	97.1%	90.5%	94.1%	

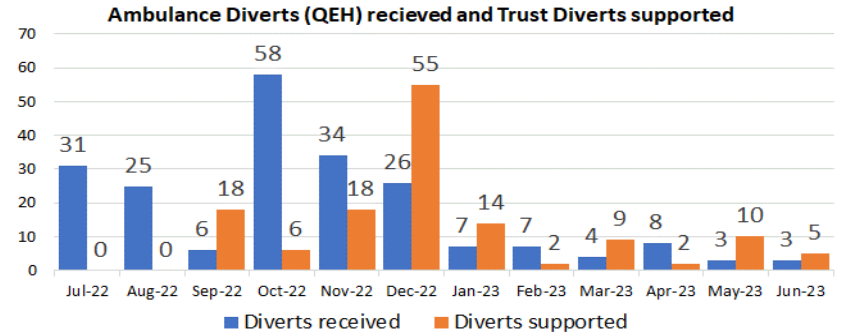
Trust – Ambulance Handovers 30-60 mins



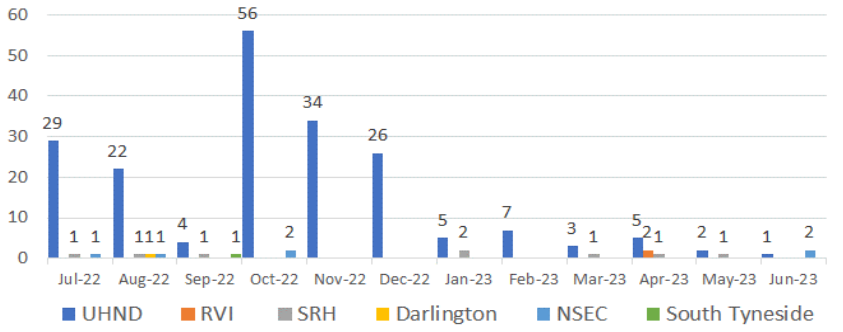
Trust – Ambulance Handovers 60 mins +



Ambulance Diverts (QEH) recieved and Trust Diverts supported



Ambulance Diverts (QEH) from originating hospital



Situation

- April to June has consistently seen some of the highest number of Ambulance attendances in the past 12 months, averaging 1838 per month, with the highest month in May at 1885. June saw 1821 attendances, the second highest in the past 12 months and only slightly fewer than May.
- In June the Trust received 3 diverts (same as May), 1 from UHND and 2 from NSEC. And the number of diverts from the Trust supported fell from 10 to 5, 1 went to UNHD, 3 to the TVI and 1 to SRH.
- 94.1% of patients arriving by ambulance waiting between 30-60 minutes for handover, just below the 95% target and an improvement from 90.5% in May.
- In June 23, there were 96 30-60 minute delays reported an and 52 60+ minutes delays, 60+ minutes was a reduction on the previous month.
- Based on NEAS handover date In June the Trust however remained the second top performing Trust in the (ICS) region for 30-60m Ambulance hand-over times and remained 5th for 60+ minute handovers.
- Work is ongoing to align Trust handover reporting in line with the NEAS approach, to ensure consistency.

NEAS Handover Data – 30-60 minutes (benchmarking)

	2019/20														
Provider	Avge	Min	Max	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
Gateshead Health NHS Foundation Trust	40	5	99	42	70	48	117	105	116	101	84	54	77	51	90	100
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	93	65	109	88	107	93	114	137	121	161	139	137	136	146	183	137
Northumbria Healthcare NHS Foundation Trust	472	283	723	442	587	556	557	484	405	426	350	288	355	273	383	441
South Tees Hospitals NHS Foundation Trust	138	105	184	348	282	413	452	339	319	187	383	368	387	429	386	387
North Tees & Hartlepool NHS Foundation Trust	64	42	116	122	69	105	87	152	134	160	139	54	55	112	87	71
County Durham & Darlington NHS Foundation Trust	313	165	438	342	374	367	368	394	373	285	225	170	237	171	151	179
South Tyneside and Sunderland NHS Foundation Trust	313	208	471	493	400	462	422	520	468	459	413	267	375	335	380	348
North Cumbria University Hospitals NHS Trust	405	265	559	201	207	297	303	316	320	381	271	111	216	172	126	135
NENC	1836	1308	2612	2078	2096	2341	2420	2447	2256	2160	2004	1449	1838	1689	1786	1798

NEAS Handover – 60 minutes + (benchmarking)

	2019/20														
Provider	Avge	Min	Max	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
Gateshead Health NHS Foundation Trust	21	0	81	18	44	41	125	132	174	279	170	49	62	20	77	53
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	2	0	6	4	3	3	1	10	8	12	9	7	13	8	10	7
Northumbria Healthcare NHS Foundation Trust	79	24	206	87	110	102	125	171	123	236	90	20	72	27	50	102
South Tees Hospitals NHS Foundation Trust	47	10	117	232	210	200	246	289	278	328	174	202	276	206	174	223
North Tees & Hartlepool NHS Foundation Trust	6	1	18	23	11	30	23	39	40	118	96	4	7	22	10	14
County Durham & Darlington NHS Foundation Trust	178	32	404	273	347	373	425	449	410	526	278	60	83	42	28	36
South Tyneside and Sunderland NHS Foundation Trust	117	23	268	181	126	160	100	270	205	407	281	58	198	111	157	70
North Cumbria University Hospitals NHS Trust	72	26	117	71	100	184	228	209	238	319	165	52	115	33	73	42
NENC	522	227	1138	883	951	1093	1273	1569	1476	2225	1263	452	826	469	579	547

Community Waiting List and 2hr Rapid Response

Responsive

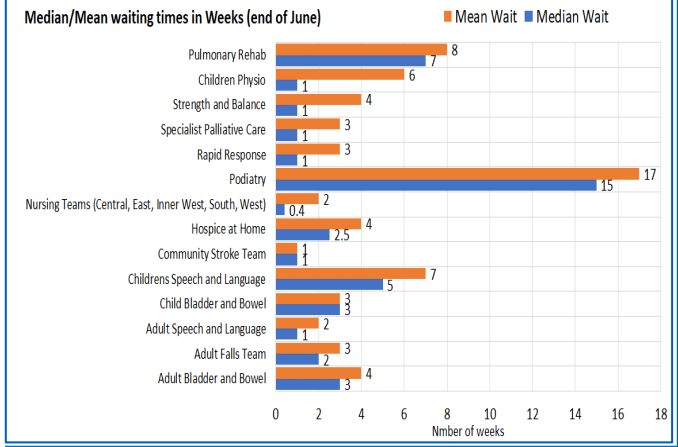
NHS Gateshead Health NHS Foundation Trust

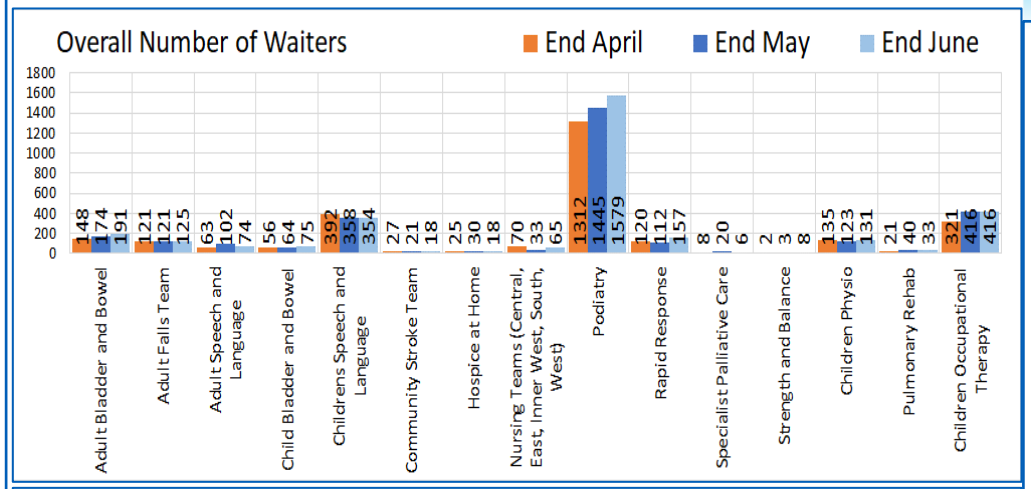
Context
Community waiting list data is now submitted as part of the monthly Community Health Services SITREP. The following data is a summary of the latest submission as the end of May 23.
Note: CYP Occupational Therapy service currently using paper based system so timescale breakdown unavailable at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

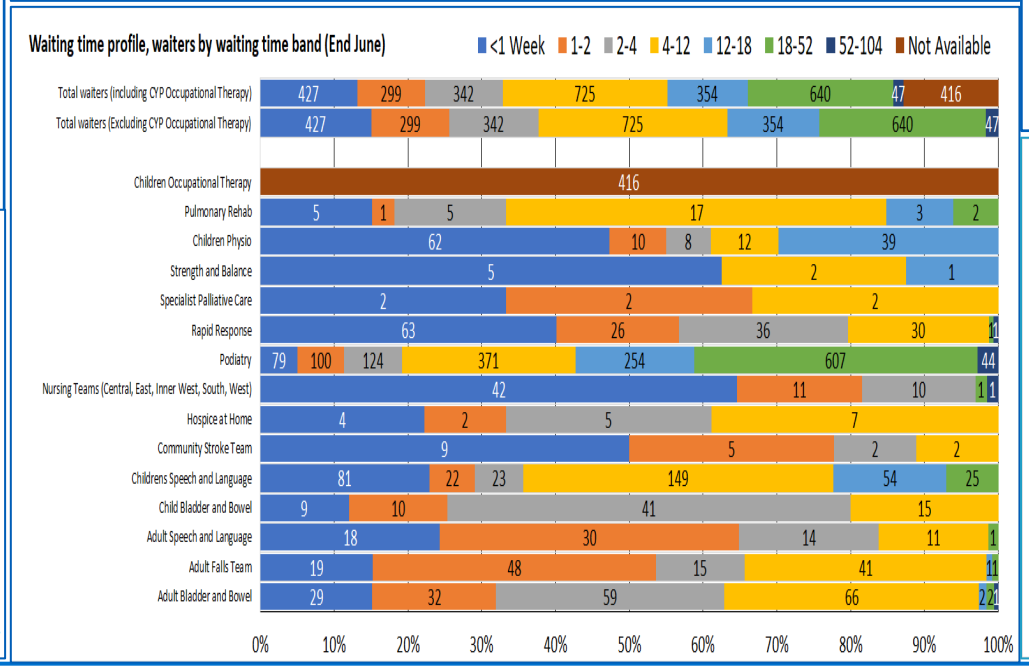
Key points

- At the end of June there were 3250 patients awaiting assessment, which is an increase of 15% since April.
- 48.6% of these patients are on the waiting list for Podiatry, followed by 12.8% for Children's OT and 10.9% for Childrens Speech and Language (chart to the right). The number of podiatry waiters has increased by 267 or 20% since April.
- The longest average waits are seen in Podiatry where waiting times are between 15 to 17 weeks, based on mean and median weeks.
- Of the total waiting lists (excluding Children's OT) (chart middle bottom), 75.8% of patients waited less than 18 weeks for assessment, 22.6% waited between 18-52 weeks, and 1.7% (47 patients) waited between 52-104 weeks; of which, 44 were waiting within the Podiatry service.

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

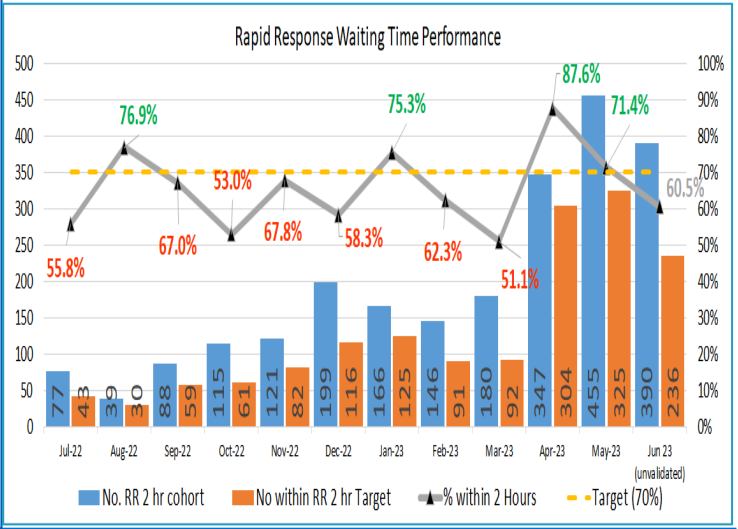






Background
Following a revision to guidance in April 23, work has been undertaken within the Community Business Unit to ensure additional activity which the services undertake, including new activity that now fits the criteria for the performance measure, is being captured appropriately in order to be reported and reflect all levels of activity being undertaken within the service. The impact can be seen in Aprils validated data.

Rapid Response
Latest validated month for May shows the Rapid Response team responded to 455 two-hour Urgent Community Responses (UCRs), of which 325 were seen within 2 hours, exceeding the 70% target at 71.4% for the second month in a row. Cumulatively since April, the service stands at 78.4% validated performance. **Indicative** (currently being validated) performance for June, shown below should be treated with caution as work is ongoing to ensure all activity and performance is being captured.



Elective Care Activity & Recovery

Responsive

NHS Gateshead Health NHS Foundation Trust

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

Elective Activity - % of planned for levels 23/24 achieved	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Year To Date
Total - Comined Elective Activity (>100%)	99.1%	99.5%	113.4%				103.7%
Daycase (>100%)	85.9%	100.6%	119.4%				101.4%
Elective Overnights (>100%)	79.1%	75.4%	71.1%				75.0%
Outpatient - New (>100%)	86.0%	98.1%	103.1%				91.9%
Outpatient - Followup (Less than <100%)	107.6%	102.6%	121.3%				109.9%
Total Outpatient	101.2%	99.7%	113.3%				98.0%

June activity is above planed levels with **Combined elective activity of 113.4%** planned activity:

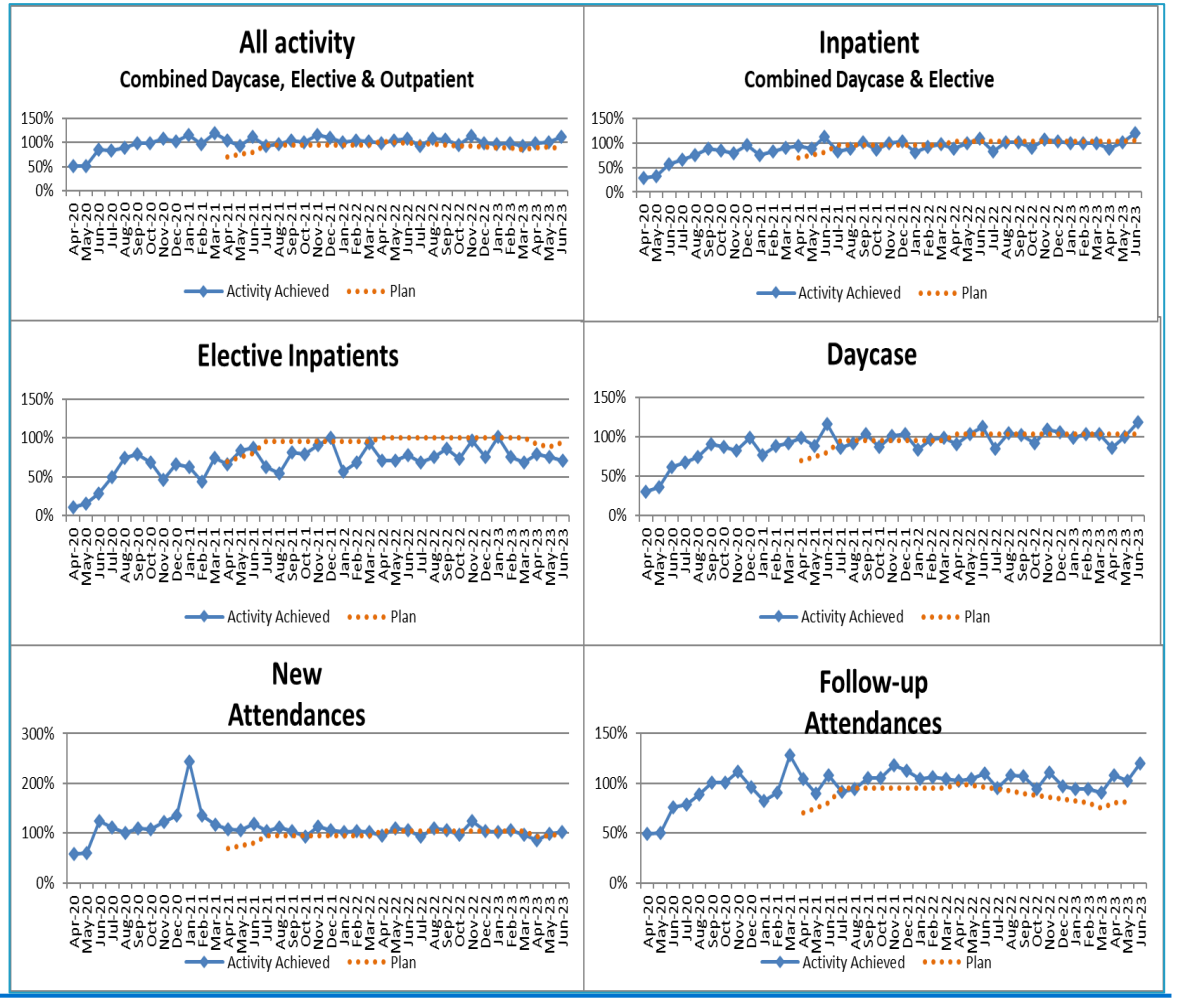
- Day cases was 119.4%
- Elective inpatients 71.1%%
- New Outpatients 103.1%
- FU Outpatients 121.3%

NOM

A combined rolling cumulative year to date figure is now included in the table above so the Trust is able to identify the overall level of activity achieved as the year moves on, as well as individual in month achievement. Day case activity in May and June exceeding planned for levels each month means year to date we are also above planned for levels. Overall, Trust Activity this year is also now above planned for levels, this however has largely been driven by above planned for levels of daycase, but also follow-up outpatient activity which is planned to reduce, but this is not the case so far. Follow-up outpatient volumes have exceeded planned for levels in each of the first 3 months of the year.

Other key requirements in June:

- The Trust is reporting 23.56% of all outpatient attendances conducted remotely, which is slightly below the 25% expectation but consistent with other months.
- 3.58% of all OP appointments recorded as Patient Initiated Follow-Up, or 4.9% of follow-up appointments – which is slightly below planned levels of 5.0% but continues to benchmark well regionally



Activity & Recovery - Diagnostic

Responsive

NHS Gateshead Health NHS Foundation Trust

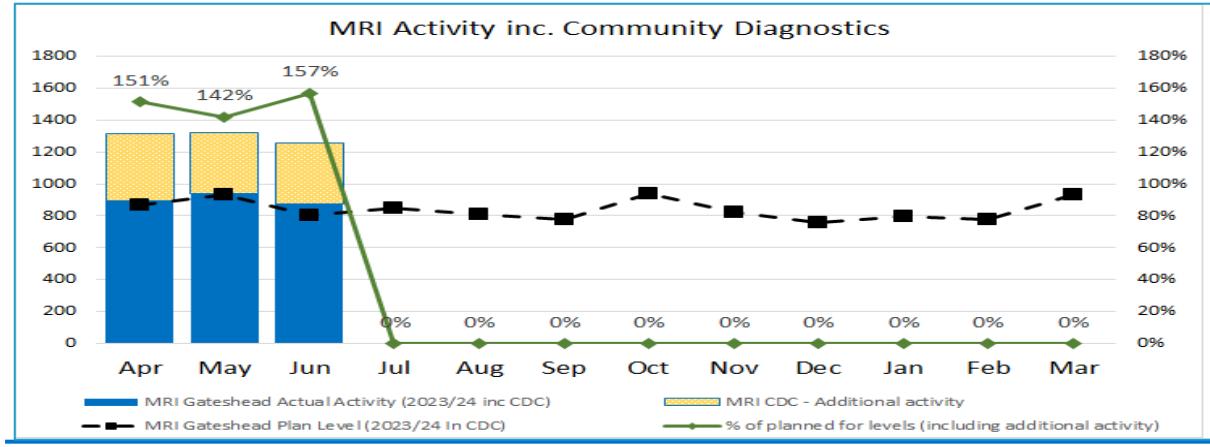
The below data tracks performance against planned for levels of diagnostic activity in 2023/24 as part of the Trusts Operational Plan. For each metric the target is to achieve 100% or higher, this would mean planned for levels of activity have been met or exceeded. The table provides in month figures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

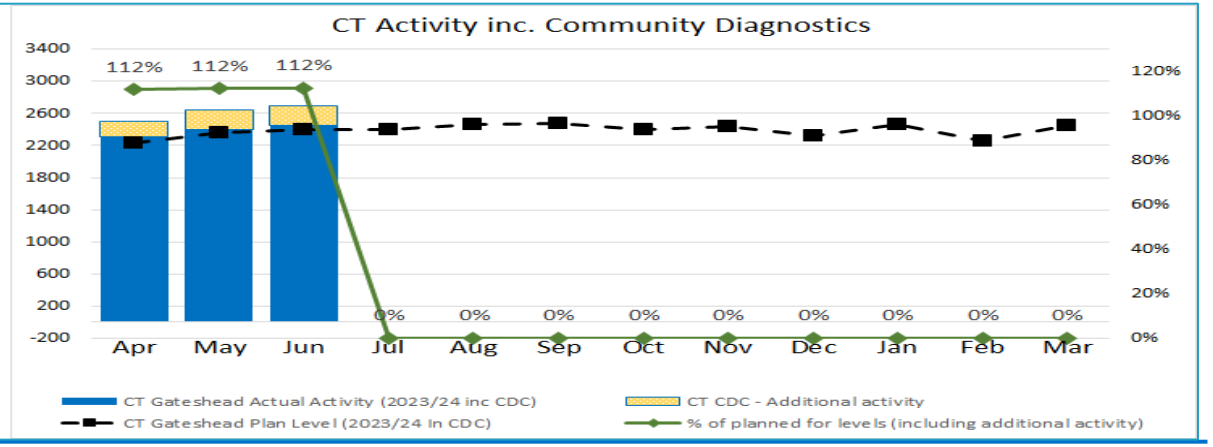
Diagnostic Activity - % of planned for levels 23/24 achieved	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Year to date
Total (>100%)	95.4%	96.1%	105.3%				98.8%
MRI (>100%)	103.0%	101.4%	109.2%				104.3%
CT (>100%)	103.5%	101.7%	102.3%				102.5%
Colonoscopy (>100%)	86.7%	121.0%	128.7%				112.1%
Non Obs Ultrasound (>100%)	90.2%	86.3%	99.4%				91.9%
Flexi Sigmoidoscopy (>100%)	65.6%	108.2%	85.2%				84.7%
Gastroscopy (>100%)	72.7%	104.6%	124.7%				99.9%
Echo (>100%)	99.4%	96.4%	125.5%				106.4%
Endoscopy (>100%)	77.1%	111.5%	120.1%				102.5%

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

In June the overall level of diagnostic activity delivered against plan for levels was above target for the first time this year, achieving 105.3% of planned for activity, an increase from 96.1% in May. Year to date the figure stands at 98.8% of overall planned for activity achieved. Both MRI and CT continue to achieve and exceeded their planned for levels of activity in all months. In June when adding on non-Gateshead activity the percentages of activity delivered including CDC were 157% for MRI and 112% for CT.

Having been below planned for levels in April, activity related to Colonoscopy and Gastroscopy both exceeded levels in May and June. Resulting in Colonoscopy being above planned for levels now also, year to date. The combined endoscopy tests achieved 120.1% of planned for levels of activity in May and 102.5% year to date. Echo activity increased sharply in in June to 125.5% of planned for levels in June, resulting in current year to date levels being achieved standing at 99.9%. NOUS is the only test consistently below planned for levels of activity.





Maximum 6-week wait for diagnostic procedures

Responsive

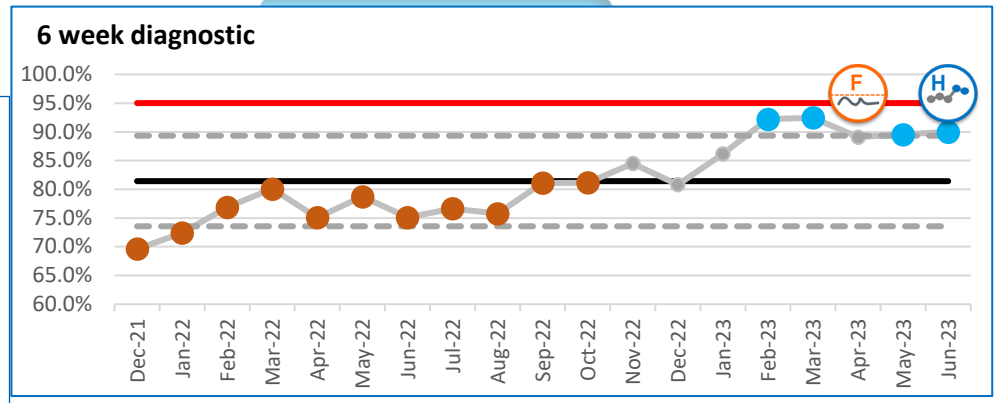
NHS Gateshead Health NHS Foundation Trust

NHSI SOF Operational Performance & National Operational Standard

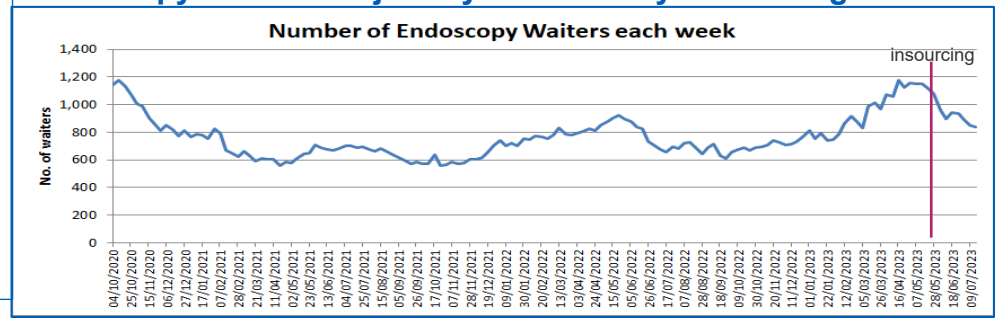
1. Number of patients waiting on a diagnostic WL at month end.
2. Number of patients waiting on a diagnostic WL at month end waiting greater than 6 weeks
3. % patients waiting 6 weeks or more for a diagnostic test at month end (target -1% moving to 5% by March 2023)
4. Number of diagnostic tests/procedures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

Trust's Diagnostic performance:

- Performance 90.0% in June, a further slight increase from 89.5% in May. Overall, Trust performance remains below 95% target.
- June's performance however continues to be above latest NENC average of 82.4% (May23) and continues to exceed the latest national average of 74.1% (May23). Numbers waiting for a diagnostic test increased from reduced from 5,739 in May to 5399 in June, with the number of patients waiting >6 weeks reducing from 600 to 540.
- The cohort of >6w waiters continues to be focussed in three main areas:
- First in Audiology, who account for 343 (63%) of the long waiters. Audiology is the single largest risk area in achieving the 95% standard for the Trust. Audiology performance fell slightly in June to 52.0% from 52.6% in May. The service have a number of challenges impacting on performance including staffing challenges and are currently developing a recovery plan as part of the weekly Performance Clinics, which is expected to be discussed on the 21st July.
- Second is Echocardiology which had seen significant improvement over the past few months, achieving its recovery trajectory in April. In May performance fell from 90.6% to 86.4%, and long waiters increased to 97. However, June has seen signs of improvement with long waiter numbers reducing to 74 and performance improving to 87.3%. Echo activity has also increased in June, being above planned for levels the first time this year. The Service has taken steps to mitigate challenges in performance, including reviewing use of current estates and utilisation of slots. Early indications in June are this is making a positive impact, however the recovery trajectory to achieve the 95% target is currently under revision as part of the weekly performance clinics.
- The other area being the 4 tests that are part of Endoscopy (Colonoscopy, Flexi Sig, Gastroscopy and Cystoscopy). Pressures around endoscopy capacity were noted in April and resulted in additional outsourced activity being sought to address the pressures, for 4 weekends, which started at the end of May, focussing on Colonoscopy, Flexi Sig, Gastroscopy. While this made an impact, it was acknowledged that further insourcing was required, which commenced at the start of July and will run to the end of August. The 5th Endo room is also now operational providing additional capacity and flexibility. As a result, the number of endo waiters has continued to reduce (middle graphic) and overall long waiters in this cohort reduced from 144 at the end of May, to 101 at the end of June. Additional insourcing for cystoscopy is also now being explored.



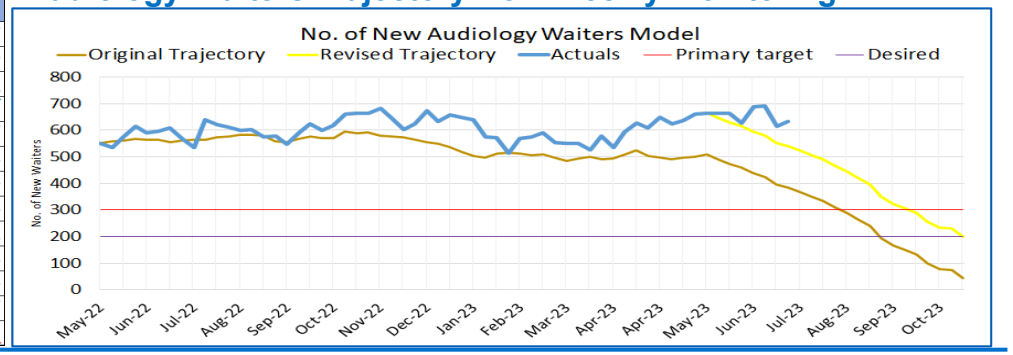
Endoscopy Waiters Trajectory from weekly monitoring:



95 % Standard

Diagnostic waiters <6 weeks	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Trend
Trust Total (95%)	76.6%	75.8%	81.1%	81.2%	84.5%	80.8%	86.2%	92.2%	92.5%	89.1%	89.5%	90.0%	
Barium Enema (95%)	100.0%	96.6%	97.6%	100.0%	100.0%	100.0%	97.8%	100.0%	100.0%	100.0%	100.0%	98.6%	
CT (95%)	99.6%	99.5%	99.8%	99.5%	99.3%	99.0%	99.5%	99.3%	99.2%	99.4%	99.8%	99.1%	
MRI (95%)	99.2%	98.0%	98.9%	99.3%	98.4%	95.4%	97.6%	99.7%	100.0%	99.7%	100.0%	100.0%	
Non-Obstetrc Ultrasound (95%)	99.2%	98.5%	99.3%	99.3%	99.6%	99.6%	99.4%	99.4%	99.5%	99.2%	98.9%	99.5%	
Audiology (95%)	57.2%	57.6%	54.9%	48.9%	52.0%	42.3%	51.1%	65.2%	60.1%	51.4%	52.6%	52.0%	
Urodynamics (95%)	100.0%	100.0%	95.2%	96.0%	97.4%	90.7%	91.2%	100.0%	88.2%	92.6%	100.0%	94.4%	
Colonoscopy (95%)	94.8%	96.2%	96.2%	94.5%	98.2%	93.5%	96.3%	92.1%	86.8%	81.6%	85.5%	89.3%	
Flexi-Sig (95%)	100.0%	98.2%	97.5%	100.0%	98.2%	94.5%	96.4%	93.1%	92.1%	81.2%	89.1%	85.5%	
Gastroscopy (95%)	98.4%	98.2%	98.3%	96.9%	97.5%	95.6%	95.1%	98.7%	95.5%	91.0%	88.6%	92.8%	
Dexa (95%)	99.2%	98.3%	97.7%	98.0%	99.0%	98.5%	99.5%	98.2%	98.7%	97.4%	99.1%	98.4%	
Echo Cardiology (95%)	29.1%	30.1%	39.1%	42.7%	52.1%	42.5%	63.0%	85.3%	93.9%	90.6%	86.4%	87.3%	
Cystoscopy (95%)	94.2%	96.7%	97.8%	100.0%	100.0%	97.0%	93.1%	90.0%	91.3%	87.6%	87.4%	84.5%	

Audiology Waiters Trajectory from weekly monitoring:



Referral to Treatment

Responsive

NHS Gateshead Health NHS Foundation Trust

RTT Long Waiters (at month end)

Waiters at month end		Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Trend
Total Waiters	Actual	11949	12244	12430	12837	12715	12593	12753	12864	12880	13389	13381	13725	
52w waiters	Plan	35	30	30	20	15	10	5	2	0	100	90	80	
	Actual	**77**	**81**	**91**	**89**	**95**	**99**	**84**	**70**	**86**	**98**	**145**	**196**	
General Surgery	Actual	12	10	17	10	13	16	8	2	8	14	13	21	
Gynaecology	Actual	2	1	2	0	1	0	1	0	4	2	2	2	
Trauma & Orthopaedics	Actual	31	28	31	17	16	16	9	11	8	10	22	25	
Urology	Actual	0	1	1	1	1	1	1	4	2	4	9	10	
Paediatrics	Actual	13	16	17	24	32	30	42	33	45	44	70	82	
Cardiology	Actual	3	5	2	3	1	5	7	7	1	2	0	1	
Gastroenterology	Actual	1	4	4	7	3	5	1	1	1	3	1	6	
General Medicine	Actual	0	0	0	0	0	0	0	0	0	0	0	0	
Respiratory Medicine	Actual	7	3	9	13	14	16	2	2	1	0	0	0	
Rheumatology	Actual	0	0	0	0	0	0	1	0	0	0	0	0	
Other	Actual	8	13	8	14	14	10	12	10	16	19	28	49	
65 week waiters	Plan	New Monitoring Measure for 2023/24									59	52	45	
	Actual										6	4	14	
78 week waiters	Plan	0	0	0	0	0	0	0	0	0	0	0	0	
	Actual	1	1	5	2	3	2	0	0	0	0	0	0	

RTT % Within 18 weeks	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Monthly Trend
Trust (92%)	75.8%	75.1%	74.3%	73.4%	72.1%	68.7%	70.2%	70.5%	71.0%	69.9%	72.4%	70.7%	
General Surgery (92%)	75.8%	78.0%	79.8%	79.0%	78.6%	73.0%	71.7%	69.7%	68.9%	67.6%	69.6%	68.3%	
Gynaecology (92%)	80.2%	78.0%	81.7%	80.5%	78.8%	77.2%	72.8%	70.4%	72.5%	68.1%	68.4%	66.3%	
Trauma & Orthopaedics (92%)	66.2%	64.0%	63.2%	62.6%	61.7%	57.6%	58.6%	60.4%	59.3%	55.4%	57.4%	57.4%	
Urology (92%)	74.8%	75.5%	77.5%	76.2%	75.2%	69.9%	68.1%	74.5%	75.4%	70.5%	73.7%	69.4%	
Paediatrics (92%)	73.3%	69.6%	68.5%	69.1%	68.1%	67.1%	67.8%	69.0%	67.8%	65.4%	67.6%	65.7%	
Cardiology (92%)	74.5%	72.0%	69.6%	71.2%	71.6%	70.3%	73.8%	75.7%	75.2%	79.1%	82.6%	79.2%	
Gastroenterology (92%)	90.0%	88.4%	80.8%	77.2%	71.5%	67.1%	72.6%	72.1%	77.4%	79.1%	87.0%	83.2%	
General Medicine (92%)	86.2%	95.0%	76.9%	88.9%	88.9%	81.8%	91.8%	95.5%	94.2%	94.3%	90.7%	96.2%	
Geriatric Medicine (92%)	89.7%	88.6%	89.1%	86.8%	83.4%	78.2%	81.9%	84.0%	79.7%	79.5%	78.4%	76.1%	
Respiratory Medicine (92%)	65.2%	67.8%	64.4%	60.9%	66.8%	65.3%	79.4%	79.1%	76.9%	79.4%	88.5%	89.2%	
Rheumatology (92%)	81.0%	83.6%	82.6%	83.2%	78.9%	75.9%	87.4%	93.3%	91.5%	90.8%	94.2%	94.3%	
Other (92%)	71.9%	70.6%	69.2%	69.2%	67.2%	65.4%	66.8%	67.8%	68.4%	68.1%	69.4%	68.1%	

NHSI SOF Operational Performance & National Operational Standard

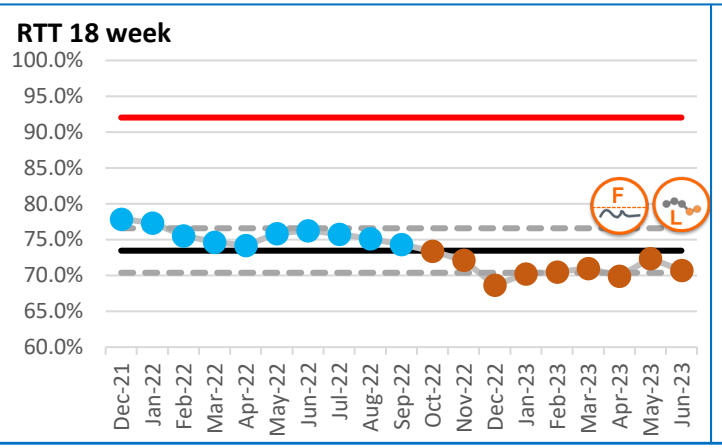
1. Number of patients waiting on an incomplete RTT pathway at month end
2. Number of patients on an incomplete pathway waiting 18 weeks or more
3. Percentage of patients waiting < 18 weeks on an incomplete pathway (target> 92%)
4. No of patients waiting longer than 52 weeks, 65 weeks and 78 weeks

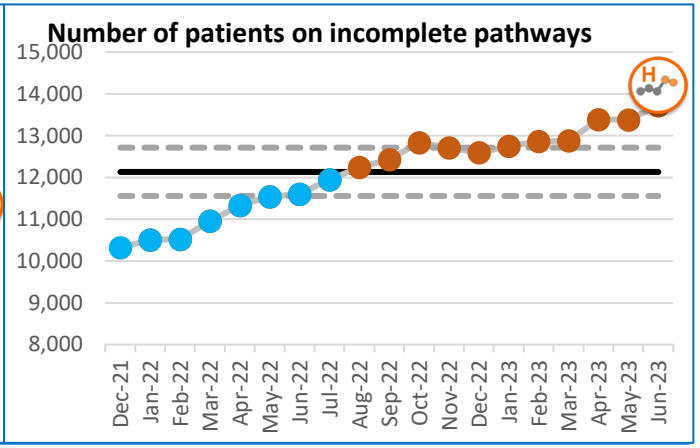
Trust's RTT performance

- June Trust performance 70.7%, an reduction from 72.4% in May - remaining below the 92% target.
- At 70.7% Trust performance exceed latest national average 59.5% (May23), and the ICB average of 70.2% (May 23)
- The Trusts total waiting list increased from 13,381 in May to 13,725 in June (increase of 344 or 2.5%).
- There continues to be 0 patients waiting more than 78 weeks in June, however the number waiting more than 65 weeks increased from 4 to 14 (this remains below planned for levels of 45 in June)
- The number patients waiting 52 weeks continued to increase as projected, and stood at 196 in June, up from 145 in May. Above planned for levels of 80 for June. The numbers in this cohort are projected to rise again in the coming months however recovery plans are being developed in the most challenged specialities (see below).
- The most challenged specialities for 52w waiters are Paediatrics and Pain, with increasing challenges noted in Trauma and Orthopaedics.

Main Risks – increasing 52w+ waiters

- **Paediatrics** – pressures continue and are increasing in Paediatric long waiters, best case projections based on current cohort indicate by the end of July there will be circa 104 over 52-week waiters, with that number reducing to 93 at the end of August. Paediatric long waiters are exclusively children aged 0-4 awaiting an autism assessment. A proposal to revisit the Pathways for these children to align them to guidance is being discussed with Commissioners in July, which would potentially change the clock stop and therefore reduce long waiters significantly.
- **Pain** –projections based on current cohort indicate by the end of July there will be circa 67 over 52-week waiters, increasing to 77 in August. However, locum capacity has been sought which commenced w/c 17/07 which will support in reducing these numbers, and new staff start in October which will provide further additional capacity, and work to address backlog. As a result, the service are revisiting the projections of their long waiters with an aim to achieve 0.
- **Trauma and Orthopaedics – P**rojections based on current cohort indicate by the end of July there will be circa 29 over 52-week waiters up from and 49 by end of August. A business case to increase capacity through the use of LLP was supported by EMT 10/07.





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

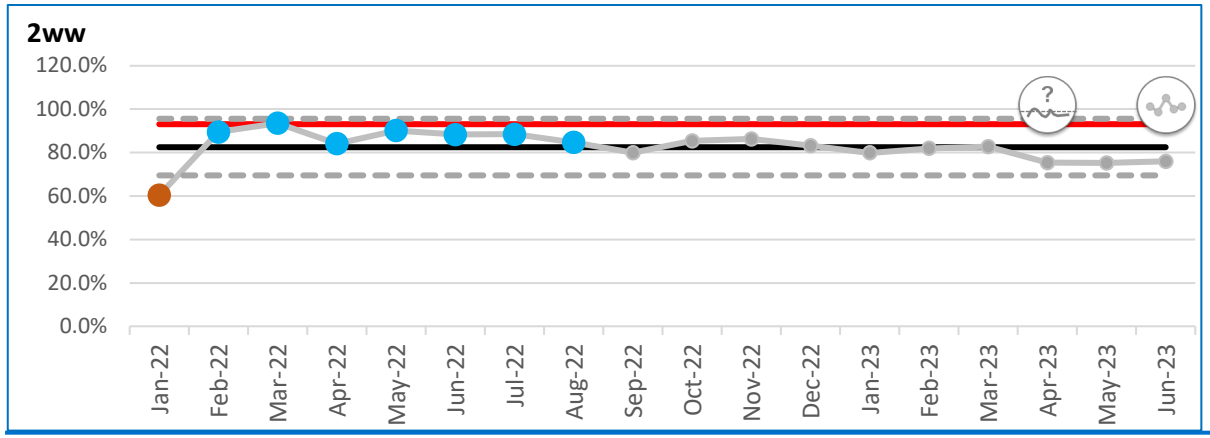
2ww performance	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Monthly Trend
Trust (93%)	89.1%	84.7%	79.9%	85.1%	86.6%	83.3%	79.8%	82.3%	82.7%	74.4%	75.1%	75.5%	
Breast (93%)	97.0%	96.8%	93.2%	93.2%	94.8%	88.0%	94.4%	96.7%	94.9%	90.3%	94.8%	96.6%	
Gynae (93%)	82.4%	86.4%	73.6%	85.9%	79.4%	93.7%	90.9%	91.1%	90.7%	70.2%	30.7%	8.0%	
Lower GI (93%)	67.6%	45.8%	36.4%	42.4%	40.2%	44.9%	37.5%	25.5%	35.6%	26.4%	35.1%	33.9%	
Testicular (93%)	100.0%	100.0%	100.0%	100.0%	100.0%	83.3%	100.0%	100.0%	100.0%	75.0%	75.0%	100.0%	
Urology (93%)	83.2%	84.4%	94.2%	93.7%	94.1%	86.5%	69.0%	86.0%	82.5%	71.4%	89.7%	90.2%	
Haematology (93%)	100.0%	92.3%	86.7%	100.0%	100.0%	100.0%	85.7%	91.7%	100.0%	75.0%	85.7%	100.0%	
Lung (93%)	77.4%	74.6%	47.2%	81.8%	88.6%	90.0%	90.8%	91.3%	79.3%	88.3%	94.0%	90.6%	
Upper GI (93%)	86.5%	84.8%	74.6%	76.3%	88.9%	85.5%	45.5%	62.0%	73.1%	45.6%	45.9%	60.1%	
												Indicative	
Symptomatic Breast (93%)	94.4%	95.0%	90.3%	100.0%	89.7%	95.7%	100.0%	100.0%	97.2%	91.2%	100.0%	97.8%	
												Indicative	

Trust's 2 week wait Cancer performance

- Trust's validated performance for May 75.1% against the 93% target
- 75.1% is below the latest England average at 80.8% (May23) and NENC average which is 85.8%, both averages increase in May compared with April
- The overall 2 week wait performance has not achieved the expected level in any month of the year so far
- Indicative performance for June stands at a fairly consistent rate of 75.5%

Tumour Update:

- Using validated final data for May only Breast, Symptomatic Breast and Lung achieved the 93% target. Both Breast and Symptomatic Breast typically achieve the target.
- This pattern has continued in the indicative figures for June. With Testicular and Haematology also achieving at present.
- There is a notable reduction in Gynae overall performance at 8.0% indicative for June, and continued pressures seen in in continuing into May and June for lower GI and Upper GI.
- Activity volumes for most tumour sites higher than 19/20 levels, with the exception of some individual months. However, no tumour site has consistent not met activity levels for longer periods recently as seen in other times of the year.



Volumes as a % of 2019/20 Activity	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
Trust (100%)	104%	141%	112%	119%	121%	113%	121%	122%	146%	111%	113%	127%
Breast (100%)	126%	141%	121%	124%	128%	113%	119%	128%	155%	118%	119%	156%
Gynae (100%)	129%	173%	163%	196%	155%	151%	134%	135%	139%	121%	126%	176%
Lower GI (100%)	60%	122%	85%	70%	83%	85%	96%	107%	153%	104%	121%	69%
Testicular (100%)	40%	138%	100%	100%	20%	150%	140%	67%	50%	160%	50%	88%
Urology (100%)	117%	163%	132%	123%	128%	150%	155%	131%	106%	94%	99%	72%
Haematology (100%)	100%	186%	136%	88%	140%	100%	100%	240%	89%	300%	78%	157%
Lung (100%)	63%	156%	89%	153%	175%	113%	224%	157%	208%	142%	144%	123%
Upper GI (100%)	84%	119%	79%	108%	103%	96%	98%	90%	120%	76%	73%	113%

Cancer Standards – 28 day Faster Diagnosis

Responsive

NHS Gateshead Health NHS Foundation Trust

Trust's 28 day Faster Diagnosis performance:

- Trust has achieved 75% target most months since June 22, but missed in the latest validated month of May at 72.2%
- Latest Trust final figure for May at 72.2% continued to exceed the latest national average 71.3% (May23) but slightly below the latest NENC average 77.8% (May23)
- In February for the first time, both the NENC and national average achieved the 75% target. However, the England average is once again below target, while the NENC remains above.
- Indicative performance for June stands at 80.9%, an improvement from May and would once again exceed national and NENC averages

Tumour Update:

- Breast and Symptomatic Breast sites exceeding the 75% target in each of the last 12 months
- Testicular and Lung noted month on month improvement between September and January, and have continued to achieve the target consistently since January
- While Trust wide performance generally achieves the standard, performance risks continue across a number specialties - Particular consistently challenged specialties Gynae, Lower GI, Urology and Upper GI

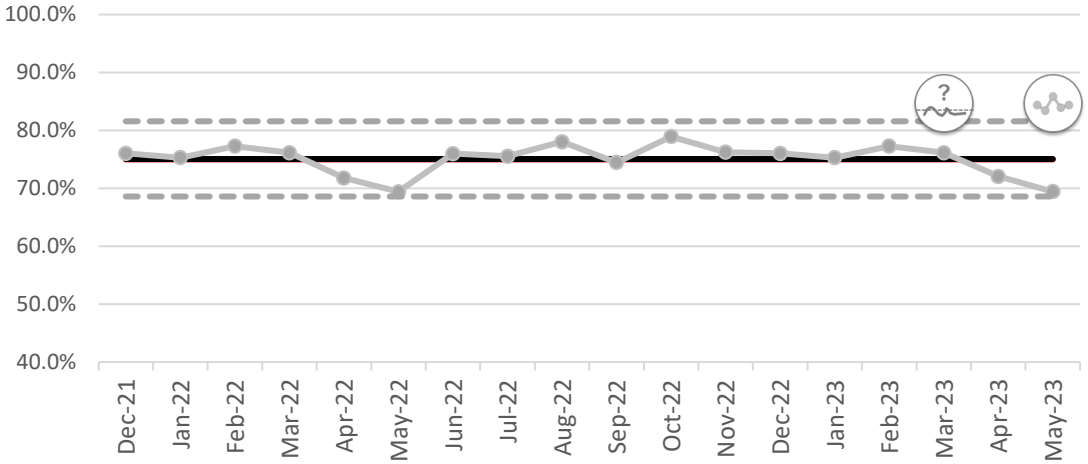
Risks

- 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	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Monthly Trend
Trust (75%)	75.7%	78.5%	74.9%	80.1%	79.0%	78.6%	75.7%	78.1%	78.5%	75.3%	72.2%	80.9%	
Breast (75%)	97.5%	97.8%	96.9%	95.4%	96.5%	98.1%	94.7%	96.6%	97.5%	97.2%	98.6%	98.3%	
Gynae (75%)	65.0%	69.7%	68.0%	61.7%	50.8%	44.6%	51.0%	49.6%	65.2%	57.1%	47.5%	57.1%	
Lower GI (75%)	44.4%	49.7%	52.3%	54.1%	51.6%	57.7%	38.1%	47.3%	34.4%	30.4%	33.6%	42.5%	
Testicular (75%)	100.0%	100.0%	66.7%	75.0%	100.0%	100.0%	100.0%	75.0%	83.3%	100.0%	75.0%	100.0%	
Urology (75%)	44.4%	50.6%	65.2%	62.4%	64.5%	66.3%	50.6%	67.6%	57.7%	33.9%	22.7%	37.7%	
Haematology (75%)	57.1%	62.5%	68.8%	28.6%	45.5%	71.4%	20.0%	66.7%	60.0%	70.0%	50.0%	66.7%	
Lung (75%)	62.1%	80.8%	53.8%	75.0%	84.1%	67.9%	80.7%	79.0%	85.7%	78.7%	82.4%	83.6%	
Upper GI (75%)	51.2%	53.8%	41.7%	55.6%	52.0%	56.4%	55.7%	54.7%	57.5%	53.8%	41.9%	64.1%	
												Indicative	
Sympt. Breast (75%)	100.0%	97.5%	100.0%	96.6%	100.0%	95.5%	100.0%	96.0%	97.2%	100.0%	100.0%	100.0%	
												Indicative	

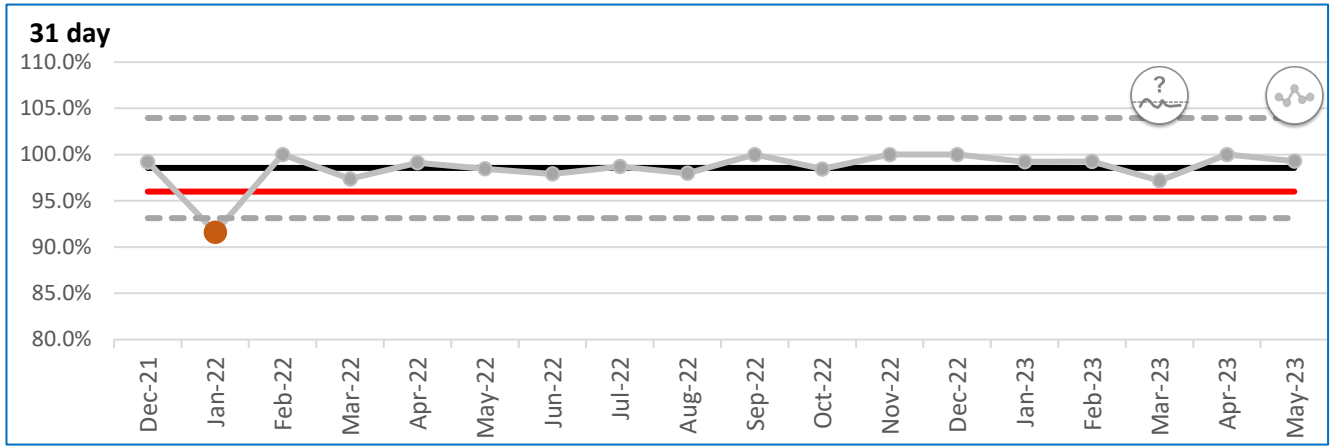
Cancer Standards - 31 Day Waits

Responsive

NHS 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%)



Trust's 31 day cancer performance:

- The Trust continues to exceed the 31-day standard for latest validated month of May
- Trust's validated performance for May stood at 99.3% with the both the Surgery subsequent treatment and Drug at 100% also
- 99.3% continues to well exceed the latest national average of 90.3% (May23) and the NENC average 93.0% (May23)
- June's indicative position is 100% overall
- Volume of 31-day activity is consistently below 19/20 baselines for some tumour sites, notably Gynae, Upper GI and haematology

Tumour Update:

- Typically, the majority of tumour sites achieve the standard each month, and in fact exceed the 96% threshold. In May all sites achieved 100% compliance, with the exception of Breast. In June to date all sites are achieving 100%.

Risks

- Capacity / shared pathways, Theatre workforce pressures

31 day performance	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Monthly Trend
Trust (96%)	98.6%	97.2%	97.5%	99.2%	100.0%	96.4%	98.3%	95.1%	97.2%	100.0%	99.3%	100.0%	
Breast (96%)	100.0%	98.6%	96.2%	100.0%	100.0%	100.0%	98.0%	100.0%	98.4%	100.0%	98.4%	100.0%	
Gynae (96%)	93.3%	95.0%	95.0%	100.0%	100.0%	100.0%	95.5%	90.0%	90.6%	100.0%	100.0%	100.0%	
Lower GI (96%)	100.0%	92.9%	100.0%	93.3%	100.0%	75.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Urology (96%)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Haematology (96%)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	50.0%	100.0%	100.0%	100.0%	100.0%	
Lung (96%)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	#DIV/0!	100.0%	100.0%	100.0%	100.0%	
Upper GI (96%)	100.0%	83.3%	100.0%	100.0%	100.0%	33.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
												Indicative	
Surgery (94%)	93.8%	100.0%	96.3%	97.1%	100.0%	100.0%	95.0%	100.0%	100.0%	100.0%	100.0%	95.5%	
Drug (98%)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	95.7%	
												Indicative	

Volumes as a % of 2019/20 Activity	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
Trust (100%)	106.9%	119.2%	100.8%	87.7%	125.4%	103.3%	95.5%	141.9%	65.2%	75.6%	107.8%	91.3%
Breast (100%)	113.7%	147.9%	89.8%	82.8%	125.9%	101.7%	100.0%	190.6%	76.7%	69.4%	126.0%	114.6%
Gynae (100%)	100.0%	78.6%	91.7%	96.3%	147.4%	133.3%	129.4%	100.0%	92.0%	52.0%	83.3%	50.0%
Lower GI (100%)	114.3%	92.3%	107.1%	94.1%	125.0%	122.2%	45.0%	88.9%	18.2%	114.3%	66.7%	30.8%
Urology (100%)	138.5%	175.0%	160.0%	200.0%	233.3%	216.7%	111.8%	166.7%	75.0%	200.0%	200.0%	183.3%
Haematology (100%)	66.7%	80.0%	71.4%	100.0%	180.0%	166.7%	80.0%	225.0%	38.0%	71.4%	85.7%	83.3%
Lung (100%)	87.5%	50.0%	91.7%	50.0%	92.3%	13.3%	42.9%	70.0%	50.0%	80.0%	120.0%	41.7%
Upper GI (100%)	116.7%	333.3%	300.0%	40.0%	27.3%	116.7%	225.0%	166.7%	42.9%	33.3%	66.7%	33.3%
												Indicative

Cancer Standards - 62 Day Waits

Responsive

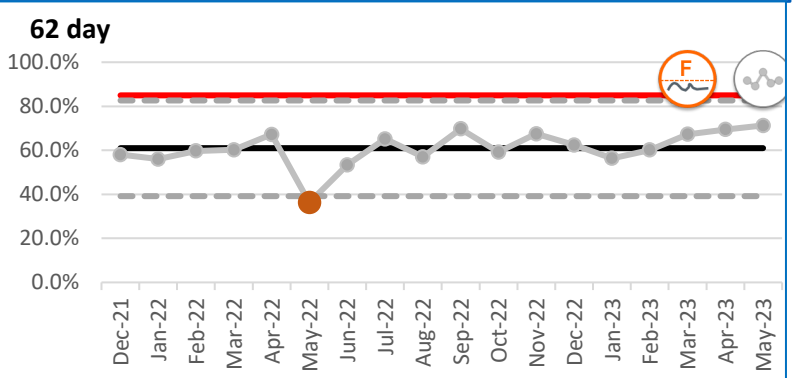
NHS Gateshead Health NHS Foundation Trust

Trust's 62-day cancer performance

- Final performance for May stood at 68.0%, was well above the latest national average 58.7% (May23) and NENC average 61.5% (May23).
- **The Trust reported 52 patients waiting over 62 days on a 2ww classic pathway (7.5% of the total waiters on a 62-day 2ww classic pathway) (71 on all pathways (8.8% of total waiters)).**
- Within the operational guidance 'Systems are being asked to plan to reduce >62-day backlogs, the Trust submitted a plan of 64 for June 2023, reporting 52 for the month, the plan has been met.
- The number of long waits (>104 days) on a 62-day (2ww) pathway at the end of June had reduced to 9 patients (1.3% of total waiters on a 62-day 2ww classic pathway) (16 on all pathways (2.2% of total waiters).
- Indicative performance for June (indicative) stands at 66.2%, remaining above both comparator averages.

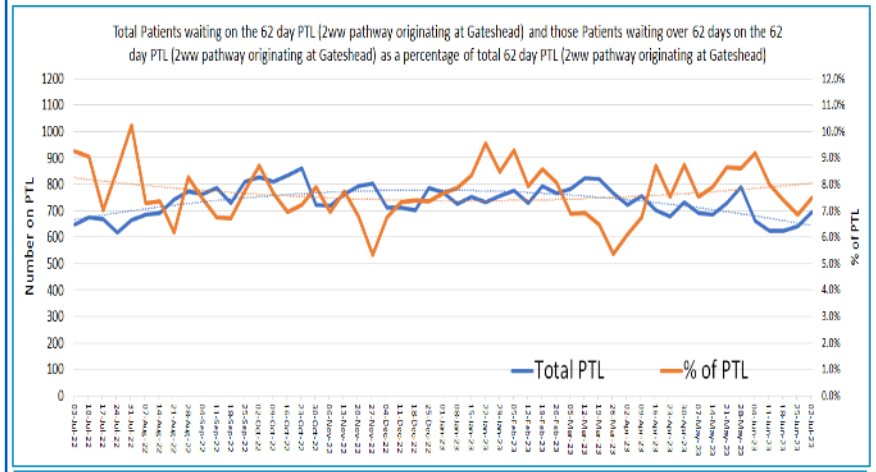
Tumour Update:

- Breast has consistently exceeded the standard since February, however performance Risks across the majority of other specialties to achieve 85%
- Monthly positions are variable but consistently challenged specialties continue to be Gynae, Lower GI, Urology, with challenges noted consistently since December in Lung and Upper GI



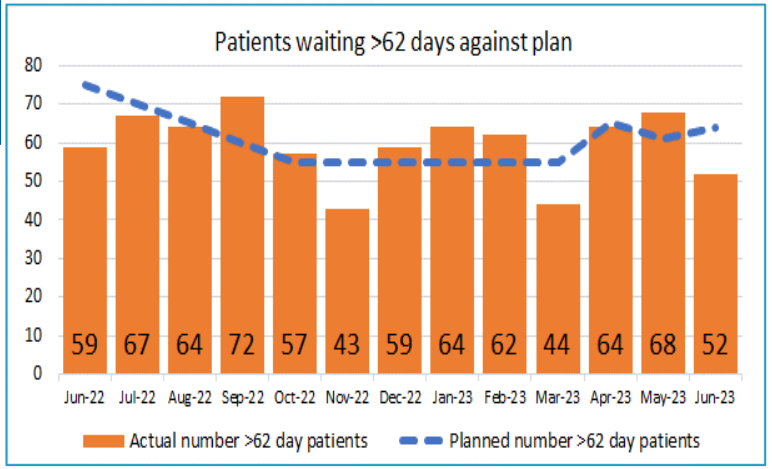
NHSI SOF Operational Performance & National Operational Standard

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	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Monthly Trend
Trust (85%)	63.2%	56.7%	70.5%	58.2%	67.1%	60.4%	53.5%	62.6%	65.2%	69.8%	68.0%	66.2%	
Breast (85%)	96.6%	78.7%	85.7%	81.1%	80.0%	76.0%	73.7%	93.2%	94.1%	100.0%	93.8%	89.0%	
Gynae (85%)	54.2%	50.0%	53.8%	36.8%	52.4%	58.8%	31.3%	27.8%	56.3%	70.0%	60.0%	36.4%	
Lower GI (85%)	16.7%	50.0%	46.2%	40.0%	20.0%	0.0%	33.3%	66.7%	40.0%	66.7%	76.5%	0.0%	
Urology (85%)	21.4%	32.6%	53.3%	45.8%	62.2%	34.8%	42.1%	25.0%	15.4%	57.1%	18.9%	27.8%	
Haematology (85%)	NA	100.0%	0.0%	57.1%	90.9%	NA	100.0%	60.0%	100.0%	33.3%	100.0%	0.0%	
Lung (85%)	42.9%	61.5%	88.2%	80.0%	85.7%	60.0%	66.7%	0.0%	55.0%	62.5%	38.5%	73.3%	
Sarcoma (85%)	0.0%	NA	NA	0.0%	0.0%	NA	NA	NA	NA	NA	NA	NA	
Upper GI (85%)	57.1%	0.0%	60.0%	66.7%	0.0%	100.0%	28.6%	25.0%	28.6%	0.0%	40.0%	40.0%	
Other (85%)	100.0%	100.0%	100.0%	100.0%	NA	0.0%	100.0%	42.9%	NA	NA	100.0%	100.0%	

Indicative



Cancer - Patients waiting more than 62 days

63 to 104 days	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Breast	7	4	2	4	2	3	4	3	2	2	3	2
Gynaecology	5	11	17	14	12	17	18	9	5	13	6	8
Haematology	3	0	2	2	1	0	0	0	1	1	1	0
Lower Gastrointestinal	6	8	12	3	5	7	5	11	10	9	19	12
Lung	3	4	2	8	5	4	6	2	3	3	3	1
Upper Gastrointestinal	11	16	12	9	5	8	7	12	10	14	6	5
Urological	15	12	11	6	4	8	12	15	6	11	19	15
Other	0	0	0	0	0	1	0	1	0	0	0	0
63 to 104 days total	50	55	58	46	34	48	52	53	37	53	57	43

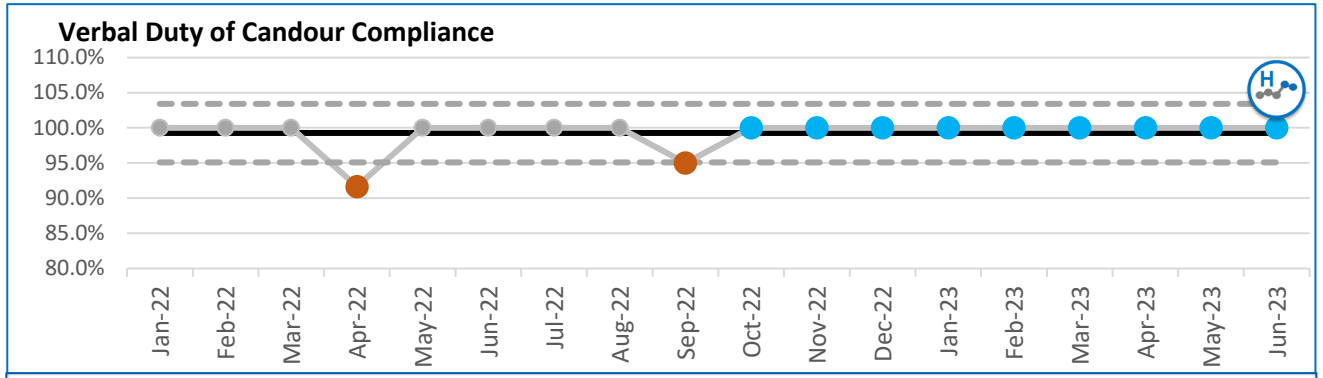
Over 104 days	July	July	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Breast	0	1	1	0	0	0	0	0	0	0	1	0
Gynaecology	3	1	4	3	3	2	3	3	0	1	1	3
Haematology	1	0	0	1	0	1	0	0	0	0	0	0
Lower Gastrointestinal	1	1	1	3	1	2	5	2	2	5	4	0
Lung	1	1	1	0	3	0	1	1	0	0	1	2
Upper Gastrointestinal	1	4	7	1	1	4	2	1	2	2	2	2
Urological	9	1	0	3	1	2	1	2	3	2	2	2
Other	1	0	0	0	0	0	0	0	0	1	0	0
Over 104 day total	17	9	14	11	9	11	12	9	7	11	11	9

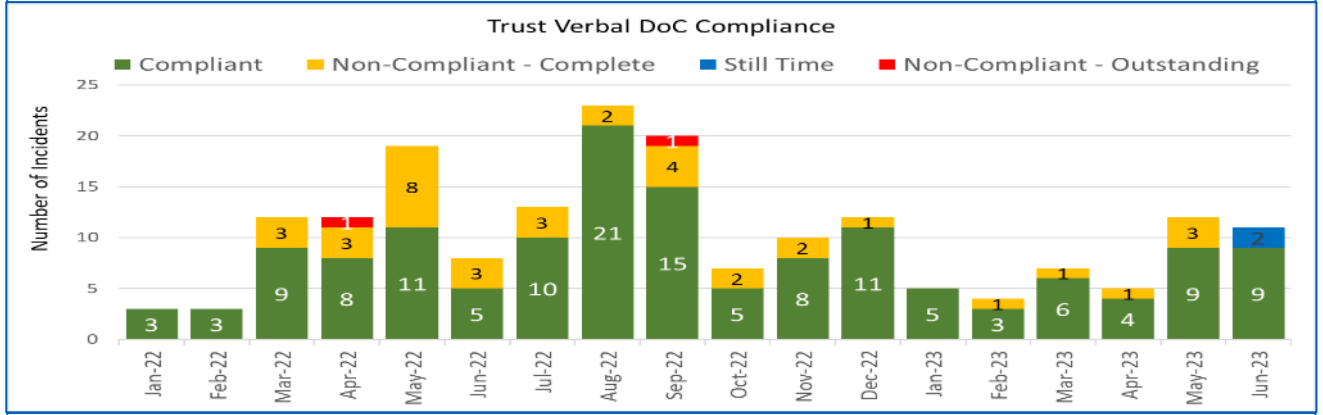
Report by exception: Responsive – Duty of Candour Compliance

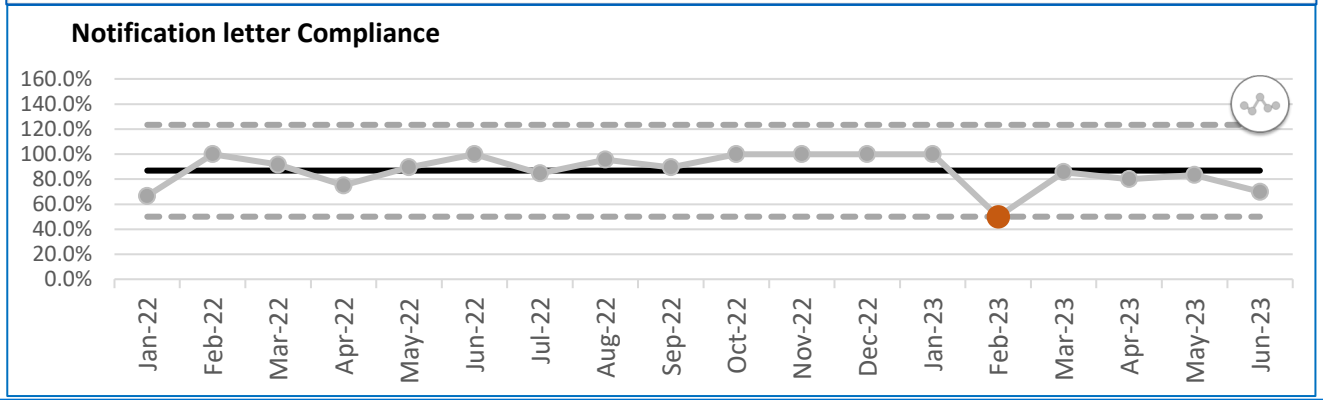
Detail on this measure is included as special cause variation (low) is identified in October 2022

Responsive

Gateshead Health NHS Foundation Trust







Situation

- Verbal Duty of Candour compliance is special common cause variation for concern from March 2023
- Notification letter compliance displaying special cause variation for May 2023

Background

- Duty of Candour (DoC) is governed by the Health and Social Care act 2008 (Regulated Activities) Regulations 2014: Regulation 20.
- Verbal Duty of Candour (stage 1): Regulation 20 and underpinning statute, stipulates that an individual (or other appropriate person) must be notified "as soon as reasonably practicable" after a notifiable patient safety incident has occurred. Notifiable is further defined as requiring three criteria to be met in the reasonable opinion of a health care professional. Once determined as notifiable, the enactment should occur verbally within 10 working days. The Trusts determines the date for this 10 days to commence as being the date agreement on the criteria being met is reached at STG. 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

- Verbal duty of candour compliance is 100% for the month of June 2023
- In relation to compliance for Notification letters, the report shows 3 letters outstanding in June 2023. One of these incidents (112629) the severity of harm has not yet been confirmed by the Safety Triangulation Group and is due to be discussed on 24/07/2023. One of these incidents (112405) shows that a Notification letter is "not required" by the family. The action to send a Notification letter has not been completed and therefore this is still flagging as outstanding. The legal team have contacted the handler to discuss why the family did not require a notification letter in order to add a reason to Datix and complete the outstanding action. The remaining outstanding notification letter (pertaining to incident 112531) has been followed up by the legal team with the incident handlers, investigators and service line manager.

Actions

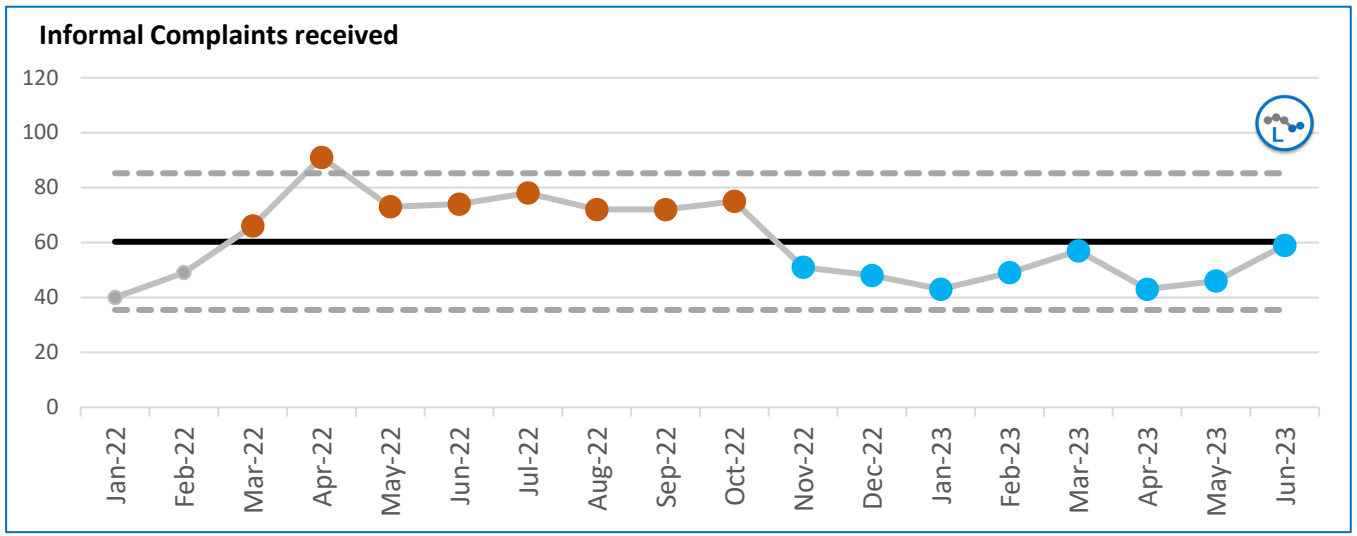
- Ensure the STG date is added to DATIX for all incidents going forward to enable the DoC 'clock' to run from the correct date. Discuss and confirm with the BI team the current format of the reports produced to ensure accuracy in data being reported.

Report by exception: Informal Complaints

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

Responsive

Gateshead Health NHS Foundation Trust



Analysis:

Even though there was a slight increase in numbers received each month from April, the number of informal complaints continues to achieve special cause variation and remain low, below numbers seen earlier in the year. The focus of informal complaints varies significantly and is very broad. Analysis of informal complaints (November 2022 to March 2023 baseline) highlighted the two main overall subjects for complaints as *Communication. And facilities* mostly linked to Car parking issues. The tables (right) provide a breakdown of the most common issues for both themes between November and March, and then each of the past 3 months.

Communication complaints - The is no patten observed regarding specially / location for poor communication. In the latest 3 months poor verbal communication is the largest single reason. Telephone waits featured highly in this category, but numbers have reduced more recently. Postponed, cancelled, or delays in treatments complaints (as might be expected) as might be expected feature more prevalently in the latest 3 months.

Facilities complaints - Car parking issues continue to be the most significant issue, the number of these type of complaints, increasing month on month since April. Complaints around inconsiderate parking in the local neighbourhood continue to persist.

Communications complaints by volume	Nov22 - Mar 23	Apr-23	May-23	Jun-23
Electronic - Length of wait (telephone)	23	7	4	1
Verbal - Poor communication	25	6	6	11
Written - Incorrect information	7	2		1
Written - Poor communication	9	3	2	3
Verbal - Delay in diagnosis	3			
Verbal - Poor staff attitude	3			1
Written - Breach of confidentiality	2			
Verbal - Premature discharge	1			
Written - Poor / incorrect signposting	1			
Verbal - Incorrect diagnosis	1			
Verbal - Delay in Treatment	5		2	5
Electronic - Poor communication	1			
General - Interpreter not available	3		1	
Verbal - Lack of community service communications	1			
Verbal - Misunderstanding	1			
Verbal - proceedure / process error	1		1	
General - Lost Mail	0	1		
Grand Total	**87**	**19**	**16**	**22**

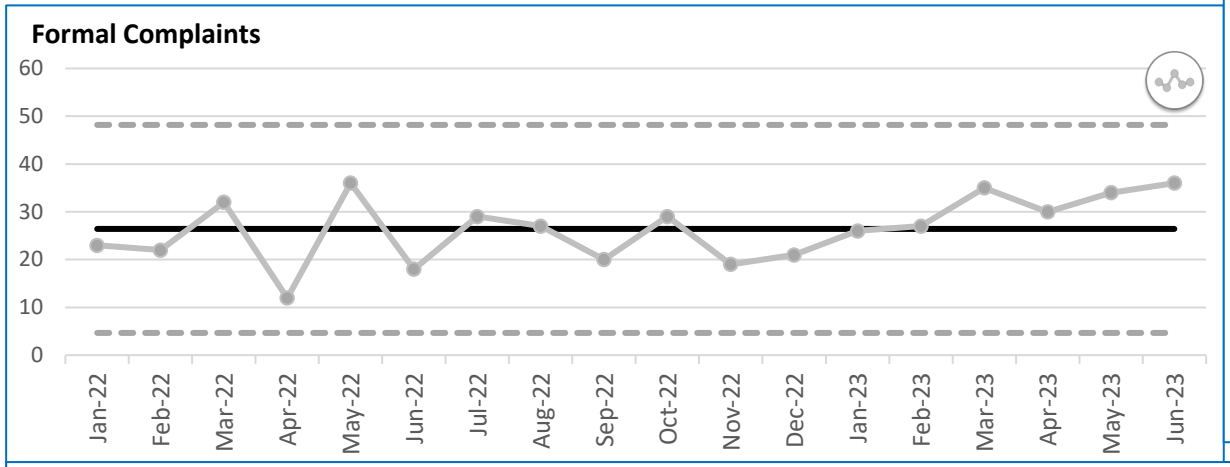
Facilities complaints by volume	Nov22 - Mar 23	Apr-23	May-23	Jun-23
General - Car parking	20		4	1
Car Parking - Parking Charge Notice (PCN)	15		1	3
Car parking - Issues with blue badge registration	6	1	1	3
Car parking - inconsiderate parking (neighbourhood)	3	2	1	3
Lack of resources - No ward bed (Not ITU/CCU/HDU)	1			
Facilities - Incomplete maintenance works	1			1
General - Lack of adequate facilities/equiptment	1			
Grand Total	**47**	**3**	**7**	**11**

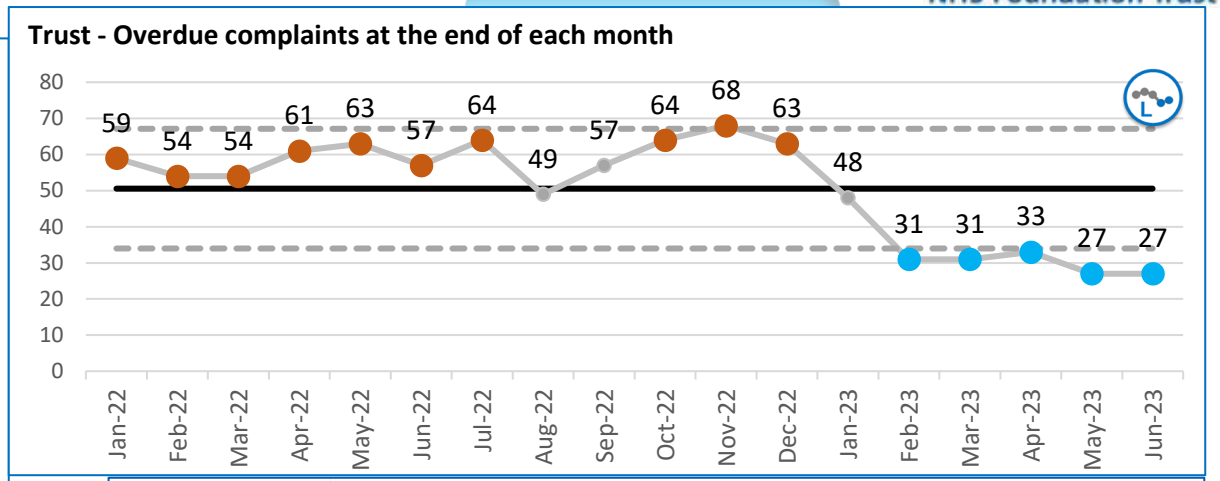
Report by exception: Formal Complaints

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

Responsive

Gateshead Health NHS Foundation Trust





Analysis – Although increasing in May and now June, the number of formal complaints received is demonstrating common cause variation and is within expected levels based on past trends. The number of overdue complaints at the end of June continues to triggering special cause variation and demonstrates improvement, having more than halved since the high of November. Analysis of recent formal complaints received since November continues to highlight two main subjects as below:

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

Overdue Complaints

There were 27 overdue complaints remaining open at the end of June, the same as the end of May 14 were within the Surgery Business Unit, 11 Medicine Business Unit. The remaining 2 were 1 in Clinical Support and Screening, and 1 in QEF Facilities outpatient Pharmacy. **This figure has continued to fall, standing at 16 as of 11th of July.**

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

- Waits and Delays, Poor communication, Busy staff contributing to perceived lack of attention and care, Pain management

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

	Accident and Emergency	Same Day Emergency Care (SDEC)	Emergency Admissions Units	Ward 8 (Cardiology)	Ward 9 (Respiratory)	Ward 10 (Respiratory)	Ward 11 (Gastroenterology)	Ward 12	Ward 14a (Trauma and Orthopaedics)	Ward 21 Escalation	Ward 22 (Care of the Elderly)	Ward 23 (Care of the Elderly)	Ward 25 (Care of the Elderly)	T27 (General Surgery)	Trauman and Orthopedics	Blaydon Urgent Treatment Centre	Gastroentorlogy - No specific Dept	General Surgery	Gynaecology	Delivery Suite (Maternity)	Cardiology (Specialty of) - No specific dept	Clinical Haematology (Specialty of) - No specific dept	CT (Radiology)	Obstetrics	Breast Screening	Paediatrics (outpatient)	PeaPod (Paediatric Emergency Assessment)	PIU Day Unit
Actions - Actions not carried out	36	2	1												1	1		1	3	1				1	1	2	3	
General - Inadequate/Inappropriate nursing care	1		3		1	3	5	2	2	1	3	1	3	4														1
General - Inadequate/Inappropriate medical care				1	1	1			1		1			1	3		1	2	1		4	1	1				1	

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

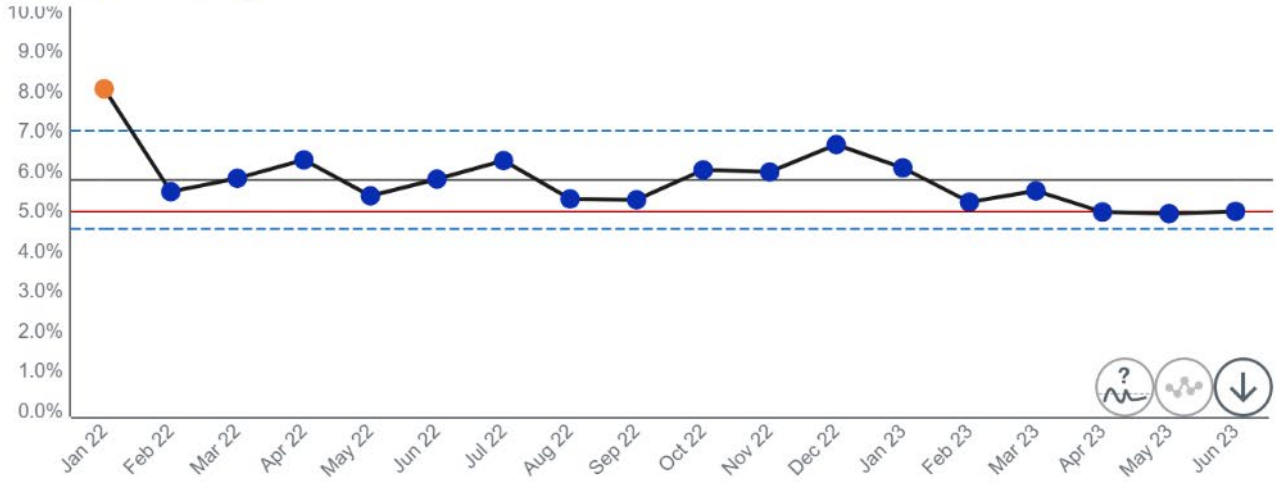
	Accident and Emergency	Same Day Emergency Care (SDEC)	Emergency Admissions Unit	Ward 9 (Respiratory)	Ward 12	Ward 14a (Trauma and Orthopaedics)	Trauma and Orthopaedics (Medical)	T27 (General Surgery)	General Surgery (Medical)	Gastroentorology	Pain Clinic	Children's Community Nursing	Breast Screening	Discharge Liason Team	Pregnancy Assesment Unit	Outpatients	Community Midwives (Maternity)	Rapid Response Team	Community Stroke
Grand Total	8	1	3	1	1	2	1	1	2	1	1	1	2	1	2	2	1	3	1

Sickness Absence

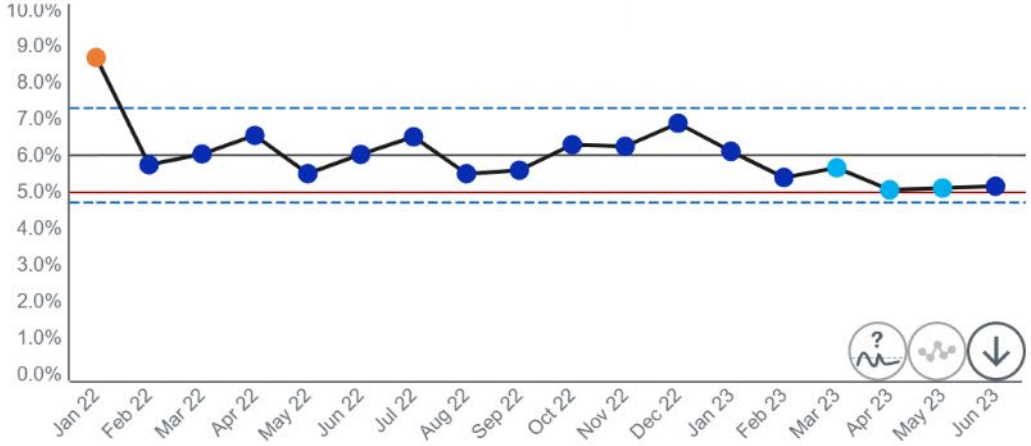
Well Led

NHS Gateshead Health NHS Foundation Trust

Sickness % - Group



Sickness % - Trust



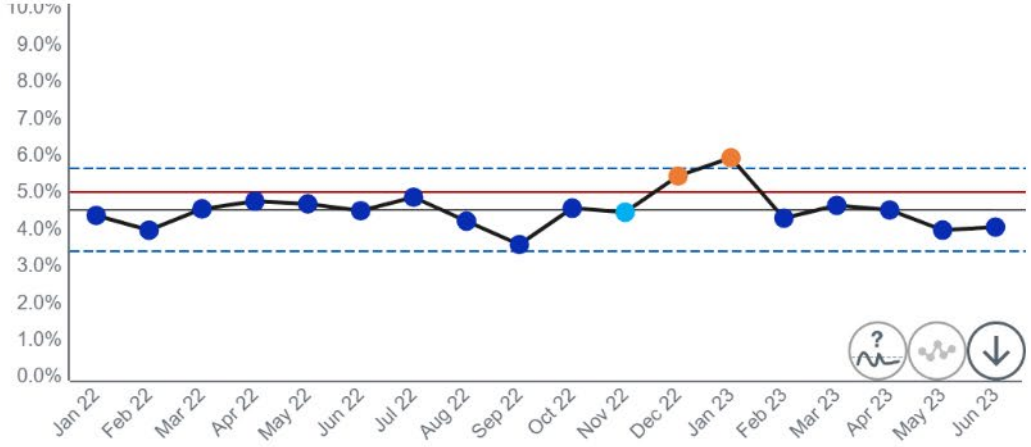
What is the data telling us?

- The data continues to show a positive reduction in absence rates across the Group with both the Trust and QEF heading towards 5% Target.

What is our plan and expected impact?

- The collective approach to managing absence continues with positive reductions in absence variances across the Business Units.
- The focused piece of work on Absence Management continues with monthly sickness absence reporting shared with the Business Units.
- POD continue to support managers to engage with the refocused collective leadership approach.
- Monthly LTS clinics within the Business Units are active and working successfully.
- The Trust SMT continue to fully support the new approach to absence management.

Sickness % - QEF



Appraisals

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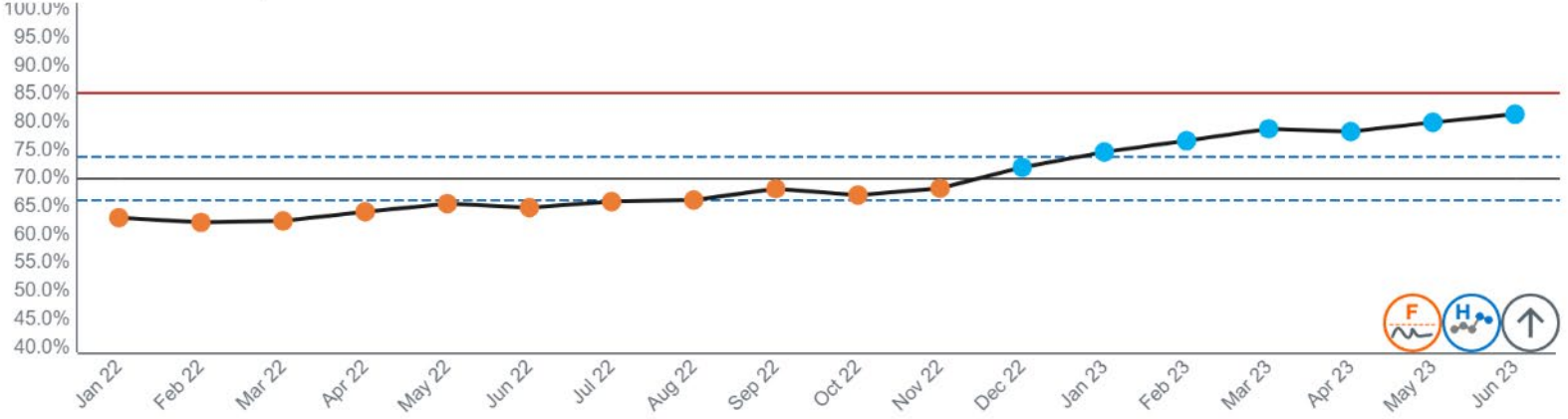
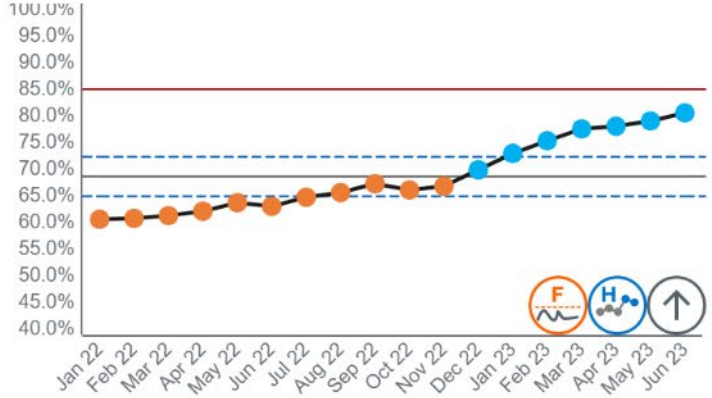
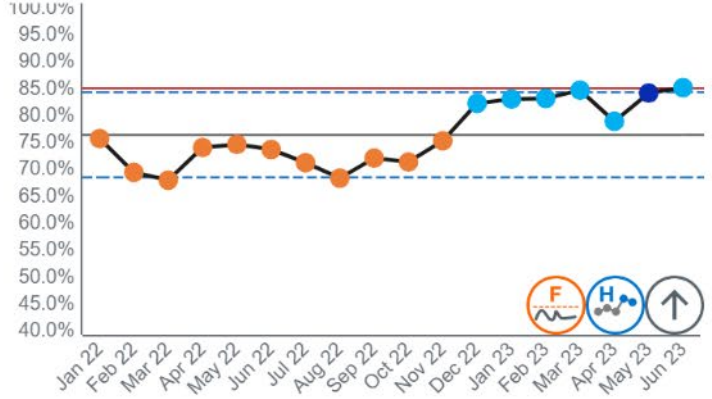
Appraisal % - Group



Appraisal % - Trust



Appraisal % - QEF



What is the data telling us?

- The target of 85% is consistently not being achieved. The data shows that there has been an increase to 81.3% for the group. There has been a sustained improvement since May 2022. The Trust and QEF have seen increases in compliance this month with the Trust sitting at 80.6% and QEF at target at 85.1%. Significant work has been undertaken to achieve the current levels
- There remain a number of areas of concern, with varying numbers of staff requiring an appraisal. There are areas of concern with regards to appraisal compliance, and a new way of inputting into ESR has been launched which will support managers.

What is our plan and expected impact?

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

Core Training

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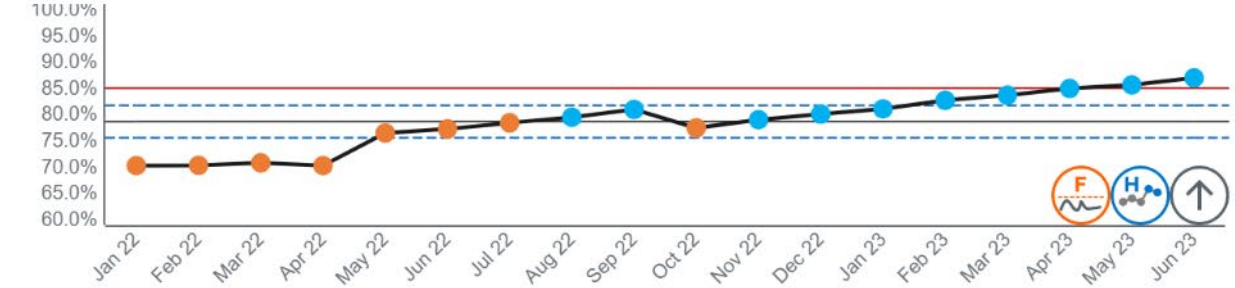
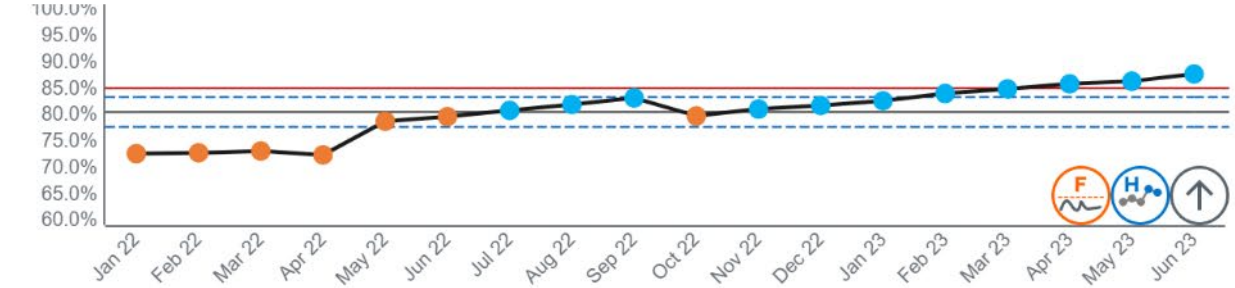
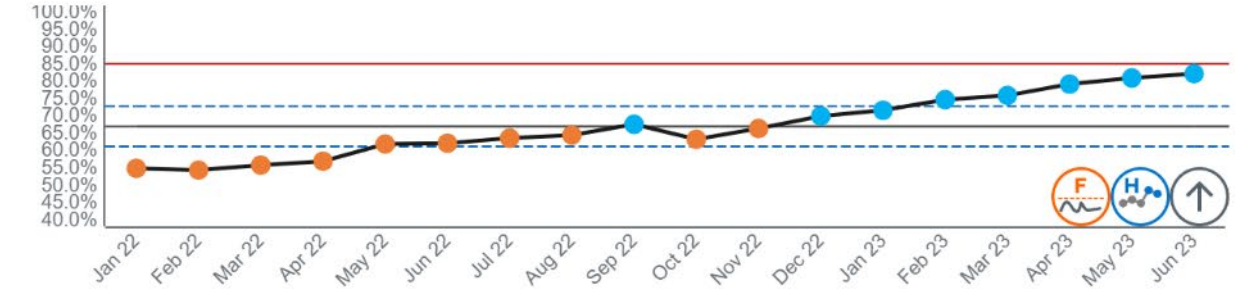
Core Skills % - Group



Core Skills % - Trust



Core Skills % - QEF



What is the data telling us?

- Another increase in compliance with a whole group compliance figure of 87 % against an 85% target.
- QEF currently have a compliance level of 82.2% against the 85% target, which is a slight increase on the last metrics report. Managers are aware that continued work is required to improve that position; however, this is another positive improvement since the last report. The additional space for QEF staff for training is available and this continues to see an increase compliance.
- The Trust has increased to 87.7% against an 85% target.
- The topics that remain under compliance targets and provide a level of risk are-Moving and handling level 2, Level 2 and 3 PMVA, Safeguarding level 3 topics and Information Governance. Work is ongoing with the SME's for these topics to increase compliance. These remain a risk within the overall compliance target. However, it is noted that Safeguarding Children level 3 recorded a significant increase.
- PMVA training will remain a risk until further staff have completed the training. Dates have now been made available and staff are booking on to attend so there should continue to be sustained increases in compliance with this topic. Work is ongoing through the violence and aggression task and finish group to manage mapping of these topics.

What is our plan and expected impact?

- Core skills compliance has been discussed at SMT, escalated to Executive Team and discussed at recent oversight meetings with business units. The addition of a couple of the topics which saw an initial reduction in overall compliance, until the staff complete the training is now paused while a full remap of core skills is underway with professional leads and subject matter experts to ensure appropriate mapping. Additional topics are also being considered due to national statutory mandates.
- 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. Training is also available as soon as people join the organisation and can be completed prior to their attendance at corporate induction.

SIP, Vacancies

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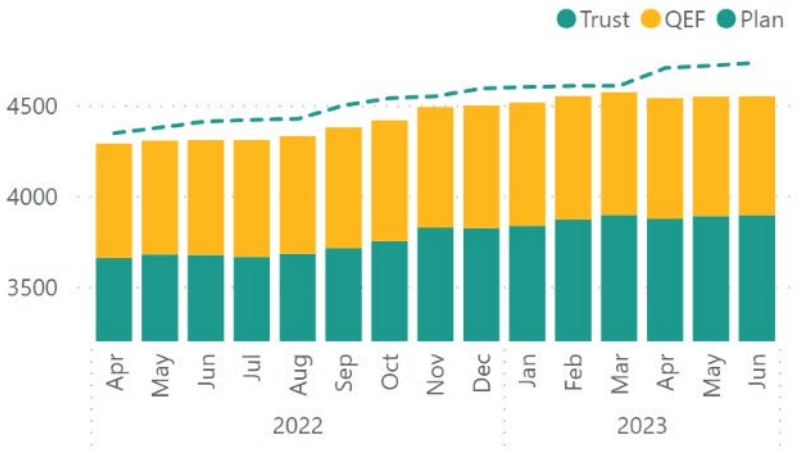
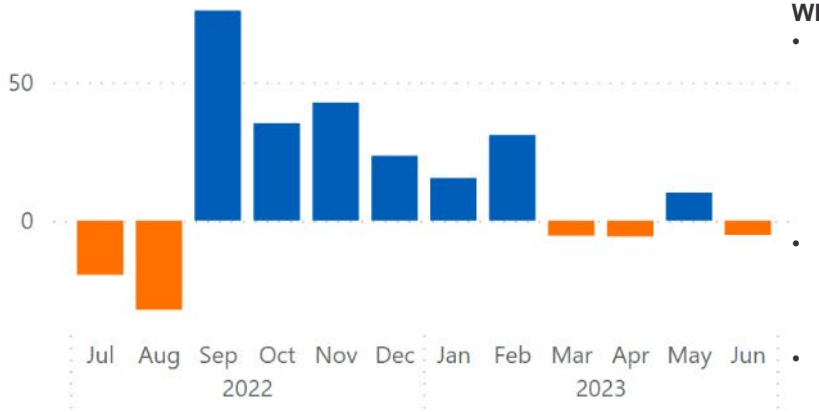
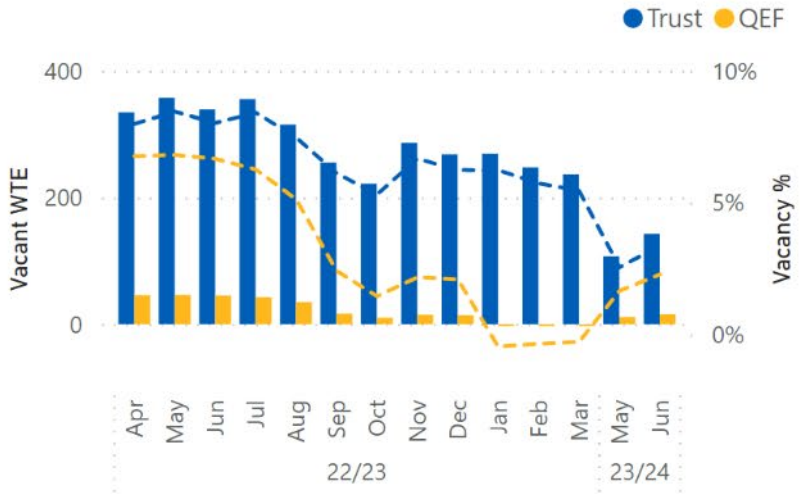
Plan vs Contracted SIP



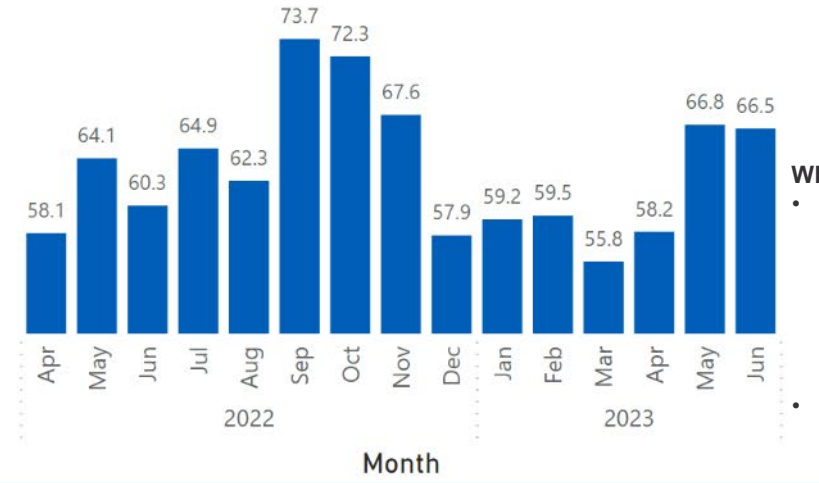
Starters & Leavers - Net change



Vacant WTE & Vacancy %



Recruitment - Advert to starting letter (Av Days)



What is the data telling us?

- The Time to hire metric used by the Trust is Advertising Start Date to Starting Letter (T19 report). The time to hire metric increased in May but has decreased slightly in June. There has been an increase in the number of Medical posts and Medical applicants going through a recruitment process in preparation for the August intake, which has impacted on the time to hire metric, but they are being cleared in preparation for August start dates.
- The data covers all posts that are being processed by the recruitment team, including Medical posts, Non-medical posts, Volunteers and Bank staff. The only staff not included in the data are those who have been recruited by Yeovil Hospital.
- Trust vacancy rate is 3.4% as of Jun 23, a 0.8%, 35.3 WTE increase since May23. QEF vacancy rate is 2.3%, a 0.6%, 4.3 WTE increase since May23. CSS increased staffing budgets by 35.8 May-Jun23, most notably Pathology by 12.5 WTE and Pharmacy by 9.8 WTE. This change increased CSS vacancy rate from 6.5% to 9.1%. The unqualified nursing vacancy rate is 13.6% over recruited, 75.1 over budget. The registered nursing vacancy rate is 4.0%, 53.5 WTE under the trust budget. The nursing vacancy rate has decreased by 3.8% since March due to budgets being reverted to October levels. Nursing SIP has increased by 51 WTE since October when the vacancy rate was 8.0%.

What is our plan and expected impact?

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

Agency and Bank Spend

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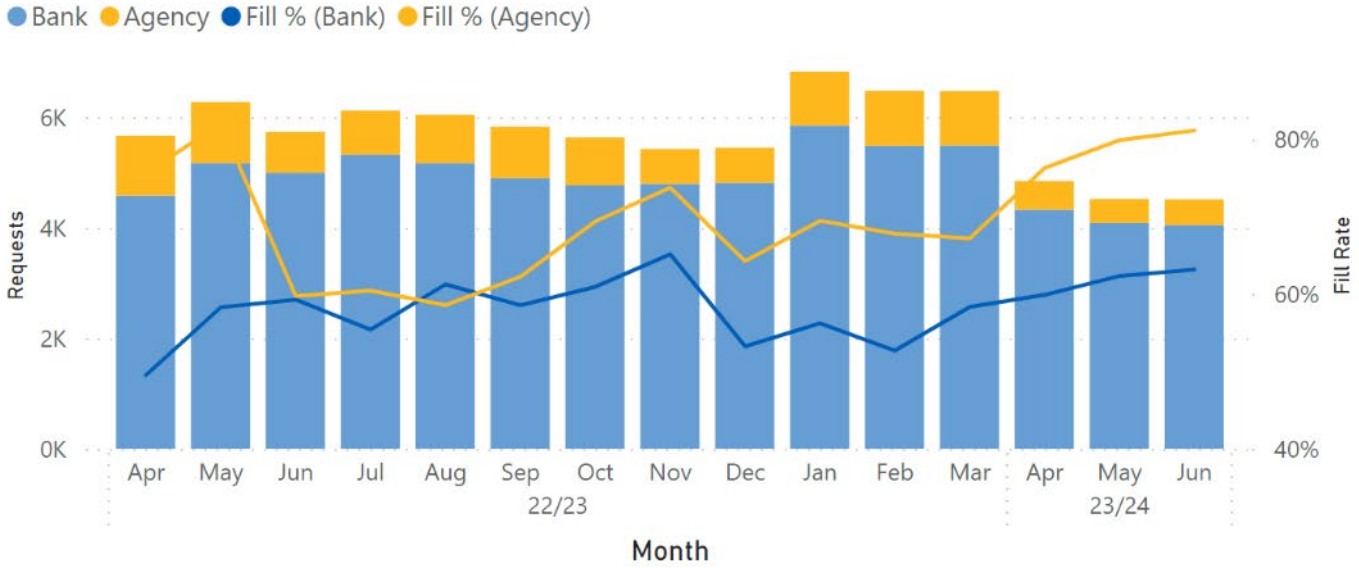
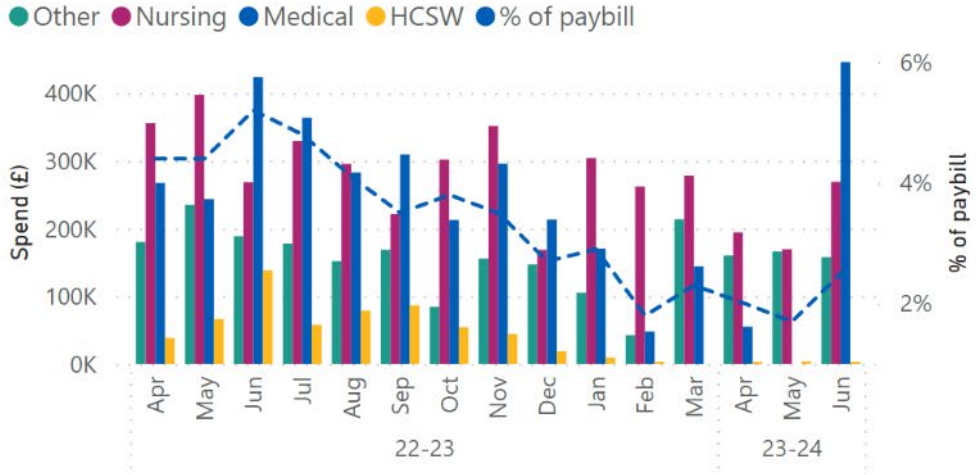
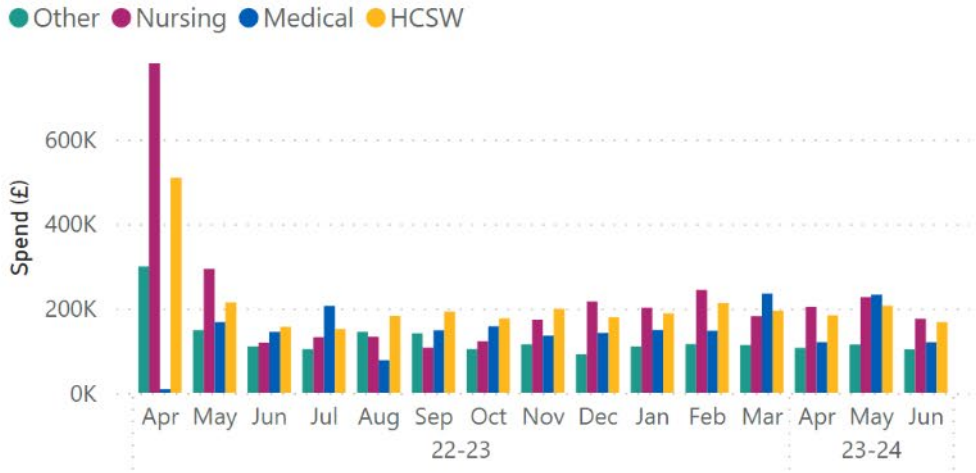
Temporary staffing fill rate and requests



Total Agency Spend (£)



Total Bank Spend (£)



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

- Total Agency spend sees a large increase in Medical agency spend after a noticeable reduction of from March 23. There is an increase in Nursing agency spend in the month of June following a period of reduced spend. Temporary staffing fill rates remain consistent over the previous two months. Bank Fill rates also remain consistent at just above 60% for the months of May and June.

What is our plan and expected impact?

- Ongoing agency control procedures remain in place, requiring divisional manager sign off for all agency shifts and escalation for 'break glass' requirements. A monthly audit to monitor governance and compliance with this practice is now undertaken by the Healthroster team and reported into the Agency Control working group. The expectation of this work is the continuation of reducing off-framework, above price cap nursing agency use within the Organisation.

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 13

Report Title:	**Nursing Staffing Exception Report**			
Name of Meeting:	Board of Directors			
Date of Meeting:	Wednesday 26th July 2023			
Author:	Andrew Rayner, Deputy Chief Nurse Laura Edgar, People Data and Information Lead			
Executive Sponsor:	Gillian Findley, Chief Nurse and Professional Lead for Midwifery and AHP's			
Report presented by:				
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 within the month of June 2023. June demonstrated some staffing challenges relating to vacancies and short term sickness absence alongside ward movements to accommodate maintenance across the Trust. Within June we continued to experience periods of increased patient activity with surge pressure resulting in escalation areas. This has impacted on staffing resource and the clinical operating model, which is supportive of maintaining elective recovery. There is continued focused work around the recruitment and retention of staff and managing staff attendance. Wards where staffing fell below 75% of the funded establishment are shown within the paper. Detailed context and actions taken to mitigate risk are documented. A staffing escalation protocol is now in operation across all areas within the organisation and			

<table>
<tr><td></td><td colspan="5">assurance of this operating as expected, is provided by the number of staffing incident reports raised through the incident reporting system.</td></tr>
<tr><td>Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper</td><td colspan="5">The Board are asked to:
receive the report for assurance
note the work being undertaken to address the shortfalls in staffing</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:</td><td>Aim 1
☒</td><td colspan="4">We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>Aim 2
☒</td><td colspan="4">We will be a great organisation with a highly engaged workforce</td></tr>
<tr><td>Aim 3
☒</td><td colspan="4">We will enhance our productivity and efficiency to make the best use of resources</td></tr>
<tr><td>Aim 4
☐</td><td colspan="4">We will be an effective partner and be ambitious in our commitment to improving health outcomes</td></tr>
<tr><td>Aim 5
☐</td><td colspan="4">We will develop and expand our services within and beyond Gateshead</td></tr>
<tr><td>Trust corporate objectives that the report relates to:</td><td colspan="5"></td></tr>
<tr><td>Links to CQC KLOE</td><td>Caring
☒</td><td>Responsive
☒</td><td>Well-led
☐</td><td>Effective
☒</td><td>Safe
☒</td></tr>
<tr><td colspan="6">Risks / implications from this report (positive or negative):</td></tr>
<tr><td>Links to risks (identify significant risks and DATIX reference)</td><td colspan="5">There were no staffing incidences raised via datix throughout the month of June. Two nursing red flags were reported and are detailed within the paper.</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
June 2023

1. Introduction

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

2. Staffing

The actual ward staffing against the budgeted establishments from June 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 June 2023

Day	Day	Night	Night
Average fill rate - registered nurses/midwives (%)	**Average fill rate - care staff (%)**	**Average fill rate - registered nurses/midwives (%)**	**Average fill rate - care staff (%)**
88.5%	**119.4%**	**89.8%**	**95.5%**

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 Covid-19 and operational pressures to maintain adequate staffing levels.

Exceptions:

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

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

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

Contextual information and actions taken

Ward 22 currently have 1.46 wte Registered Nurse vacancies and ward 24 currently have 3.68 wte Registered Nurse vacancies. There is active recruitment ongoing for these positions.

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

The exceptions to report for June are as below:

June 2023	
Registered Nurse Days	**%**
Ward 22	73.8
Ward 24	72.0
Registered Nurse Nights	**%**
N/a	
Healthcare Support Worker Days	**%**
N/a	
Healthcare Support Worker Nights	**%**
N/a	

In June, 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 June, 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 June, the Trust total CHPPD was 9.1. This compares very well when benchmarked with other peer-reviewed hospitals and when compared with the same month last year.

4. Monitoring Nurse Staffing via Incident Reporting system

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

A report of staffing concern related incidents is generated monthly and discussed at the Nursing Professional Forum. There were no staffing incidents raised via the incident reporting system for the month of June.

5. Nursing Red Flags

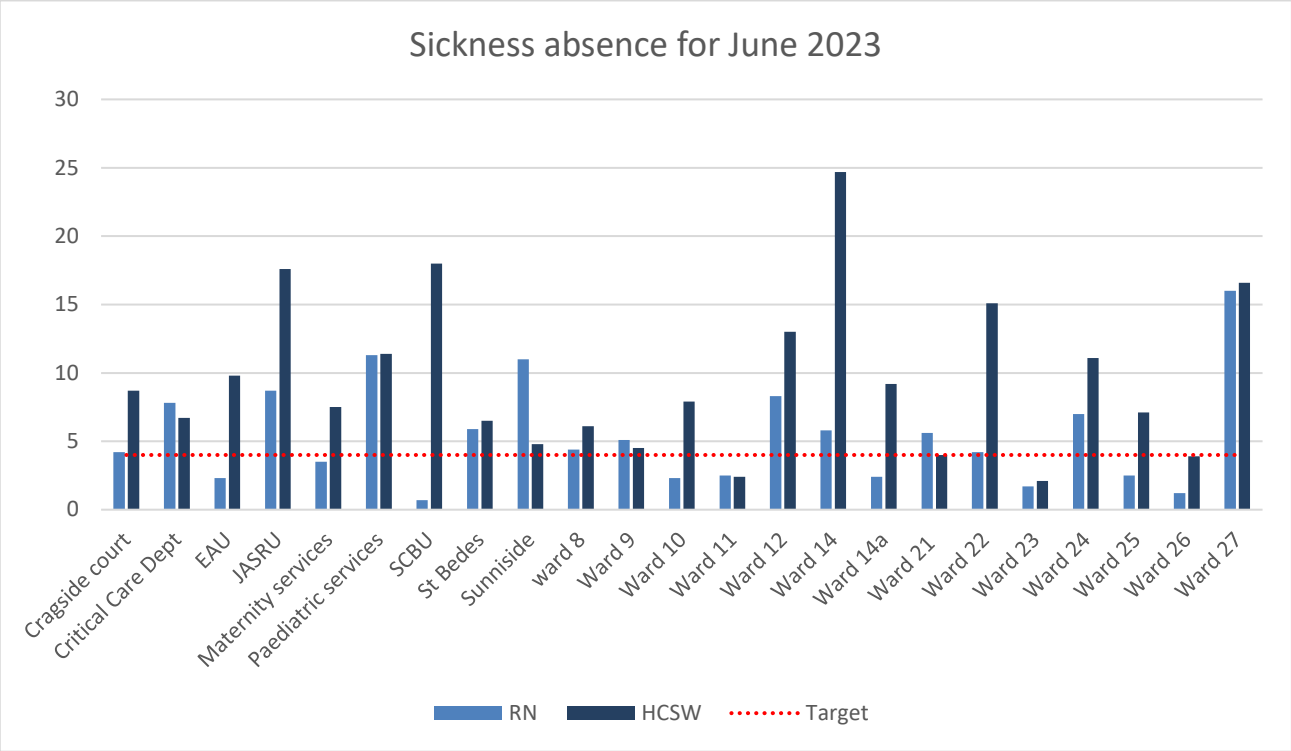
The National Institute for Health and Care Excellence (NICE) guideline for Safe Staffing for nursing in adult inpatient wards in acute hospitals (2014) recommend the use of nursing Red Flag reporting. A Nursing red flag can be raised directly as a result of rostering practice/shortfall in staffing or by the nurse in charge if they identify a shortfall in staffing requirements resulting in basic patient care not able to be delivered. Throughout the month of June there were two nursing red flags reported.

Date	Shift type	Ward	Flag Type	Notes
07/06/2023	Day	24	Missed 'intentional rounding'	4 patients with challenging behaviors and wandering into each others room unable to cohort in one bay as aggressive toward each other 07/06/2023 11:12
23/06/2023	Day	23	Shortfall in RN time	x2 patients requiring 1-1 care on the ward due to falls risk and x5 members of staff on the late 23/06/2023 08:08

Of the above recorded red flags, ward 23 was documented on the resilience bulletin as requested additional staff to manage shortfall.

6. Attendance of Nursing workforce

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



7. 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.

8. Conclusion

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

9. 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 June 2023

	Day		Night		Care Hours Per Patient Per Day (CHPPD)			
Ward	**Average fill rate - registered nurses/midwives (%)**	**Average fill rate - care staff (%)**	**Average fill rate - registered nurses/midwives (%)**	**Average fill rate - care staff (%)**	**Cumulative patient count over the month**	**Registered midwives / nurses**	**Care Staff**	**Overall**
Cragside Court	90.4%	111.1%	91.8%	99.5%	158	11.4	12.6	24.0
Critical Care Dept	79.8%	112.4%	83.0%	91.9%	180	37.4	7.5	45.0
Emergency Care Centre - EAU	85.4%	134.2%	81.1%	114.9%	1348	5.9	4.4	10.3
JASRU	86.6%	84.8%	97.8%	135.8%	556	3.4	4.5	7.9
Maternity Unit	156.1%	175.8%	104.1%	94.0%	561	15.4	5.8	21.2
Paediatrics	135.7%	123.3%	109.3%		42	60.0	16.1	76.1
Special Care Baby Unit	90.6%	100.9%	101.8%	79.2%	123	13.5	4.3	17.9
St. Bedes	104.4%	207.9%	101.5%	79.8%	279	5.6	5.7	11.3
Sunniside Unit	97.6%	127.4%	88.4%	100.1%	283	5.8	4.2	10.1
Ward 08	108.6%	164.9%	117.1%	128.7%	605	3.9	4.4	8.3
Ward 09	84.1%	176.0%	100.3%	96.9%	701	2.7	3.7	6.4
Ward 10	96.7%	144.8%	113.5%	114.6%	645	3.3	3.7	7.0

	Day		Night		Care Hours Per Patient Per Day (CHPPD)			
Ward	**Average fill rate - nurses/midwives (%)**	**Average fill rate - care staff (%)**	**Average fill rate - nurses/midwives (%)**	**Average fill rate - care staff (%)**	**Cumulative patient count over the month**	**Registered midwives / nurses**	**Care Staff**	**Overall**
Ward 11	81.4%	141.6%	106.7%	116.2%	526	3.5	5.1	8.7
Ward 12	80.3%	118.9%	101.7%	100.5%	632	2.9	3.6	6.5
Ward 14 Medicine	124.0%	110.0%	109.8%	107.4%	677	3.7	3.0	6.7
Ward 14A Trauma	87.3%	146.8%	101.7%	96.3%	666	3.0	4.3	7.3
Ward 21 Elective Ortho	78.2%	94.8%	84.6%	90.7%	171	7.2	6.3	13.5
Ward 22	73.8%	116.9%	110.3%	90.0%	892	2.2	3.2	5.4
Ward 23	77.8%	164.2%	101.9%	106.1%	695	2.4	4.6	7.0
Ward 24	72.0%	107.7%	106.9%	101.6%	896	2.1	3.2	5.3
Ward 25	89.6%	117.7%	104.7%	101.6%	952	2.3	3.1	5.4
Ward 26	97.8%	127.3%	108.7%	118.2%	708	3.4	4.0	7.4
Ward 27	88.6%	123.9%	138.4%	114.6%	714	3.4	3.9	7.3
QUEEN ELIZABETH HOSPITAL - RR7EN	**88.5%**	**119.4%**	**89.8%**	**95.5%**	**13010**	4.8	4.2	9.1

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 14

Report Title:	**Maternity Integrated Oversight Report**			
Name of Meeting:	Trust Board of Directors			
Date of Meeting:	Wednesday 26th July 2023			
Author:	Ms Karen Hooper, Lead Midwife for Risk and Patient Safety, Mrs Jane Conroy, Head of Midwifery and Ms Kate Hewitson, Service Line Manager			
Executive Sponsor:	Dr Gill Findley, Chief Nurse and Professional Lead for Midwifery and AHPs and Deputy Chief Executive			
Report presented by:	Mrs Jane Conroy, Head of Midwifery			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
	This report presents a summary of maternity indicators for the Trust from the month of May 2023.			
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 departmental and BU Safecare in June 2023, and the Safecare/Risk and Safety Council in July 2023.			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	**Maternity dashboard:** • In May 2023, we had 160 births, 0 serious incidents (SI's) and 0 HSIB cases. • CO Monitoring at booking and 26 weeks is flagging as high (over target) based on SPC at 85%. However, in May 2023, new national targets were released at 95%. • Our rates of induction of labour have declined over Q4 22/23 and the beginning of Q1 23/24. This appears to be aligned to an increase in caesarean sections (including elective). • Our PPH rate (>1.5 L blood loss after birth) was 9 which is higher than our target of 2. **National policy drivers/incentive schemes:** • The technical specifications of number of new national policy drivers/incentive schemes were released on 31st May 2023, including the Maternity Incentive Scheme (MIS), with compliance against the 10 safety actions required for submission by 1 February 2024. Full gap analysis underway, which highlights a risk of non-compliance for MIS (noting this is reflected in all Trust's			

<table>
<tr><td></td><td colspan="5">across the region). An emerging risk has been added to the Risk Register, as per the Risk Register exception report within this slide pack.

Risk Register review – exception reports:
• Compliance with Maternity Incentive Scheme Year 5
• SCBU staffing

ATAIN (Avoiding term admissions to SCBU):
• In Q4 (22/23), 28 babies avoided SCBU admission through transitional care (TC), 21 term infants were admitted to SCBU
• Themes included:
o Caesarean section
o No steroids
o Raised maternal BMI
o Gestational Diabetes
• Learning identified that out of the 85 babies who received either transitional care or an admission to SCBU, only 27 had received a feed within 1st hour
• Actions include increased deployment of MSWs to Labour Ward to support with early feeding and for MDT discussion at Transitional Care meeting July 23</td></tr>
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Outline what the meeting is expected to do with this paper</td><td colspan="5">Members of the Trust Board of Directors are asked to review the detail provided within this report for assurance.</td></tr>
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<tr><td>Has a Quality and Equality Impact Assessment (QEIA) been completed?</td><td colspan="2">Yes
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☒</td></tr>
</table>

Gateshead Health NHS Foundation Trust

Maternity Integrated Oversight Report

Maternity data from May 2023

Maternity IOR contents

- Maternity Dashboard 2023/24:
    - May 2023 data

- Exception reports:
    - Maternity dashboard
        - CO Monitoring at booking and 36 weeks
        - Induction rate and C-section rate
        - PPH >1.5L
    - National policy drivers/incentive schemes:
        - Maternity Incentive Scheme Year 5
        - Saving Babies Lives Care Bundle v3
        - Core Competency Framework v2
    - Risk Register – emerging risks
    - ATAIN – Avoiding term admissions to SCBU (Q4 2022/23)

- For information:
    - No SIs reported in May 2023
    - No HSIB cases reported in May 2023

Maternity Dashboard 2023/24

Maternity

NHS

Gateshead Health

NHS Foundation Trust

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Responsive

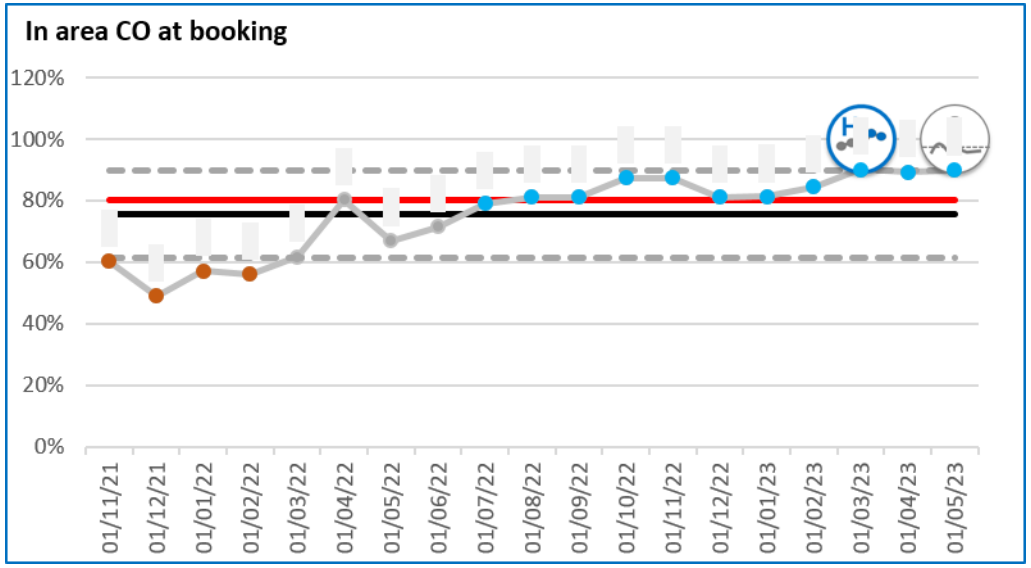
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Total Births	May 23	160	-			149	113	185
Spontaneous vaginal deliveries	May 23	81	-			80	60	100
Assited births	May 23	79	-			69	37	102
Induction of Labour	May 23	68	-			68	44	91
Maternity Readmissions	May 23	5	-			3	0	6
Neonatal Readmissions	May 23	6	-			5	-1	11
Smoking at time of booking	May 23	11.48%	15.00%		?	11.30%	7.07%	15.53%
Smoking at time of delivery	May 23	7.55%	6.00%		?	11.54%	3.35%	19.73%
In area CO at booking	May 23	89.95%	80.00%	H	?	75.52%	61.40%	89.64%
In area CO at 36 weeks	May 23	83.23%	80.00%	H	?	71.05%	56.70%	85.39%
Admitted directly to NNU (SCBU) (>37 weeks)	May 23	3	4		?	3	-3	9
Percentage Admitted directly to NNU (SCBU) (>37 we	May 23	1.99%	6.00%		?	2.10%	-2.08%	6.27%
Preterm birth rate <=36+6 weeks at birth	May 23	5.03%	6.00%		?	5.42%	1.11%	9.72%
Continuity of Carer: Percentage placed on pathway (2	May 23	16.13%	-			18.16%	11.22%	25.09%
Continuity of Carer: Percentage from BAME backgrou	May 23	27.27%	-			30.19%	2.42%	57.97%
Spontaneous Vaginal Births (%)	May 23	50.94%	-			53.85%	39.68%	68.02%
Induction Rate	May 23	42.77%	-	L		45.72%	32.73%	58.70%
Instrumental Delivery Rate	May 23	13.21%	-			12.14%	2.25%	22.04%
Elective C Section Rate	May 23	20.75%	-			17.75%	9.20%	26.30%
Emergency C Section Rate	May 23	15.72%	-			16.01%	7.09%	24.93%
C Section Rate	May 23	36.48%	-			33.76%	25.15%	42.38%
3rd or 4th degree tear (Total) Precentage	May 23	1.89%	5.00%		?	1.89%	-1.71%	5.48%
Massive PPH >=1.5L (All births)	May 23	9	2		?	6	-3	14
Breastfeeding: Percentage of Initiated Breasfeeding	May 23	76.58%	66.20%		?	68.29%	49.44%	87.14%
Breastfeeding: Breasfeeding at Discharge (Transfer to	May 23	54.09%	56.20%		?	50.48%	36.98%	63.97%

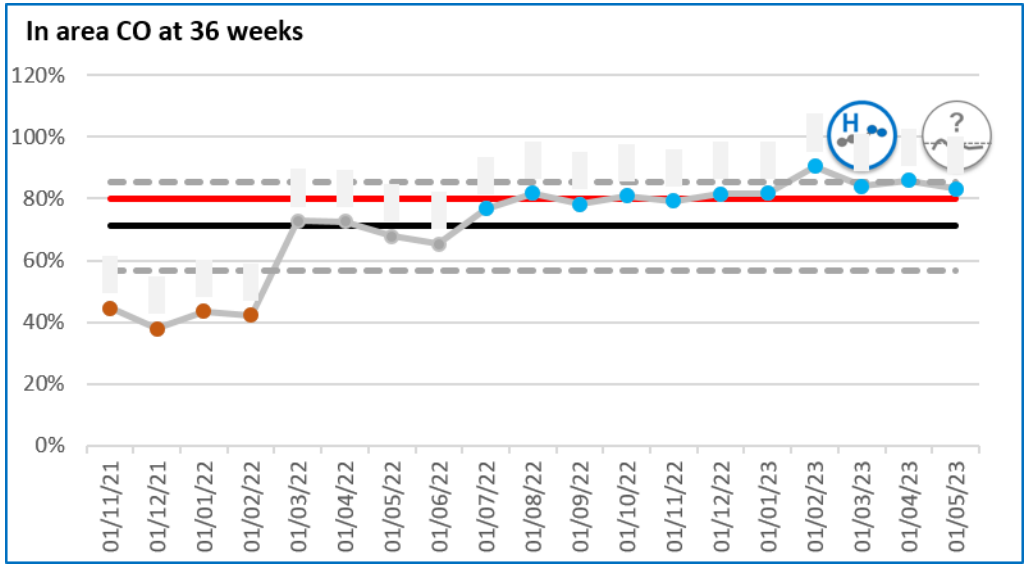
Maternity Dashboard 2023/24 – Exception report

Maternity

Gateshead Health NHS Foundation Trust

Safe





- **Background**
  - Maternity Incentive Scheme Safety Action 6 requires compliance with Saving Babies Lives care bundle – Element 1: reducing smoking in pregnancy
- **Assessment**
  - Year 4 MIS compliance of 80% CO monitoring at booking and 36 weeks – full compliance declared
  - Year 5 new standards require 95% compliance
- **Actions**
  - Update target compliance on dashboard
  - Additional engagement by Tobacco team with community midwives around increased target
  - Roll-out new NICE NG209 additional CO testing of smokers at every contact – including all acute contacts
- **Recommendations**
  - Risk of non-compliance added to departmental Risk Register

Maternity Dashboard 2023/24 - Exception report

Maternity

NHS Gateshead Health NHS Foundation Trust

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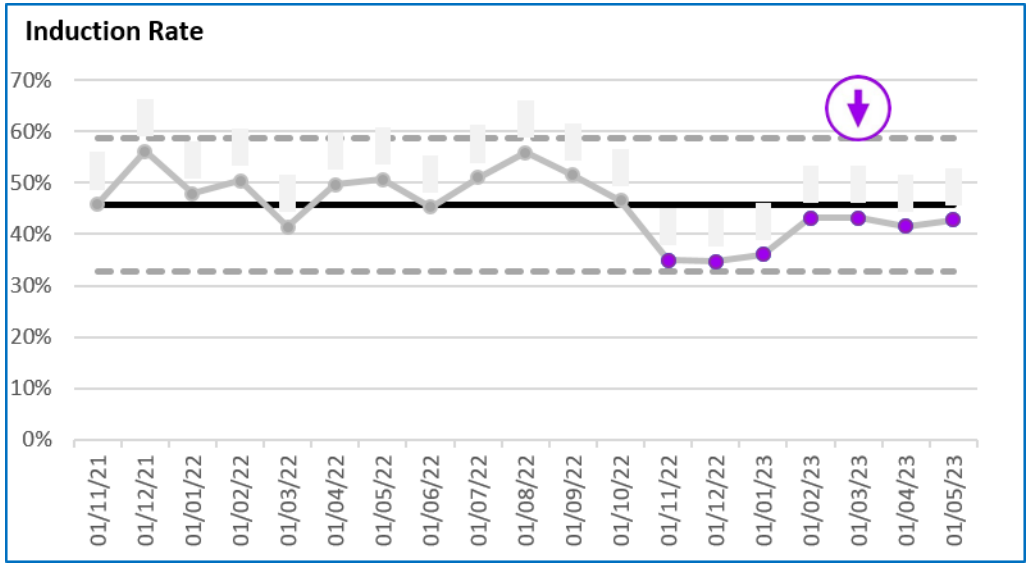
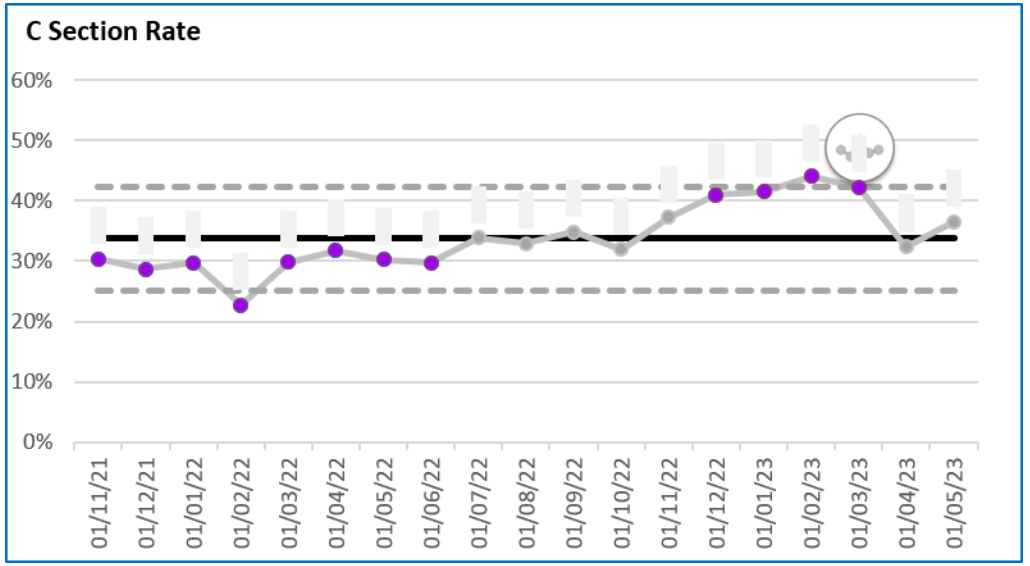
Responsive





- **Background**
  - Reduction in Induction of Labour rates observed
- **Assessment**
  - Appears to be aligned to an increase in overall caesarean section rate
- **Actions**
  - Overall increasing acuity of maternity patients and impact on workforce, theatre use, and outcomes linked to risks 2398, 2928, 3158
- **Recommendations**
  - Continue to monitor via Dashboard and Induction of Labour (IOL) / Lower Segment Caesarean Section (LSCS) audits

Maternity Dashboard 2023/24 - Exception report

Maternity

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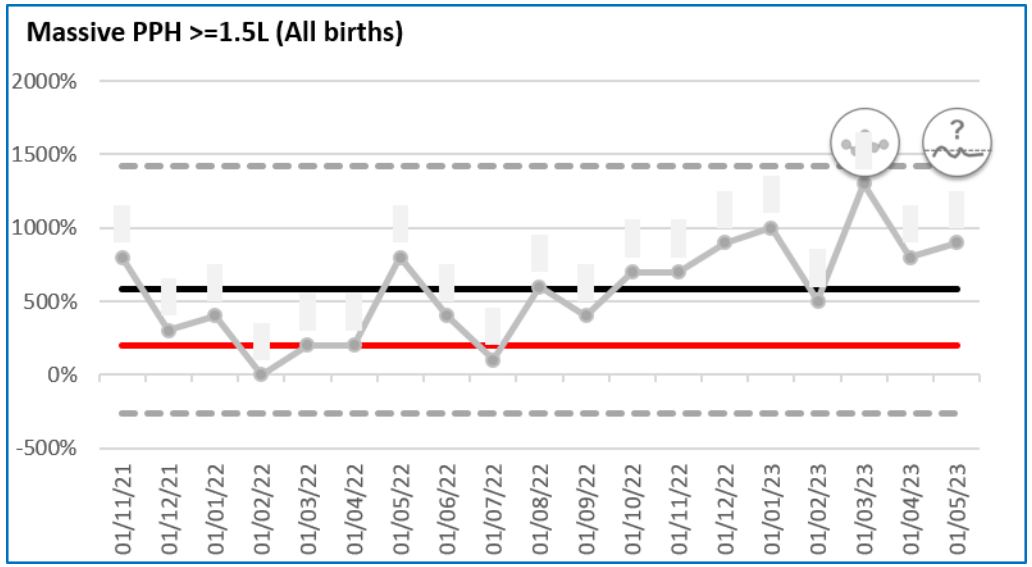
Gateshead Health NHS Foundation Trust

Safe

Responsive



- **Background**
  - Increase in massive PPH noted via risk management reporting and review towards end of 2022
  - Sustained PPH>1.5l above internal target
- **Assessment**
  - Implemented Measured Blood Loss (MBL) for all excessive blood loss to replace Estimated (EBL) – anticipated increase in PPH following this as under-estimation is well reported internationally in research
- **Actions**
  - PPH audit on annual audit plan
  - PPH audit to be reported to July 2023 departmental Safecare
  - Regional Maternity Patient Safety Learning Network focus on PPH at July meeting
  - MBL implemented for ALL births – appropriate equipment has been ordered and is now in place
- **Recommendations**
  - Continue to monitor rates and review ‘target’ of 2
  - Engage and share learning with regional network to consider shared quality improvement work

National policy drivers/incentive schemes:

- Maternity Incentive Scheme Year 5
- Saving Babies Lives Care Bundle v3
- Core Competency Framework v2

Maternity

NHS Gateshead Health NHS Foundation Trust

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All were published on 31st May 2023, alongside the implementation plan for the Single Delivery Plan for Maternity and Neonatal Care.

Submission of compliance with ten safety actions is required by **1 February 2024**.

Full gap analysis underway. Initial review highlights a risk of non-compliance for MIS year 5 for the Trust (noting this is reflected in all Trust's across the region). An emerging risk has been added to the Risk Register, as per the Risk Register exception report within this slide pack.

Risk Register review – Exception report (Maternity Operational Board 26/5/2023)

Maternity

Gateshead Health NHS Foundation Trust

Safe

Responsive

Emerging Risk 1

Compliance with Maternity Incentive Scheme Year 5

- MIS Year 5 standards were released 31/5/2023. To receive the 10% CNST/MIS rebate, the Trust must demonstrate compliance with ten nationally defined Maternity and Neonatal safety actions.
- Initial gap analysis against these safety actions:
  - significant risk that we will not be able to meet compliance with Safety Action 8 – MDT training requirements require additional full day training for all Midwifery and Obstetric staff, plus additional half day for Anaesthetic and HCA staff, to be achieved by December 2023
  - moderate risk that we will not be able to meet compliance with Safety Action 4 – medical staffing – need to review rest days and rotas for Obstetric Consultants following on-calls, confirm Anaesthetic attendance available within 5 minutes, ANNP impact on ability to meet BAPM medical staffing
  - moderate risk that we will not be able to meet compliance with Safety Action 6 – Saving Babies Lives care bundle – requirement for >95% CO monitoring (previous target of 80%), and an additional element has been added for those with pre-existing diabetes in pregnancy, which may be impacted by reduced Diabetic Specialist Nurse capacity

Actions:

- MDT in-depth review of new standards to take place
- Escalate concerns around significant changes required to Safety Action 8
- Paper to EMT
- Co-design regional ICB/LMNS approach to training

Risk Register review – Exception report (Maternity Operational Board 26/5/2023)

Maternity

NHS Gateshead Health NHS Foundation Trust

Safe

Responsive

Emerging Risk 2

Special Care Baby Unit (SCBU) staffing

- Due to staff leaving/maternity leave/reduction in hours, there is a risk that the SCBU will not be able to maintain cot capacity
- Due to 1 wte ANNP leaving the organisation, there is a significant risk that the ANNP will not be able to support current Junior Dr rotas
- Management and training time has been reallocated to cover clinical shifts

Actions:

- Critical shift payment uplift agreed by SMT and in place for 8 weeks from early June
- Series of solution focussed SCBU staff engagement meetings in place, to understand and improve recruitment and retention issues
- Review of ANNP banding to align role with NENC region – consider business case/medical staffing funding
- To be escalated to Regional Neonatal ODN as will impact regional cot capacity

- **2996 – Midwifery staffing levels -** Risk moved to managed

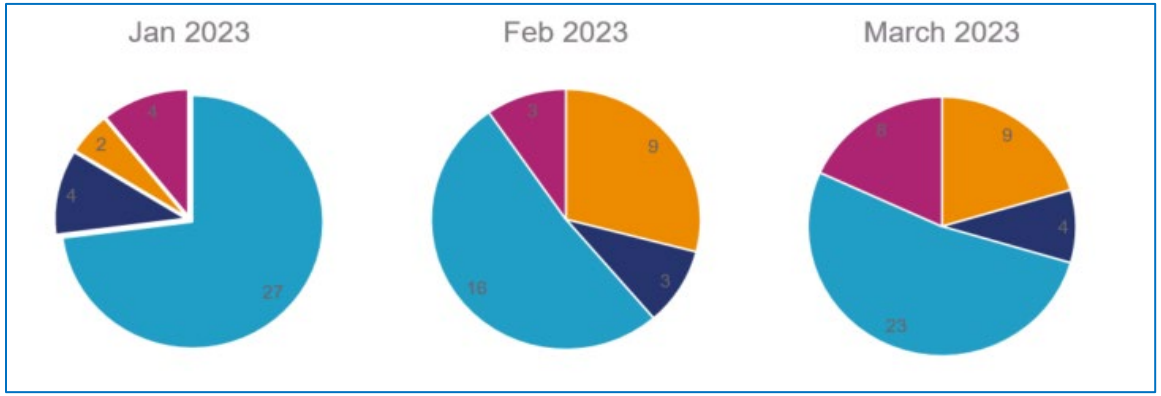
ATAIN - Avoiding term admissions to SCBU

Maternity

NHS Gateshead Health NHS Foundation Trust

Q4 2022/23	Total births	Births >37 weeks	Total term admissions	Reason for admission	Avoidable term admissions*
Jan – March 2023	397	363	21	Caesarean section No steroids Raised maternal BMI Gestational diabetes	Case reviews to be completed

Q4 2022/23	TC days	Babies receiving TC	Reason for TC	Number of babies avoiding SCBU
January 2023	84	27	Preterm, low birth weight, sepsis	10
February 2023	59	16	Preterm, low birth weight, sepsis, jaundice	9
March 2023	93	23	Preterm, low birth weight, sepsis	9



In Q4 (22/23), 28 babies avoided SCBU admission through transitional care (TC)

21 term infants were admitted to SCBU

Themes:
- **Caesarean section**
- **No steroids**
- **Raised maternal BMI**
- **Gestational Diabetes**

Learning:
- **27/85 term admissions/TC babies received feed within 1st hour**

Actions:
- **MSWs deployed to labour ward to support with early feeding**
- **Plan for MDT discussion at Transitional Care meeting July 2023**

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 15

Report Title:	**Quality Account 2022/23**			
Name of Meeting:	Trust Board			
Date of Meeting:	26th July 2023			
Author:	Multiple authors from across the Trust			
Executive Sponsor:	Gill Findley, Chief Nurse and Professional Lead for Midwifery and AHPs			
Report presented by:	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:** ☐
	Presented here is the Trust's Quality Account 21/22.The membership of the Quality Governance Committee are asked to review and approve this document ahead of the requirement to submit nationally prior to 30th June 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*	The Trust's Quality Account 22/23 has been presented at a number of meetings including: • Healthwatch • The Oversight and Scrutiny Committee • The CCG • The Trust's Council of Governors • The Patient, Public and Carers Involvement and Engagement Group (PPCIEG) • The Safecare/Risk and Safety Council			

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 Quality Account 2022/23 includes:
	• A statement from our Chief Executive
	• Progress updates on the nine Quality Account Priorities from 2022/23
	• Our Quality Priorities for improvement for 2023/24 (three within patient experience, three within patient safety, three within clinical effectiveness and for the first time, three within staff experience)
	• Statements of Assurance from the Board including:
	  ○ Participation in National Clinical Audits 2022/23
	  ○ Participation in clinical research
	• Learning from deaths
	• Seven day hospital services
	• Freedom to Speak Up			

<table>
<tr><td></td><td colspan="5">NHS Doctors
Mandated Core Quality Indicators
Review of quality performance
Good news stories and celebrations</td></tr>
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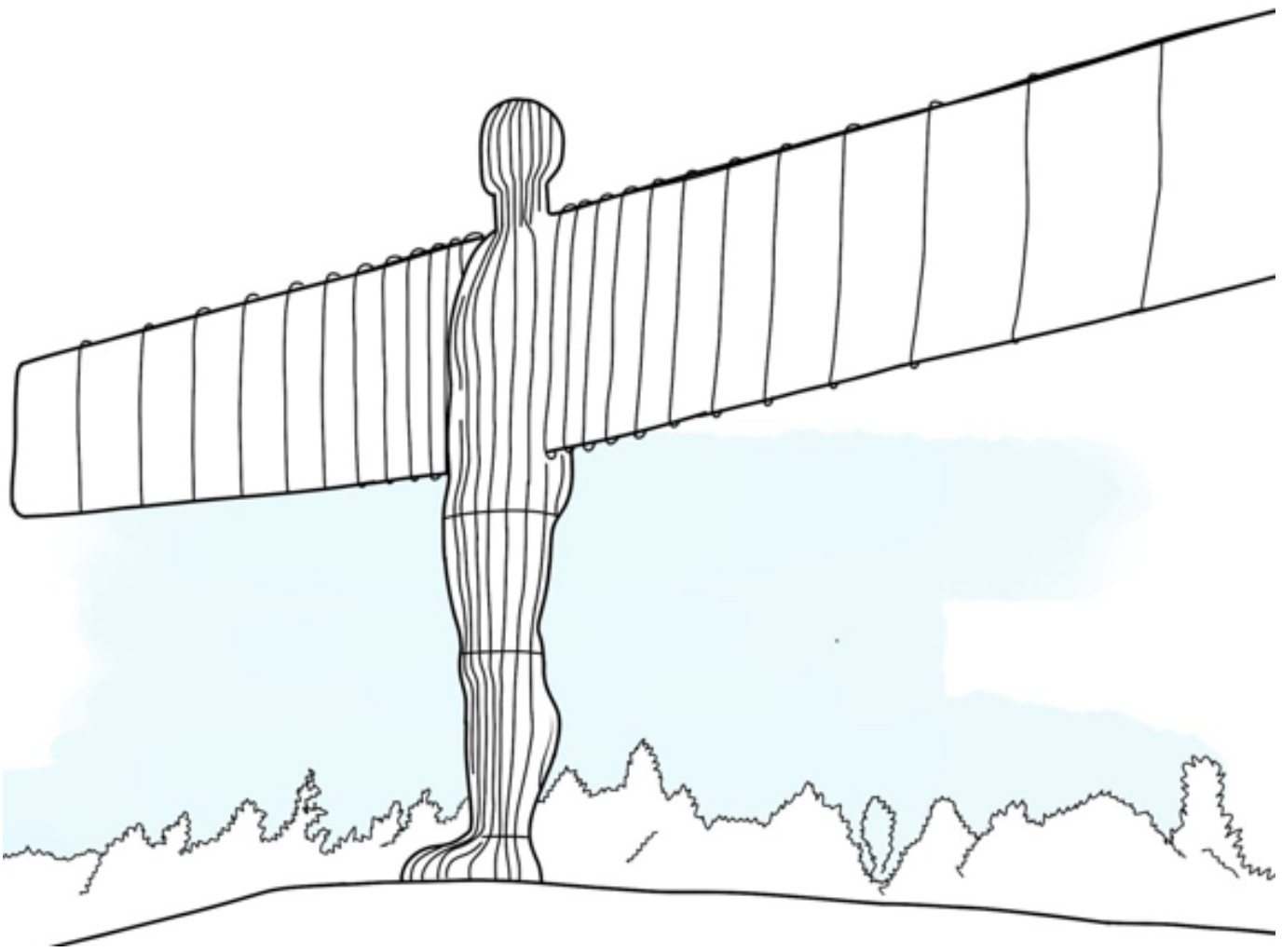
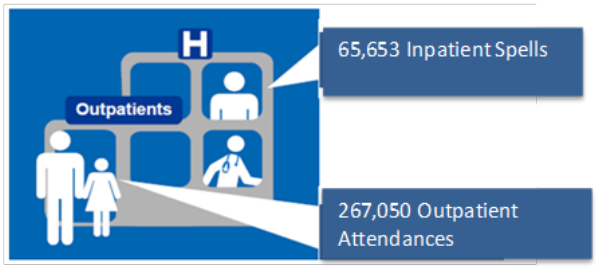


Quality Account

Gateshead Health NHS Foundation Trust 2022/23

Gateshead Health NHS Foundation Trust at a glance…



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Part 1

Quality Account – Chief Executive's Statement

Statement on Quality from the Chief Executive

#HelloMyNameIs Trudie. I am delighted to be able to present my first Quality Account as Chief Executive of Gateshead Health NHS Foundation Trust. Providing great care and achieving great outcomes for our patients, their families and carers is at the heart of everything we do. There is no doubt that 2022-23 has again been a challenging year for us here at Gateshead as well as across the wider NHS and social care system. Covid-19 has not gone away and we have seen a high number of patients needing urgent and emergency care, twinned with high numbers of patients who are in a hospital bed but who are medically fit and could be cared for elsewhere in our community – all of which present both quality and operational challenges. From my first days at the Trust to the present, I've been blown away by the way our teams respond to challenges and how our dedicated colleagues have continued to transform care for the better, make innovative improvements and improve our culture.

In this Quality Account, we share with you details about the quality of patient care we have provided over the past 12 months and our achievements as well as our quality priority areas for 2023-24. These incorporate the pillars of quality - patient experience, patient safety, clinical effectiveness and for us here at Gateshead, we also include staff experience as it is inextricably linked to the quality of care. Our biggest priority over the next 12 months is to reduce length of stay. Spending a long time in hospital can lead to an increased risk of patients falling, sleep deprivation, catching infections and sometimes mental and physical deconditioning. By ensuring patients return to their usual place of residence, or another care setting, as soon as it's safe to do so, not only will this have a positive impact for our patients in terms of their safety and experience, but also on 'flow' (the movement of patients, information or equipment between wards and departments) which will improve right through the system. Beds will be free for those needing quick admission for emergency care or for a planned operation, which in turn will have a positive impact on reducing crowding in our emergency department. This is not something that can be solved by just working harder, or faster, we need to do something different and I am looking forward to working with our colleagues across the Trust and wider health and social care system to make this a reality.

Gateshead Health NHS Foundation Trust has started on a journey to further increase our partnership working. It is therefore crucial that our Quality Account priorities link with our strategic aims around our patients, people and partners. In terms of enhancing patient experience, we are continuing our journey of collaborative working at PLACE with the introduction of further patient forums which are patient led and patient chaired, in collaboration with the NHS North East and North Cumbria Integrated Care Board. I am committed to lead Gateshead Health with vision and clarity towards our common goal of achieving success and we will continue to do this through developing trusted relationships, being inclusive and respectful of others and ensuring that as a good partner, the standard of care delivered within the hospital and within Gateshead's community remain high.

Over the last twelve months, we have continued to foster an open and responsive culture to inform learning and shape practice and this will continue over 2023-24 as we implement the Patient Safety Incident Response Framework (PSIRF) as one of our Quality Account priorities. We will continue to actively encourage all of our staff to report incidents and any issues they may face, and we will continue to participate in national audits, and share findings across teams to inform practice, and to improve safety and outcomes for our patients.

We understand that in order to ensure high quality care for our patients, we must look after our people and ensure that they have what they need to be able to perform to a high level. In

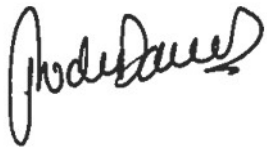
response to this, we have made a significant investment in staff wellbeing, with a dedicated health and wellbeing team and a comprehensive range of support for our people. These include wellbeing and financial advice, menopause support, wellbeing check-ins, therapy sessions in collaboration with Gateshead College and an enhanced catering offer, particularly in times of extreme pressures such as Opel 4 where we have offered all staff free teas, coffees, breakfasts and soup, in response to staff feedback.

We know we still have so much to do as the NHS, both locally and nationally, continues to face immense challenges. Nevertheless, we have much to be optimistic about and, despite these challenges, I am confident we will continue to improve the quality of care we provide because our dedicated teams focus on what matters most, supporting each other as well as our patients and carers to have the very best of experiences of our services here at Gateshead.

Our staff selflessly step forward both night and day, with courage to care for, help and support patients, families and colleagues in the most challenging of circumstances. As an Executive team, we believe that the people who do the job know best how to do it and we are driven to listen to our staff and encourage innovation. On behalf of myself and our Trust Board, I would like to thank every member of staff, our governors, our volunteers and partners for their hard work and commitment during these challenging times.

To ensure that the Quality Account fairly presents our position, it has been reviewed by key stakeholders and by Trust Board members, including our Non-Executive Directors. I can confirm, in accordance with my statutory duty, that to the best of my knowledge, the information provided in this Quality Account is accurate.

Signed Date: 21/06/2023



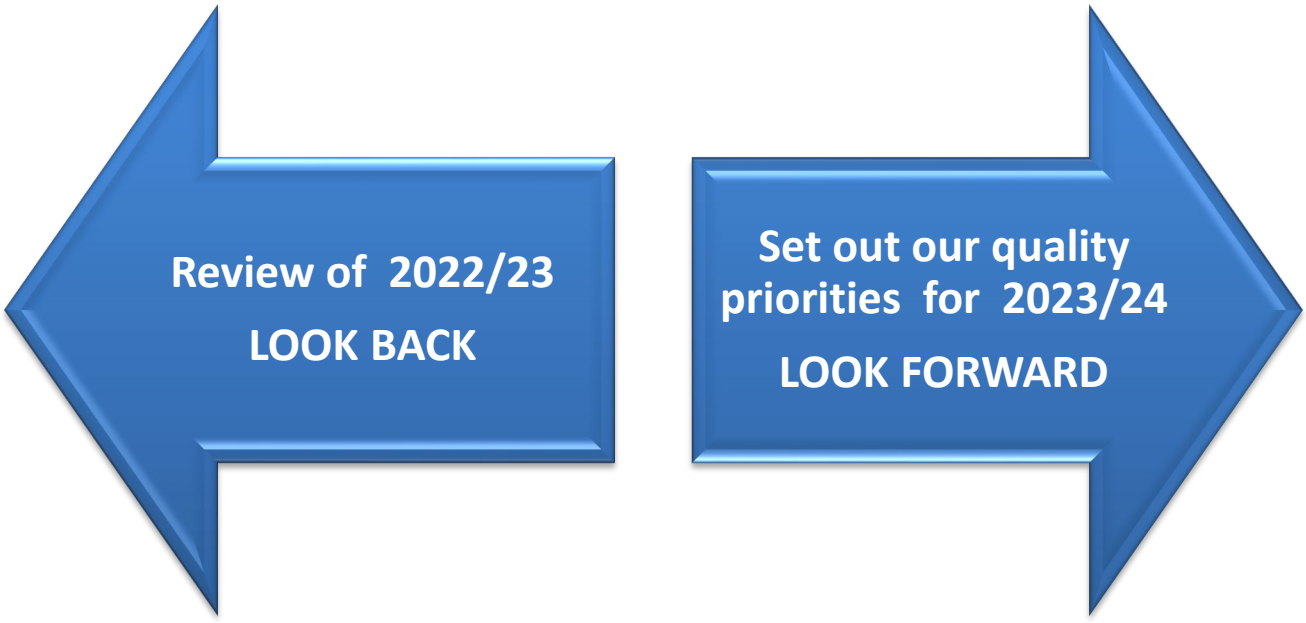
Chief Executive

What is a Quality Account?

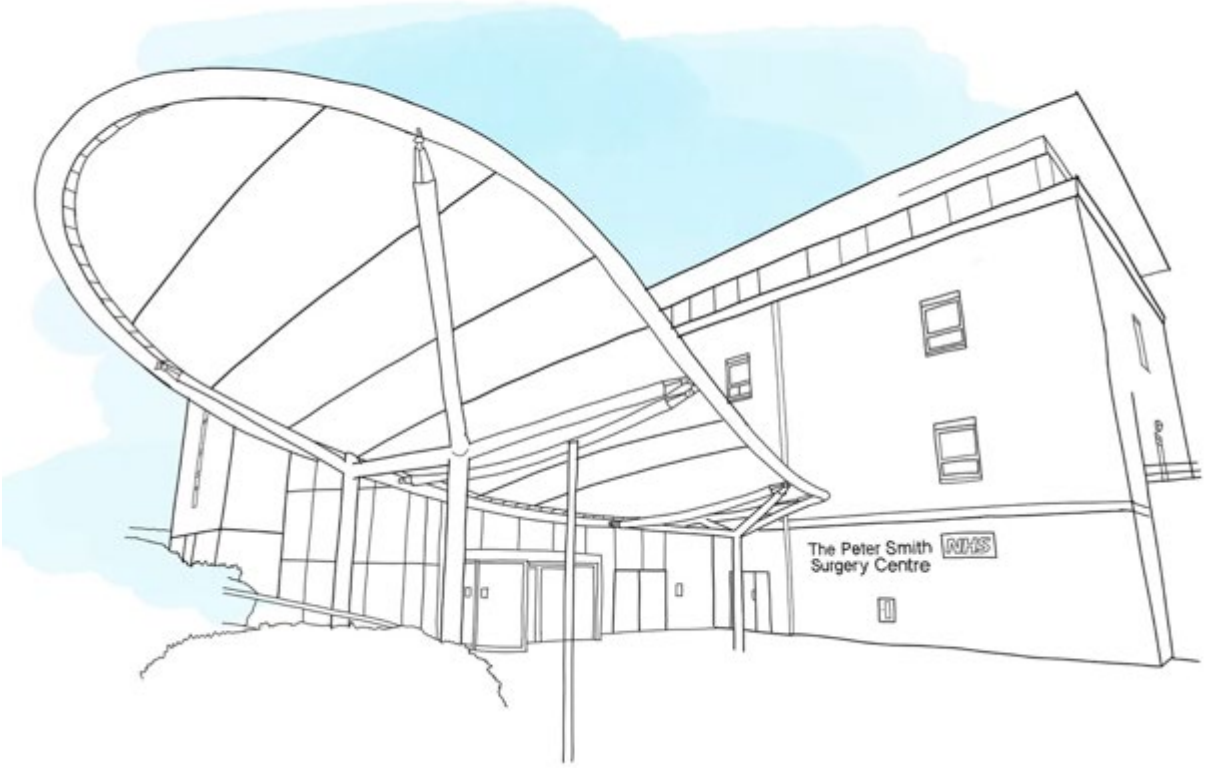
The NHS is required to be open and transparent about the quality of services provided to the public. As part of this process all NHS hospitals are required to publish a Quality Account (The Health Act 2009). Staff at the Trust can use the Quality Account to assess the quality of the care we provide. The public and patients can also view quality across NHS organisations by viewing the Quality Accounts on the NHS Choices website: www.nhs.uk.

The dual functions of a Quality Account are to:

- Summarise our performance and improvements against the quality priorities and objectives we set ourselves for 2022/23.
- Outline the quality priorities and objectives we set ourselves going forward for 2023/24.



Part 2
Quality Priorities



2. Priorities for Improvement

2.1 Reporting back on our progress in 2022/23

In our 2021/22 Quality Account we identified 12 quality priorities that we would focus on. This section presents the progress we have made against these.

PATIENT EXPERIENCE:

Priority 1: Reinvigorate the Volunteers Service

➢ What did we say we would do?

- Increase volunteer numbers
- Full evaluation of the 'Response Volunteer Programme' and 'Patient Experience Volunteer Programme'
- Develop a contingency plan for the recruitment and mobilisation of external volunteers

➢ Did we achieve this?

- Yes we achieved this priority.

➢ Progress made:

- We increased the number of people volunteering within the Trust by 50, with further volunteers in our recruitment process.
- Each day (except weekends), our Patient Experience Volunteers visit the wards and spend time talking to patients thus enhancing patient experience. They have also supported our international Nurses on-boarding and acted as patients in preparation for clinical assessments called OSCEs by having their observations such as blood pressure and pulse taken. This has been very successful. If a patient raises any concerns, the volunteers will feedback to the Ward Manager and/or patient experience team and concerns are logged, or comments forwarded to the team/department for early resolution. Our Response volunteers wear an electronic communications device and are available Monday to Friday, to support staff with a wide range of tasks. These include assisting with the delivery and collection of patients notes; and more recently, collecting and delivering Chemotherapy medication to the Chemotherapy Day Unit, so that this vital medication can be administered in a timely manner.

- New volunteer communication materials have been developed which has included videos and blogs which have been shared both internally and externally on social media posts.

- A number of our volunteers have shared their stories about the journey to volunteering and their experiences at the Trust, to both the Patient, Public and Carer Involvement and Engagement Group (PPCIEG) and to the Trust Board of Directors. This was very well received and our volunteers continue to inspire us daily.
- We have evaluated Patient Experience and Response volunteer programmes. The results of this are being shared internally in quarter 1 of 2023/24.
- The Patient Experience Team have worked with the Trust's People and OD team and have agreed the processes that would be needed around external provider volunteer support (such as in future cases of a pandemic). Any recruitment with external providers will be advertised online and prospective volunteers will go through the necessary NHS employment checks.

➢ Next steps:

- Whilst this priority has been achieved, we continue to publicise the fantastic work of our volunteers and welcome prospective volunteers contacting the Trust to explore the opportunities available. A Quality Account priority for 2023/24 relating to volunteers is outlined further within this document.

Priority 2: Understand and improve the experiences of service users with Learning Disabilities and Mental Health needs

➢ What did we say we would do?

- Ensure we identify service users
- Understand the experiences of service users with Learning Disabilities (LD) and Mental Health needs and look at where improvements can be made
- Review patient information leaflets to identify core areas where easy read leaflets are needed
- Provide easy read appointment letters
- Increasing biopsychosocial assessments to a minimum of 60%

➢ Did we achieve this?

- We partially achieved this.

➢ Progress made:

- Alert on Careflow (our patient administration system) for patients who identify as having a learning disability. However, there is still work to do to ensure that everyone is flagged appropriately; issues with information governance in terms of information sharing using GP register, conversations remain ongoing with the ICB to rectify this. Ongoing weekly meeting with the community LD team to link and improve potential alerts to be added.

- Workshop with Lawnmowers; theatre production group ran by and for people with a learning disability was arranged after funding agreed. 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 Trust's 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 were able to attend.
- 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.

➢ Next steps:

- Improving the care and experiences for patients with a learning disability is a priority for 2023/24.

Priority 3: Working with patients as partners in improvement

➢ What did we say we would do?

- Demonstrate that we value the contribution of our patient partners
- Ensure the patient partner voice is heard
- To provide a forum for staff to seek feedback, engagement, and involvement from patient partners

➢ Did we achieve this?

- Yes we achieved this priority.

➢ Progress made:

- We considered developing a policy to enable remuneration and found this was covered in an existing policy
- We have held a number of co-design improvement workshops across the Trust which have provided an opportunity for multidisciplinary point of care staff to work in partnership with patients. This has involved listening to each other's experiences and talking together about what we can learn and improve on based on this. Significant improvements have come to fruition from this such as those across our maternity services in relation to our gestational diabetes pathway.

As a result, two of our Midwives received Chief Midwifery Officer (CMO) Awards in recognition for the improvements implemented.

- A small number of patients now sit on key groups across the Trust including the Mortality & Morbidity Steering Group and six patients volunteered to take part in ward visits called 'Your time to shine'.
- We have worked collaboratively with NHS North East and North Cumbria Integrated Care Board and established a jointly facilitated Patient Forum, with a focus on long term conditions.

➢ Next steps:

- We aim to build on this work around collaborative working in terms of patient engagement and involvement and this will be done through a new Quality Account priority for 2023/24.

STAFF EXPERIENCE:

Priority 4: We will focus on the health and wellbeing (HWB) of our staff

➢ What did we say we would do?

- Being responsive to staff feedback

➢ Did we achieve this?

- We partially achieved this

➢ Progress made:

- Over 200 managers have completed the Managing Well Programme which acts as a prompt and educational opportunity around the importance of HWB check ins.
- New appraisal documentation includes prompts to ensure HWB check ins are conducted on at least an annual basis.
- Flu vaccination campaign completed – 54% of frontline healthcare workers took up the vaccine.
- The trust achieved the Better Health at Work Silver Award in December 2022.
- Many other initiatives have been rolled out including free teas, coffees, soups and breakfasts during periods of extraordinary pressure, free therapy sessions such as massage and nails, hampers, implementation of the 'listening space' etc.
- Further initiatives continue to be tracked through the health and wellbeing board which includes work on menopause support, health and wellbeing check-ins, financial wellbeing and more.
- The organisation approved and ratified its health and wellbeing strategy at senior management team meeting in early September 2022.

➢ Next steps:

- A new campaign, #GHMoneyMatters, has been launched to promote financial wellbeing specifically, while an item bank has been launched on site. The team are currently working to implement the provision of free sanitary products and introduce a staff wellbeing support dog. A staff lottery is being looked at as a means of generating a stable income stream to reinvest directly into staff wellbeing initiatives.
- A health needs assessment is currently being promoted as means of gauging employee views on where support is required most. This also feeds into our work to achieve the Better Health at Work Gold award.
- 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.

Priority 5: We will advocate for equality, diversity, and inclusion for all of our staff

➢ What did we say we would do?

- Demonstrate progress in meeting the Workforce Disability Equality Standard (WDES) recommendations
- Demonstrate progress in meeting Workforce Race Equality Standard (WRES) recommendations
- Staff inclusion and ensuring all professional voices are heard (e.g., Allied Health Professionals (AHP), pharmacy, community, staff networks)
- Increase the number of professional development opportunities

➢ Did we achieve this?

- We partially achieved this.

➢ Progress made:

- An overarching Equality and Objectives and Action Plan has been developed for 2020-24.
- Links with community groups and local schools, colleges and universities established.
- Revised data collection has been implemented and analysis.
- Bitesize recruitment and selection 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.
- Reciprocal mentoring programme offered within the Trust.
- Nine Cultural Ambassadors have been trained to be utilised during disciplinary processes where BME members of staff are involved.
- AHP Conference took place in September 2022.
- AHP leads forum has been established. Actions and outcomes from this will be completed at annual AHP review.
- Participated in National Workforce Supply project - 18 month strategic workforce plan submitted. Learning and further actions from the trust have been identified within the AHP five year strategy document which has now been completed.
- National AHP day campaign launched and due for celebration in October 2023.
- Three career events in June/July 2022 have taken place which have highlighted to local school groups the diversity of AHP careers

➢ Next steps:

- A Zero Tolerance Policy to be ratified by Policy Review Group

Priority 6: We will promote a just, open, and restorative culture across the organisation

➢ What did we say we would do?

- We will implement and embed all principles of a just culture across the organisation

➢ Did we achieve this?

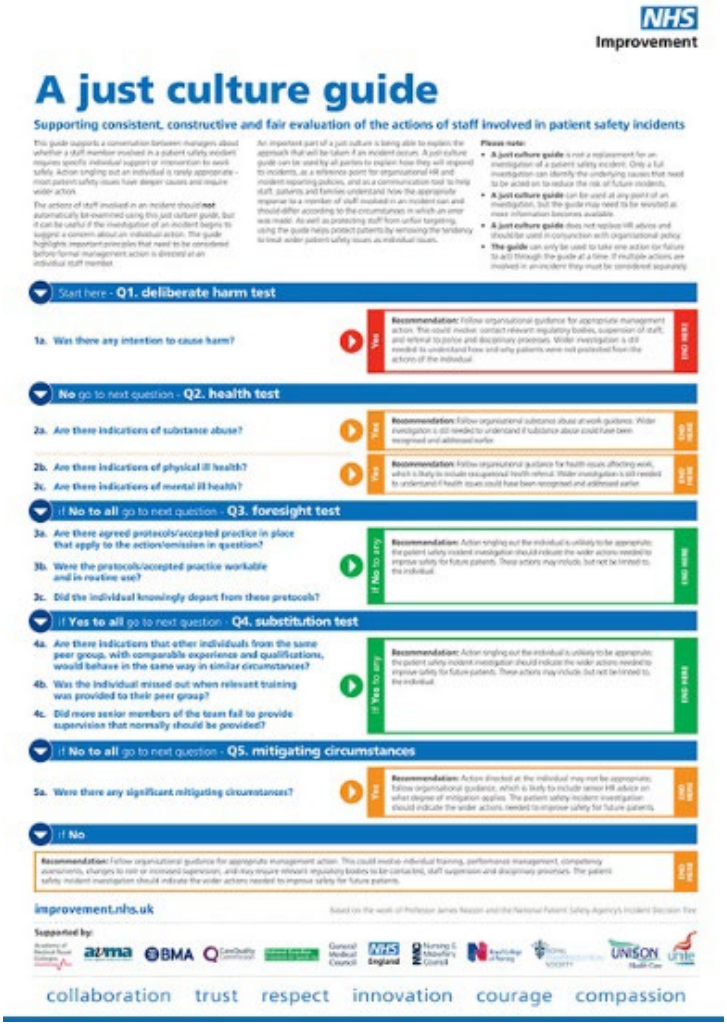
- We partially achieved this.

➢ Progress made:

- A dedicated session of the new Patient Safety Incident Response Framework and Learn from Patient Safety Events was delivered to the Trust Board in February 2023.
- Links between People and Organisation & Development (POD) and patient safety in relation to culture and civility saves lives has been established.

➢ Next steps:

- A culture steering group is to be established.
- An organisation wide cultural survey has been devised and will be presented to the Trust's SafeCare/Risk and Patient Safety Council for approval in April 2023.
- Staff survey results to be triangulated with a culture benchmarking survey.



PATIENT SAFETY:

Priority 7: To maximise safety in maternity services through the implementation of the Ockenden Recommendations

➢ What did we say we would do?

- To fully implement all immediate and essential actions.

➢ Did we achieve this?

- Yes we achieved this.

➢ Progress made:

- We are compliant with all immediate and essential actions.
- Audits of this are built into our audit cycle.
- Monitoring has been built into our Maternity Integrated Oversight Report.

➢ Next steps:

Continue monitoring via the Maternity Integrated Oversight Report, a new priority relating to maternity services is outlined within section 2.2 which will build on this established body of work.

Priority 8: Staffing

➢ What did we say we would do?

- 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.
- Recruit 50 Nurses within 12 months.

➢ Did we achieve this?

- We partially achieved this.

➢ Progress made:

- A bi-annual assessment was undertaken in January and July 2022, this data was presented to the Board who approved all the recommendations made by the Chief Nurse.
- Standardised display boards are being considered by the Matron teams. A new uniform board has been development and will be shared in all areas.

- A task and finish group has been established to review signage across the trust and will meet monthly to progress work. Initial meeting took place in December 22 and actions assigned.
- The Shelford Group has since supported pilots with safer nursing care tool (SNCT) in the following areas:
    - Emergency Care
    - Mental Heath
    - Community

- To date the Trust has welcomed 38 overseas nurses as part of the International Recruitment work. Cohorts are currently undertaken OSCE training and examinations of which 15 have successfully obtained their NMC pin.

➢ Next steps:

- Gateshead Health is committed to welcome 122 Internationally recruited registered nurses before April 2024. National funding has been secured to support a recruitment and pastoral program to support the international workforce joining our team.
- Working with our local schools and colleges to recruit 20 new to healthcare recruits and support through an apprenticeship program to become a registered nurse. This program will take four years to complete but will provide opportunities to the local population of Gateshead to enter the nursing profession who may not have had the ability to do this via the university degree route.
- Working across the organisation to develop our current workforce, providing apprenticeships and academic support to staff who wish to progress into a registered professional role across Nursing, Midwifery and Allied Health professions.
- Build on the tools available to support review and audit of our workforce to help gain a better understanding on future workforce planning.
- Legacy mentorship program to support and retain our experienced staff to remain part of our workforce and support newer staff members to continue to develop.

Priority 9: Undertake improvement work to agree a safe method of processing clinical results

➢ What did we say we would do?

- 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.

➢ Did we achieve this?

- We partially achieved this.

➢ Progress made:

- An improvement workshop was held in March 2023, this had been rescheduled from earlier in this year due to operational pressures. The workshop was attended by members of the transformation team, medical director, general surgeon/medical digital lead, patient safety lead, clinical risk lead, clinical effectiveness lead and members of the ICE system team. The workshop mapped out the process for requesting and managing blood test results and the following actions were agreed:
    - Ensure the list of requesting clinicians is accurate by requesting an to update list of clinicians from the workforce information team.
    - Ensure the ICE team are provided with a list of starters and leavers on a monthly basis to ensure the system can be kept up to date.
    - Develop a standard operating procedure to standardise requests and accessing results safely.
    - Develop user guides to showcase best practice.
    - Explore options to develop process to inform patients when blood results are normal.
    - Action plan developed with a deadline for the actions to be completed by end of April 2023.

➢ Next steps:

- The half day workshop did not provide enough time to review all elements of the ICE system. A further Rapid Process Improvement Workshop (RPIW) to be held in July 2023 to review process for radiology and histology requests with a view to developing a complete standard operating procedure.
- Audit One to carry out audit of new process in Q4 of 2023/24.
- Priority to be carried over into 2023/24.

CLINICAL EFFECTIVENESS:

Priority 10: We will revisit the core fundamental standards of care

➢ What did we say we would do?

- We will revisit the core fundamental standards of care.

➢ Did we achieve this?

- We partially achieved this.

➢ Progress made:

- There has been a revision of the Care Quality Accreditation Framework (CQAF) programme which includes panel and assessors.
- Professional leadership and development days have been reinstated supported 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.
- Further development is being undertaken by the Head of Nursing to strengthen the panel as a development opportunity for senior nurses.
- It was agreed at the November 2022 SafeCare, Risk and Patient Safety Council that we are going to use a revised audit tool of the six essential safety criteria to allow all wards and outpatient areas to be visited. This has now been implemented and improved compliance levels are being achieved.
- Phases one to three of the implementation of the Trust's CQC monitoring approach have now been implemented.

➢ Next steps:

- Trust's CQC Monitoring approach - this work will be reviewed in 2023 to update the master document with compliance achieved.

Priority 11: We will encourage, help, and support all staff to engage with research

➢ What did we say we would do?

➢ We will embed research into our ways of working

➢ Did we achieve this?

➢ We partially achieved this.

➢ Progress made

- Promotion continues that **"Research is Everyone's Business"** and the different ways that staff can get involved. Promotion also continues through annual events.
- There has been an increase of four new Principal Investigators and five Associate Principal Investigators.

➢ Next steps:

- The Royal College of Physicians (RCP) and National Institute for Health and Care Research (NIHR) have published a joint position statement setting out a series of recommendations for making research part of everyday practice for all clinicians which include:
  - Developing strong links between Medical Directors, R&D Directors and Chief Executives
  - Encouraging support for research to be recognised as part of direct clinical activity and not an additional speciality.
  - Including research as a key element in all Trust policies, strategies and documentation.
  - Ensuring that staff have the resources, time and support they need to engage with and/or deliver quality research, which feeds into clinical change.
  - Ensuring that multidisciplinary workforce planning encompasses those who support research.
- Taking opportunities to implement proportionate training requirements for those involved or would like to be involved, including Good Clinical Practice training, and the Associate Principal Investigator Scheme.

Priority 12: We will support the continual improvement of clinical record keeping (both paper and electronic) throughout the Trust

➢ What did we say we would do?

- Review and reinstate a revised programme of documentation audits

➢ Did we achieve this?

- Yes we achieved this.

➢ How we achieved this:

- We revised the methodology for the documentation audit, this involved reviewing the audit tool, frequency, sampling and group of auditors. This was consulted on and communicated widely across the organisation. The new documentation audit commenced in February 2023.
- 45 sets of notes were audited in the first cycle.

Chart 1 - Trust wide compliance with basic record keeping elements:

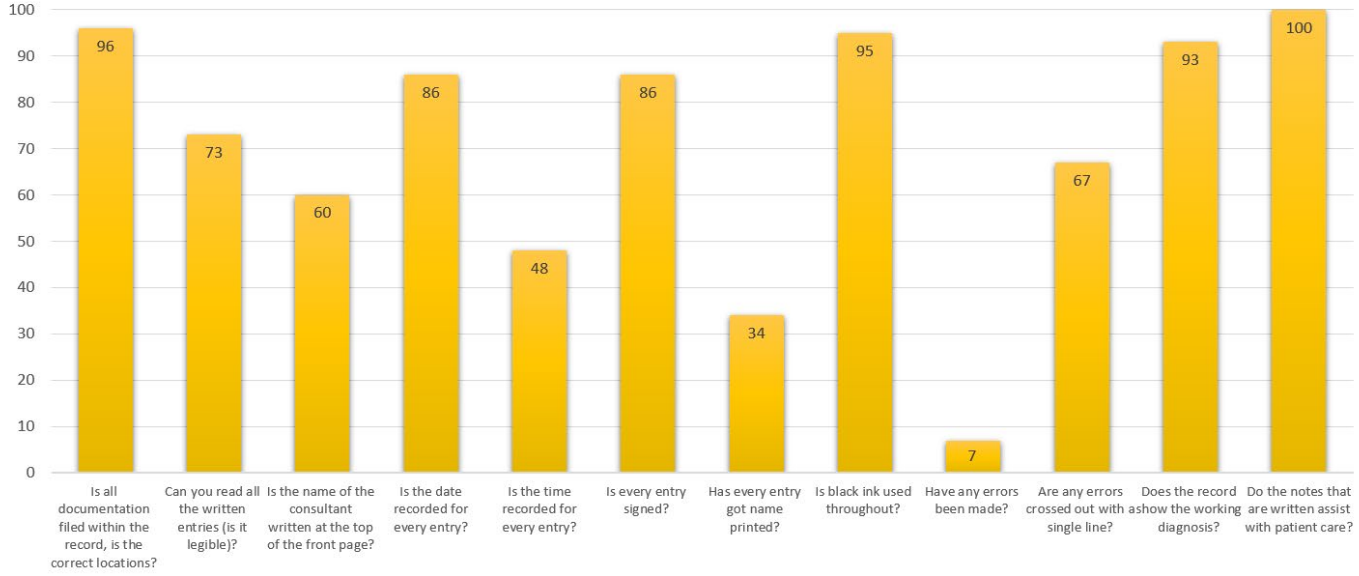


Chart 2 - Overview of compliance with risk assessments:

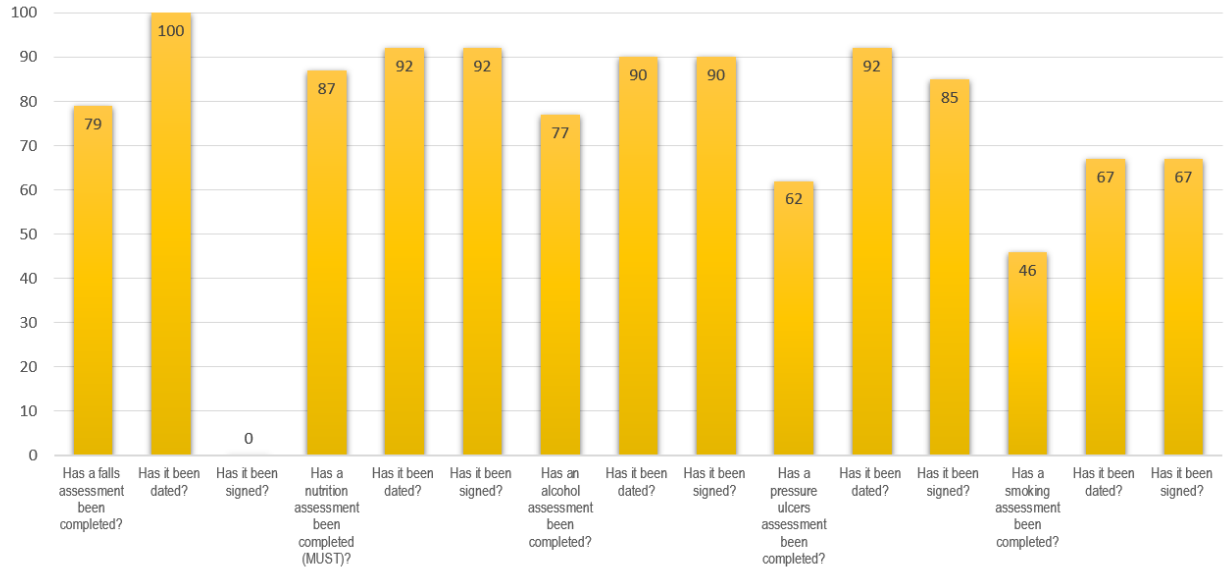


Chart 3 – Overview of compliance with discharge criteria

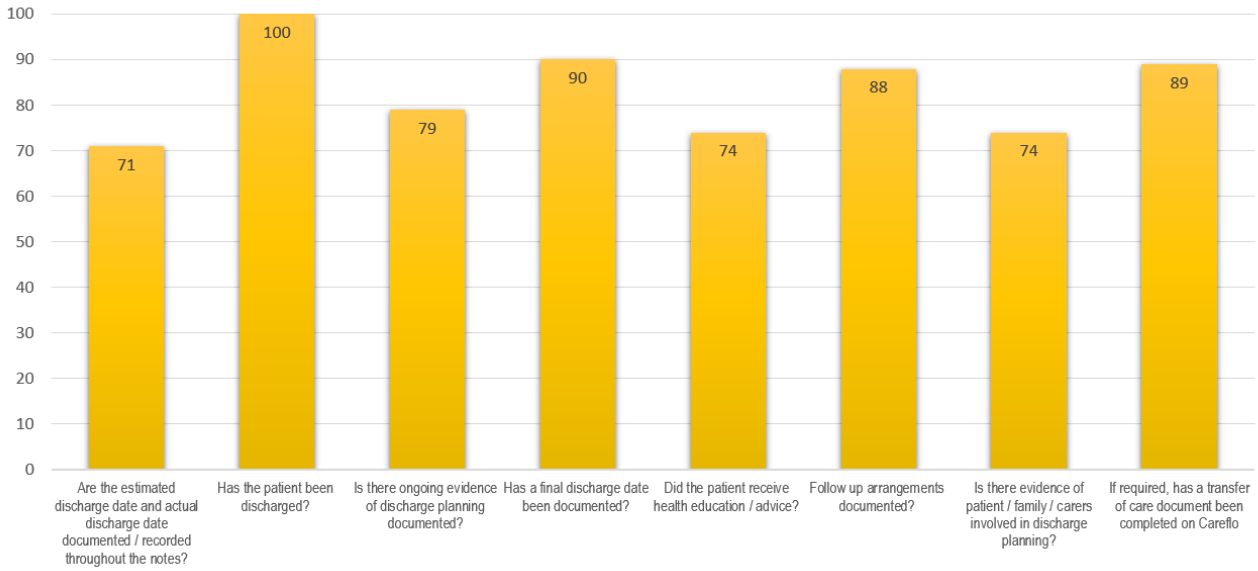


Chart 4 - Overall compliance with each section

Section	Qtr. 4 22/23
Basic Standards	56%
Electronic Records	54%
Nursing Records	59%
Clinical Records	77%
Risk Assessments	82%
Discharge Details	83%
Miscellaneous	89%

➢ Next steps:

- Continue the audit on a quarterly cycle
- Present first quarter results to the SafeCare/Risk and Patient Safety Council in May 2023

2.2 Our Quality Priorities for Improvement 2023/24

PATIENT EXPERIENCE				
Quality Priority	**What will we do?**	**How will we do it?**	**Expected Outcome?**	**How will it be measured?**
We will work with our Volunteers Service to develop new roles.	We will develop new volunteer roles.	We will review the evaluation of our existing volunteer programmes and consider the suggestion for where volunteers could further support across the organisation. We will introduce a volunteer programme task and finish group with multidisciplinary team input to develop volunteer role profiles and associated training requirements and plans (if applicable).	We will introduce a new volunteer programme.	Number of volunteers joining the new volunteer programme. Evaluation of the new programme.
We will improve the way we learn and make improvements following complaints.	We will demonstrate learning and improvements made as a result of feedback from complaints.	We will implement InPhase. We will develop a section on the Trust's Learning Library to share learning and improvement made. We will work with the Trust's Transformation team to collaboratively support business units to identify opportunities for service and	Evidence of learning and improvements made following complaints will be accessible and will be shared widely across the organisation.	Number of learning bulletins and improvements made as shared on the Learning Library.

		quality improvements		
We will strengthen our partnership working with collaborative patient forums to enhance patient engagement and involvement.	We will develop and introduce new patient forums in collaboration with the North East and North Cumbria Integrated Care System (ICS).	We will seek patient and service line feedback and collaborate with the North East and North Cumbria Integrated Care System (ICS) to identify where further patient forums could be introduced (eg. the specific clinical area such as a Cancer Services Forum)	A new patient forum will have been introduced.	A new patient forum will have been introduced.

STAFF EXPERIENCE				
Quality Priority	**What will we do?**	**How will we do it?**	**Expected Outcome?**	**How will it be measured?**
We will improve the way we listen, act upon and learn from concerns.	Develop supporting leaflets on Freedom to Speak Up for both staff and leaders in the organisation. Update our Freedom to Speak Up Policy based on national guidance and local people strategy. Refresh our approach to reporting on Freedom to Speak Up across the organisation.	Consider timing for further campaigns to recruit more champions again. Review a proactive approach to reach out to people who we think will be good at the champion role.	Increasing the number of Freedom to Speak Up Champions, we have across the organisation. Increasing staff awareness of what Freedom to Speak Up is and who the champions across the organisation are.	Training figures compliance for all staff groups and Board members.

	Develop a communication plan to make staff aware of what Freedom to Speak Up is, communicate what the role involves and look to seek expressions of interest for additional Freedom to Speak Up Champions.			
We will listen to staff experience in relation to waste and duplication.	We will listen to staff experience in relation to waste and duplication.	On a monthly basis, the Trust's Directors will hold events in the Hub and dedicated sessions will be initiated that are focused on reducing waste and duplication.	A number of events will have been facilitated and there will be a reduction in waste and duplication.	A target % is to be agreed by the Trust.
We will focus on safe staffing, including reducing the movement of staff between clinical areas.	We will use approved tools for all clinical areas in line with national requirements, making sure we are assessing staffing appropriately eg. Birthrate plus, SNCT, Mental Health Optimal Staffing Tool (MHOST) etc.	We will understand our staffing data. We will recruit to posts where a staffing gap is identified. We will manage staffing in accordance with Trust policy.	We will reduce the movement of staff between clinical areas.	A target % is to be agreed by the Trust.

PATIENT SAFETY				
Quality Priority	**What will we do?**	**How will we do it?**	**Expected Outcome?**	**How will it be measured?**
We will reduce length of stay.	We will reduce length of stay.	We will understand our data and know what our length of stay is and metrics associated. A Task and Finish group will be set up. We will have a robust monitoring and reporting structure in place.	Length of stay will reduce.	A target % is to be agreed by the Trust.
We will implement the Patient Safety Incident Response Framework (PSIRF) with further work streams on falls and civility.	We will create a project board and working group.	Workstreams will have leads with a weekly report. Oversight and liaison with ICB to agree Patient Safety Incident Response Plan (PSIRP).	Implementation of PSIRF	Measures will be agreed by national deadline for 2023.
	We will strengthen our existing falls prevention group workstreams through improved engagement with business units.	We will review the current falls prevention capacity in the organisation, identifying any capacity to provide in-patient in-reach, or whether a business case will be required to meet deficits.	Reduced inpatient falls, particularly those resulting neck of femur fractures and head injuries.	Reduction in the number of falls.
	Understand the organisations current position with regards to	Culture survey Thematic analysis of incident reporting related to incivility	Reduction in number of instances of incivility	Reduction in number of instances of incivility

	civility and its impact on patient safety and staff wellbeing.	Restorative conversations		
We will undertake improvement work around the safe processing of clinical results.	Building on the workshop held in Q4 we will hold a full rapid process improvement workshop (RPIW) to review the processes for managing all results on the ICE system with a view to developing a standard operating procedure	Hold full RPIW with key stakeholders in Q2 Map current processes Develop standard operating procedure Communication strategy to raise awareness of new process Videos/paper how to guides to be developed	Reduction in incidents in relation to ICE reporting	Monitoring via incident management system Mortality reviews RPIW 30, 60, 90 day report out
We will implement a maternity and neonatal improvement plan.	Continue to give the Board of Directors assurance around the Trust's compliance with the Immediate and Essential Ockenden action (IEA).	Audits of seven IEA built into audit cycle.	All required audits will be completed and assurance is gained.	Monitoring via Maternity Integrated Oversight report which is presented to a range of meetings across the Trust.
	Review existing bodies of work that are running concurrently and incorporate into an overarching maternity and neonatal plan for the Trust. This will	Implementation of a delivery plan steering group.	Delivery plan steering group will be set up by May 2023.	Regional monitoring via quarterly reports to NENC LMNS and regional perinatal surveillance and oversight group Implementation of the Delivery plan steering group.

	include the national Maternity and Neonatal Delivery Plan; any actions outlined by CQC in the latest Maternity inspection report as well as existing projects such as Birmingham Symptom Specific Obstetric Triage System (BSOTS) and cycles of audit.			

CLINICAL EFFECTIVENESS				
Quality Priority	**What will we do?**	**How will we do it?**	**Expected Outcome?**	**How will it be measured?**
We will embed a culture of research in the Trust and make “Research Everyone’s Business”.	Offer every patient and member of staff the opportunity to “Be Part of Research”	Make research more visible and accessible to our staff and patients and highlight that we are a Research Active Trust.	The number of recruitment accruals will increase.	Recruitment figures in the National Institute for Health Research (NIHR) Open Data Platform (ODP) Database
		Attract and host more commercial studies.	Increased funding and Trust reputation.	Increased number of hosted commercial studies (North East North Cumbria (NENC) Clinical Research Network (CRN) Local Portfolio Management System (LPMS) Weekly Report

		Incorporate recently released National research strategies into the Trust's policies, strategies and documentation to highlight that the Trust is research active.	That all Trust policies strategies and documentation are updated to include research.	Attendance/ membership of Trust decision making councils/forums.
			That research is included as a key element within the job descriptions of all clinical staff.	
			The number of hosted research projects in Paediatrics / Mental Health will increase.	
		Broaden our hosted research portfolio, especially in under- served clinical specialty areas and in areas of health inequality.	The number of health inequality studies will increase.	Increased number of hosted studies (NENC CRN LPMS Weekly Report)
		Encourage a research positive culture and ensure that staff have the resources, time and support they need to engage with and/or deliver quality research, which feeds into clinical change.	As a minimum staff should have an awareness of research activity so that they are able to signpost patients to the relevant Research Team(s).	
We will strengthen how we learn from deaths.	Expand the medical examiner system to non coronial deaths outside of the Acute Trust	Expand the medical examiner system to non coronial deaths outside of the Acute Trust by April 2024	All non coronial deaths that occur outside of the Acute Trust will be scrutinised by a Medical Examiner	Quarterly returns to the National Medical Examiner Office.

We will work with our clinical effectiveness team to improve the experiences of people with a learning disability, mental health or autism.	Raise awareness of learning disabilities and autism to improve the healthcare outcomes and reduce health inequalities for this group of patients.	In line with the Diamond Standards, roll out of the mandatory level 1 learning disability and autism training for staff from April 2023. Encourage patient facing staff to complete the level 2 learning disability and autism training – prior to this becoming mandatory with the publication of the Oliver McGowan Code of Practice training – expected to be during 23/24. Promote the roll of the Learning Disability Nurse via attending professional forums, team meetings, via Trust's social media channels. Share good practice and patient stories across the organisation.	Increase staff awareness of learning disabilities and autism and their individualised needs Reduction in those cases where there is room for improvement in clinical and organisational care following Mortality Council reviews Increase in staff confidence when caring for patients with a learning disabilities and autism Increase in number of MCA1 and 2 and DoLs completed correctly DNACPRs to be completed correctly and appropriately	ESR reports Evaluation pre and post training Audit of MCA 1, 2 and DoLs Audit of DNACPRs for patients with a learning disability and autism

2.3 Statements of Assurance from the Board

During 2022/23 the Gateshead Health NHS Foundation Trust provided and/or sub-contracted 30 relevant health services. The Gateshead Health NHS Foundation Trust has reviewed all the data available to them on the quality of care in 100% of these relevant health services. The income generated by the relevant health services reviewed in 2022/23 represents 100% of the total income generated from the provision of relevant health services by Gateshead Health NHS Foundation Trust for 2022/23.

Participation in National Clinical Audits 2022/23

During 2022/23, 36 National Clinical Audits and four National Confidential Enquiries covered relevant health services provided by Gateshead Health NHS Foundation Trust.

During that period Gateshead Health NHS Foundation Trust participated in 89% of National Clinical Audits and 100% of National Confidential Enquiries which it was eligible to participate in.

The National Clinical Audits and National Confidential Enquiries that Gateshead Health NHS Foundation Trust participated in, and for which data collection was completed during 2022/23, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Audit title	Participation	% of cases submitted/number of cases submitted
Cardiac Rhythm Management	Yes	169 cases submitted no minimum requirement
National Heart Failure Audit	Yes	392 cases submitted no minimum requirement
Acute coronary syndrome or Acute myocardial infarction (MINAP)	Yes	244 cases submitted no minimum requirement
Falls & Fragility Fractures (FFFAP) - National Hip Fracture Database	Yes	337 cases submitted no minimum requirement
UK Parkinson's Audit	Yes	100% (20/20)
Dementia	Yes	40 cases submitted no minimum requirement
National Diabetes Core Audit	Yes	Data not yet available
Major Trauma Audit (TARN)	Yes	40.3% (485 cases submitted of 80% requirement)
Care at the End of Life (NACEL)	Yes	49 cases submitted no minimum requirement
Chronic obstructive pulmonary disease	Yes	867 cases submitted no minimum requirement
National Lung Cancer Audit	Yes	238 cases submitted no minimum requirement
Pulmonary Rehabilitation	Yes	98 cases submitted no minimum requirement
Cardiac Rehabilitation	Yes	Data not yet available
Adult Asthma (Secondary Care)	Yes	79 cases submitted no minimum requirement

Sentinel Stroke National Audit Programme (SSNAP)	Yes	199 cases submitted no minimum requirements – data is up to end of Q3, Q4 not yet available
National Cardiac Arrest Audit	Yes	62 cases submitted no minimum requirement
Learning Disability Mortality Review Programme (LeDeR)	Yes	100%
National Emergency Laparotomy Audit (NELA)	Yes	122 cases submitted no minimum requirement
Case Mix Programme (ICNARC)	Yes	735 cases submitted no minimum requirement
Bowel Cancer (NBOCAP)	Yes	215 cases submitted no minimum requirement
Oesophago-gastric cancer (NAOGC)	Yes	58 cases submitted no minimum requirement
Maternity and Perinatal Audit (NMPA)	Yes	100%
Paediatric Diabetes (NPDA)	Yes	140 cases submitted no minimum requirement
Neonatal Intensive and Special Care (NNAP)	Yes	100%
Elective Surgery (PROMS)	Yes	533 cases submitted no minimum requirement
National Joint Registry (NJR)	Yes	Data not yet available
Prostate Cancer	Yes	184 cases submitted no minimum requirement
National Pregnancy in Diabetes Audit	Yes	16 cases submitted no minimum requirement
National Audit of Cardiac Rehabilitation	Yes	348 cases submitted no minimum requirement
National Audit of Inpatient Falls	Yes	22 cases submitted no minimum requirement
Pain in children	Yes	23 cases submitted no minimum requirement
Mental health self-harm	Yes	94 cases submitted no minimum requirement
National Audit of Seizures and Epilepsies in Children and Young People	No	Due to clinical commitments at present the teams do not have the capacity to participate.
Inflammatory Bowel Disease Audit IBD Registry	No	Benefits of the audit did not outweigh the cost to participate.
National Early Inflammatory Arthritis Audit	No	Due to staffing levels, we would have to reduce our clinic capacity to allow time for collecting & uploading data.
Diabetes Foot Care	No	Due to staffing levels, we have been unable to upload the required information during this annual period

Participation in National Confidential Enquiries 2022/23

Enquiry	Participation	% of cases submitted
Child Health Clinical Outcome Review Programme National	Yes	Data not yet available
Confidential Enquiry into Patient Outcome and Death	Yes	Data not yet available

Learning Disabilities Mortality Review Programme NHS England	Yes	100%
National Confidential Inquiry into Suicide and Safety in Mental Health	Yes	Data not yet available
Transition from child to adult health services: Organisational questionnaire Clinician questionnaire	Yes	Questionnaire not yet completed 6/6 questionnaires not yet completed
Crohn's disease: Organisational questionnaire Clinician questionnaire	Yes	Questionnaire not yet completed 4/4 questionnaires not yet completed
Epilepsy Study: Organisational questionnaire Clinician questionnaire	Yes	Questionnaire not yet completed 6/6 questionnaires not yet completed
Community Acquired Pneumonia Hospital Attendances: Clinician questionnaire	Yes	7/7 questionnaires not yet completed

The Trust utilises clinical audit as a process to embed clinical quality at all levels in the organisation and create a culture that is committed to learning and continuous organisational development. Learning from clinical audit activity is shared throughout the organisation.

The reports of six national clinical audits were reviewed by Gateshead Health NHS Foundation Trust in 2022/23 and Gateshead Health NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

National Hip Fracture Database (NHFD)

The Queen Elizabeth Hospital has been one of the top performing hip fracture units in England for a number of years, data supplied by the NHFD for the 2021-22 year has shown the Trust to be the top performing unit in England over this period for overall achievement of Best Practice Tariff and hip fracture care and the best performing unit in the northeast. This proud achievement has been recognised by trust management and is a level that we will endeavour to maintain. We performed well in all areas, notably in the top quartile nationally for timely admission to the Orthopaedic ward, perioperative medical assessment, efficient assessment by the physiotherapy, nutrition and mental health teams, timely surgery and efficient discharge practice. We continue to improve our performance in terms of the frequency of perioperative pressure damage and now lie below the national average for this area. The only area for ongoing improvement is the hip fractures sustained by existing inpatients and this is being addressed by the falls team as part of the National Audit of Inpatient Falls (NAIF).

Action Points:

- All hip fracture cases who fail to meet Best Practice Criteria for any reason are reviewed in the monthly Orthopaedic department SafeCare meetings. Any learning points are recorded and fed back, with a Datix completed in each case. This practice will continue. Further work is planned to further review our situation regarding inpatient fractures and will look to instigate the actions of the falls team audit. These include better awareness of falls risk in vulnerable patients and optimising the availability of nursing and healthcare staff for this patient group.

National Joint Registry (NJR)

The Trust continues to contribute to the NJR. Data is entered regarding all hip, knee, ankle, elbow and shoulder replacement operations, enabling the monitoring of the performance of joint replacement implants and the effectiveness of different types of surgery. In 2014 the NJR introduced annual data completeness and quality audits for hip and knee cases, with the aim of improving data quality. From 2020/21 the data quality audit was extended to include ankle, elbow and shoulder cases. The Trust continues to contribute to these audits and was awarded as an NJR Quality Data Provider for 2021/22.

Action Points:

- Continue to ensure that robust systems are in place to guarantee that a Minimum Dataset form is generated for all eligible NJR procedures.

The Case Mix Programme (CMP)

The Case Mix Programme is an audit of patient outcomes from adult and general critical care units (intensive care and combined intensive care/high dependency units) covering England, Wales, and Northern Ireland. It is run by the Intensive Care Audit and Research Centre (ICNARC). Data is collected on all patients admitted to the Critical Care Unit. Data on various outcomes and process measures are then compared with the outcomes from other Critical Care Units in the UK. In the past 12 months the Critical Care Unit has uploaded data on 735 patients to the CMP. The increased frequency of data submission requested by ICNARC in response to the Covid-19 pandemic has reduced and data uploads are being performed on an approximately weekly basis. CMP/ICNARC continue to publish Quarterly Quality Reports (QQR) for each individual critical care unit. Our most recent QQR, including data up to the end of Q3 22/23 shows good performance in all areas reported on. Our overall standardised mortality rate was slightly below what would have been expected (17.6% v 18.4%), and mortality for patients with a predicted mortality of <20% was at the low end of the normal range (3.2% v 4.3%).

The Software system for collecting and submitting data has changed in the last 12 months, moving from WardWatcher to Medicus which is a new web-based system. This has involved a significant amount of input and training with several problems encountered during the implementation which have mostly been resolved.

Action Points:

- Continue to collect and submit data to Intensive Care National Audit and Research Centre (ICNARC)/CMP.
- Continue to work with Medicus to ensure that any issues with the data collection system are resolved.
- Ongoing education of ward clerks and Nursing/Medical staff regarding the correct entry of data, assisted by the ICNARC data clerk.
- Consideration of the ICNARC data clerk role becoming a full-time role to allow more data collection to occur e.g., quality measure data, etc.
- Use the QQR to ensure timely identification of any areas of deterioration in performance and address these when they occur.
- Continue to share QQR and other CMP/ICNARC data with relevant teams within the Trust.

Trauma Audit & Research Network (TARN)

The latest TARN report for Queen Elizabeth Hospital Gateshead was published in March 2023 which includes data up to 30/09/2022. Case ascertainment was 69% in 2022 compared with 40.3% in 2021. This is an improvement compared with previous years and represents a

degree of recovery from Covid-19 performance. However, remains below the target of 80% set by TARN. Data remains difficult to interpret with ongoing questions about reliability.

Action Points:

- After updating our business intelligence report and moving to electronic documentation we are still experiencing difficulties identifying all of the patient eligible for TARN submission. We are due to make a site visit to a neighbouring Trust in order to review their TARN processes. Following this we intend to implement further improvements.
- We have charitable funding secured for the recruitment of a Trust Trauma Coordinator and possibility of a TARN data administrator. We will advertise the post once the job description has been completed.
- The Trust are also preparing for a trauma network peer review that is due in June 2023.

National Audit of Inpatient Falls (NAIF)

From January 2019, NAIF changed to become a continuous audit of in-patient falls resulting in in-patient hip fractures, one of the most severe harm events occurring as a result of falling. The records are cross linked with the National Hip Fracture Database (NHFD) which is part of the same audit programme. The NAIF report 2022 uses 2021 clinical data. 22 cases of inpatient femoral fracture were uploaded during this period. There were five key performance indicators (KPI). 91% of patients had a multi-factorial risk assessment (MFRA) done prior to the fall. Five out of six components of the MFRAs completed was deemed a high-quality assessment. The median quality score for the Trust was five. Undertaking and recording of lying and standing blood pressure was the most poorly completed component, only done in 45% of cases. KPI two, three and four relate to post fall checks. 95% of patients were checked for signs of injury before moving, flat lifting equipment was used in 41% (29% nationally) and medical assessment within 30 minutes in 32% of patients (69% nationally).

Action Points:

- The latter two aspects could be improved by adequate access and training to flat lifting equipment and the roll out of the Nervecentre (electronic system) post falls assessment (currently developed but under review for use).
- Although not a KPI, hot debrief after an inpatient femoral fracture was not done in any cases, perhaps reflective of the lack of a dedicated inpatient falls team. As per the pervious audit there is no mandatory falls training for all clinical staff (in 50% trusts this is the case).
- A number of initiatives have been identified to support the increase in compliance with undertaking lying and standing blood pressure including; how to guides produced, training for individual wards, recording the outcomes on an electronic system. More recent compliance has subsequently increased.

National Paediatric Diabetes Audit (NPDA) 2022-23

Real time data is collected and reviewed locally quarterly by the diabetes team and six monthly by the Northeast & North Cumbria Regional Children and Young People's (CYP) Diabetes Network. We have submitted data on 140 patients to the NPDA during 2022-23: 134 of these patients had Type 1 diabetes; 64.2% are on insulin pump therapy; 33.6% are on an intensive multiple daily injection regime; 71% are on continuous glucose monitoring (CGM) with alarms; 100% of patients had a HbA1C; 98.1% had a BMI; 91.7% had their thyroid function; 93.7% had a blood pressure; 87.3% had a urinary albumin; 81.7% had their feet examined; 100% new patients had thyroid screening and 100% had coeliac screening within 90 days diagnosis, 100% newly diagnosed patients had dietetic support with

carbohydrate counting within 14 days diagnosis; 97.2% were recommended influenza immunisation; 73.1% were given sick day rules advice. The mean HbA1C was 64.5mmol/mol (median 62mmol/mol.) This is an improvement since the 2021-22 audit.

Action Points:
Over the last year 2022-23 the CYP Diabetes team has:

- Continued to develop our service for CYP living with Type 2 diabetes in line with NICE and the National Guidelines including dietetic and psychology led support and education clinics in addition to their routine three monthly MDT clinics. However there has been no MDT dietitian January 2023 onwards. A new dietitian has been appointed and is expected to start in June 2023.
- Continued to participate in a Poverty Proofing Project with Children Northeast and Type 1 Kidz patient support group to increase awareness of healthcare professionals and the trust of the difficulties those CYP and families living with T1 diabetes face and to enable strategies to be put in place to facilitate equitable access to health care and diabetes technologies. This is particularly important as 69% of CYP in our clinic live within the two most deprived quintiles which is significantly higher than the regional and national average and a greater proportion of those living in the least deprived quintile had access to insulin pump therapy and rtCGM compared to those in the other four quintiles (data from 2020-21 NPDA report)

The reports of three local clinical audits were reviewed by Gateshead Health NHS Foundation Trust in 2022/23 and Gateshead Health NHS Foundation Trust intends to take actions to improve the quality of healthcare provided. Below are examples from across the Trust that demonstrate some of the actions taken to improve the quality of our services:

Business Unit	Speciality	Actions identified
Community	Mental Health	**Community Mental Health Nursing (CMHN) Teams Initial Assessment Documentation Audit** Audit has shown pockets of excellent note keeping. However overall standard is not meeting that outlined in Operational Policy for CMHN teams. There were several incidences where assessments were not completed in timeframe set within policy therefore not meeting required standards which could potentially impact patient care. Audit has been fed back through team meetings and will be re-audited in July 2023. Training to be put in place to support team with current standards. Areas for improvement are training regarding good practice in relation to note keeping. Review of current Operational Policy and standards. Timeframes of completion of assessment documentation. • Training, awareness, review of policies- further audit this has been linked to transformation work- task and finish group. Teams working as one.

		• Part of transformation work and ongoing and workforce strategy meetings. Identification of training sessions e.g. Face Risk Train the trainer sessions for FACE risk completed- sessions to be set up for teams. Session on Duty of Candour and Defensible documentation. Continued review of training needs through Education and Workforce strategy group. • Required to Review of current pathways/processes/policies a Working group set up with Clinical leads across services- policies/processes to be review and updated accordingly- ongoing work
Community	Cragside	**Audit and Re-audit on the current practice of documentation of NEWS score on the MDT document in the Old age Psychiatry inpatient wards** A sample of eight patients were taken and around 35 MDT documents/meetings were then reviewed, from the sample of patients taken from the old age inpatient wards, it was identified that on the MDT documents, the NEWS score was documented in only 34.2% times on the MDT meetings over a four week period. From the sample of patients taken from the old age inpatient wards staff were assigned/documented to each plan documented on the MDT document for about 45.7% times on the MDT documents/meetings over a 4 week period. From this reaudit, it is evident that there has been a significant improvement in the documentation of NEWS score and staff member being assigned to each plan documented on the MDT document after the weekly MDT meeting. Thus, there has been a reduction in risk in terms of patient safety, documentation, clinical care/treatment and clinical communication. • From the sample of patients, NEWS score was documented for a total of 79%. • From the sample of patients, staff member was assigned to each of the plan documented in about 85%. It was discussed in the junior doctor/trainee meeting that there has been a huge improvement in the documentation of NEWS score and staff assigned to each plan documented after the weekly MDT meeting. • A small percentage of sample did not have the above-mentioned parameters documented after the weekly MDT meeting.

		• It was agreed to document the NEWS score and to assign a staff member to each plan documented after the weekly MDT meeting. • Practice changed before the MDT meeting begins, trainee documented the MDT meeting to ensure that NEWS score is reviewed on the Nerve centre and to document this before the MDT meeting begins.
Clinical Support & Screening	Diagnostic Imaging	**The Importance of Patient Centering on CT Radiation Dose Optimisation** This study has shown that patient mis centering occurs frequently in clinical practice and impacts radiation doses and image quality. It remains essential for CT radiographers to endeavour for accurate patient positioning in the isocentre of the CT gantry. Where positioning is not performed correctly, the position compensation system can automatically detect mis centering and modify the scan but this only compensates the dose on larger distances. • Extra training regarding patient positioning within CT gantry was required, this has been offered via a Webinar presentation available to all CT staff by GE on Dose optimisation and patient centring.

Participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by Gateshead Health NHS Foundation Trust in 2022/23 that were recruited during that period to participate in research approved by the Health Research Authority (HRA) was 1,818.

Recruitment by Managing Specialty	Total
Ageing	43
Anaesthesia, Perioperative Medicine and Pain Management	4
Cancer	294
Cardiovascular Disease	2
Critical Care	15
Dementias and Neurodegeneration	158
Diabetes	78
Gastroenterology	2
Haematology	5
Health Services Research	6
Hepatology	18
Metabolic and Endocrine Disorders	10
Musculoskeletal Disorders	1
Public Health	13
Reproductive Health and Childbirth	995

Stroke	26
Surgery	29
Trauma and Emergency Care	119
Total	**1818**

In line with the Research Strategy, Gateshead Health NHS Foundation Trust remains a research active organisation which ensures that our patients have access to the very latest treatments and technologies. Evidence shows clinically research active hospitals have better patient care outcomes. Our top recruiting studies include: -

INGR1D2 INvestigating Genetic Risk for type 1 Diabetes (2)

Type 1 diabetes is a common chronic disease in childhood and is increasing in incidence. The clinical onset of type 1 diabetes is preceded by a phase where the child is well but has multiple beta-cell auto-antibodies in their blood against insulin-producing beta cells, which are present in the pancreas.

Neonates and infants who are at increased risk of developing multiple beta cell auto-antibodies and type 1 diabetes can now be identified using genetic markers. This provides an opportunity for introducing early therapies to prevent beta-cell autoimmunity and type 1 diabetes.

The objective of this study is to determine the percentage of children with genetic markers putting them at increased risk of developing type 1 diabetes, and to offer the opportunity for these children to be enrolled into phase II b primary prevention trials.

Choice Study — Cervical Ripening at Home or In-Hospital - prospective cohort study and process evaluation (CHOICE study)

In most pregnancies labour starts on its own, but sometimes induction of labour (IOL) is needed. The first part of IOL is 'cervical ripening', where medication or a specialised balloon is used to prepare the cervix (neck of the womb) for labour.

Cervical ripening used to be performed only in hospitals. However, about half of UK maternity units now offer 'home cervical ripening' – where women have the procedure started off in hospital, then spend some time at home whilst waiting for the treatment to work. This may help reduce demands on maternity services and reduce the time women spend in hospital. Women may also prefer it. However, the benefits are not yet proven.

The CHOICE study aims to see if home cervical ripening is safe, acceptable to women and their partners, and cost-effective for the NHS.

Contraception after you've had a baby in the Northeast and North Cumbria: The PoCo Study

Postnatal contraception (contraception provided up to eight weeks after a birth, defined by NICE as the postnatal period) is vital in preventing unplanned pregnancy and in reducing the risk of harm associated with a short inter-pregnancy interval and with having an abortion.

However, it is known that relatively few women access contraception services in the postnatal period, and that some vulnerable groups are poorly served by services and more likely to miss out on contraception counselling and support.
The aim of the PoCo Study is to undertake a comprehensive review of the current provision of postnatal contraception in the Northeast and North Cumbria, in both community and maternity settings, to better understand the current provision in relation to National guidelines.

Evaluation of MCM5 in postmenopausal bleeding patients

The objective of this study is to evaluate the performance Arquer's in vitro diagnostic test kit ADXGYNAE, an MCM5 ELISA as an aid in detecting endometrial cancer using urine specimens. Research has shown that detection of MCM5 in urine sediment is a sensitive and specific diagnostic test for endometrial cancer.

The results obtained with the MCM5 ELISA will be compared with the diagnosis based on standard of care clinical investigations in order to establish its utility in helping to diagnose endometrial cancer.

The DETERMIND Study

Dementia is one of the most common and serious disorders with over 800,000 affected in the UK, costing £23billion annually. Negative impacts on those with dementia and their families are profound. Evidence has emerged of major inequalities in care for dementia driven by factors including ethnicity, whether your care is self-funded or paid for by local authorities, and whether you are diagnosed earlier or later.

DETERMIND is designed to address critical, fundamental, and as yet unanswered questions about inequalities, outcomes and costs following diagnosis with dementia. These answers are needed to improve the quality of care, and therefore the quality of life, of those with dementia and their carers.

PROcalcitonin and NEWS2 evaluation for Timely identification of sepsis and Optimal use of antibiotics in the Emergency Department

Sepsis is a common, potentially life-threatening complication of infection. The optimal treatment for sepsis includes early recognition, prompt antibiotics and fluids into a vein (intravenous/IV).

Currently, clinicians assess severity in patients in the Emergency Department with a scoring system based on simple to measure observations: The National Early Warning Score (NEWS2).

NEWS2 helps clinicians identify the sickest patients, but it is not specific and tends to over diagnose sepsis leading to over prescribing of antibiotics and promoting antimicrobial resistance.

The PRONTO study is looking to improve assessment of patients with suspected sepsis in the Emergency Department using a 20-minute Procalcitonin (PCT) blood test, which is not widely used in the NHS and helps to identify bacterial infection.

The Trust continues to demonstrate its commitment to improving the quality of care it offers and making its contribution to wider health improvement, including the UK R&D Roadmap mission https://www.gov.uk/government/publications/uk-research-and-development-roadmap/uk-research-and-development-roadmap which sets out to inspire and enable people from all backgrounds and experiences to engage and contribute to research and innovation and show that science (and research) is for everyone.

In September, the R&D Team launched the Allied Health Professions' Research & Innovation Strategy for England at their conference at the Marriott Hotel, Gateshead.

The scope of the Strategy addresses four domains. Each of these aspects are inter-dependent and are all equally important to achieve transformational impact and sustainable change.

Capacity and engagement of the AHP workforce community, to implement research into practice;

Capability for individuals to undertake and achieve excellence in research and innovation activities, roles, careers and leadership;
Context for AHPs to have equitable access to sustainable support, infrastructures and investment;
Culture for AHP perceptions and expectations of professional identities and roles that "research is everybody's business".

In October the R&D Team attended the first ever Health Care Support Workers (HCSWs) conference at the Marriott Hotel, Gateshead to encourage HCSWs to become **Research Champions** to help promote research awareness within the Trust.

The R&D Team have also been promoting the **Associate Principal Investigator Scheme** which aims to develop doctors, nurses and other health professionals to become the Principal

Investigators (PIs) of the future. (A PI is the person responsible for the conduct of a research study at a site).

The Associate PI Scheme is a six month in-work training opportunity, providing practical experience for healthcare professionals starting their research career who would not normally have the opportunity to take part in clinical research in their day-to-day role. The scheme gives them the chance to experience what it means to work on and deliver a NIHR portfolio trial under the mentorship of an enthusiastic Local PI as a trainee PI.

Participating healthcare professionals receive formal recognition of engagement in NIHR Portfolio research studies through the certification of Associate PI status, endorsed by the NIHR and Royal Colleges and is open to any healthcare professional willing to make a significant contribution to the conduct and delivery of a local research over a period of at least six months:

The Trust needs to maintain a strategic overview of how research and development resources are being used to deliver the management and governance requirements for NIHR portfolio trials.

Research activity within the Trust attempts to achieve National priorities, however without a sustainable, supported research delivery workforce and healthcare professionals unable to undertake the role of Principal Investigator because they are not allocated the time to deliver research, nor is it seen as a key element of their job description, research will just remain a limited “add on” activity and embedding it as core business in line with National priorities will be unachievable.

Use of the Commissioning for Quality and Innovation Framework (CQUIN)

A proportion of Gateshead Health NHS Foundation Trust income in 2022/23 was conditional on achieving quality improvement and innovation goals agreed between Gateshead Health NHS Foundation Trust (and any person or body they entered into a contract, agreement, or arrangement with for the provision of relevant health services), through the Commissioning for Quality and Innovation payment framework. A notional monetary total of £2.781m of the Trust’s income in 2022/23 was conditional upon achieving quality improvement and innovation goals, however due to their suspension as part of the NHS Covid-19 funding regime the funding was received into the Trust without full achievement of the targets.

Registration with the Care Quality Commission (CQC)

Gateshead Health NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is registered without conditions.

The Care Quality Commission has not taken enforcement action against Gateshead Health NHS Foundation Trust during 2022/23.

Gateshead Health NHS Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

There was one announced inspection by the CQC in 2022/23. This was focussed on Maternity Services and took place in February 2023. At year end of 2022/23, the Trust are awaiting the outcome from this inspection. In September 2022, the Trust voluntarily took part in a Medicines Optimisation pilot inspection and received an overall rating of "Good". As this was a pilot inspection, the results were made available to the Trust and shared via social media, but not published by CQC to their website.

There was one Mental Health Act (1983) Monitoring visit to Sunniside in May 2022.

Data Quality

Gateshead Health NHS Foundation Trust recognises that it is essential for an organisation to have good quality information to facilitate effective delivery of patient care, and this is essential if improvements in the quality of care are to be made.

Gateshead Health NHS Foundation Trust submitted records during 2022/23 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data. The percentage of records in the published data is shown in the table below:

Which included the patient's valid NHS Number was:	Trust %	National %
Percentage for admitted patient care*	99.8%	99.6%
Percentage for outpatient care*	99.9%	99.8%
Percentage for accident and emergency care†	99.2%	95.5%

Which included the patient's valid General Medical Practice Code was:	Trust %	National %
Percentage for admitted patient care*	99.8%	99.7%
Percentage for outpatient care*	99.8%	99.5%
Percentage for accident and emergency care†	99.9%	98.2%

* SUS+ Data Quality Dashboard - Based on the April-22 to March-23- SUS+ data at the Month 11 inclusion date extracted on the 17th of March 2023

†ECDS DQ Dashboard from Friday 1st April 2022 up to and including Thursday 31st March extracted on Tuesday 18th April

Key

	The Trust % is equal or greater than the National % valid
	The Trust is up to 0.5% below the National % valid
	The Trust % valid is more than 0.5% below the National % valid

Information Governance Toolkit

Gateshead Health NHS Foundation Trust's Information Governance Assessment Report overall score for 2022/23 graded as – submission is 30/06/2023 and draft audit report has not been provided.

Standards of Clinical Coding

Gateshead Health NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2022/23 by the Audit Commission.

Gateshead Health NHS Foundation Trust will be taking the following actions to improve data quality:

We are currently updating our data quality strategy to support the continual improvement of data entry/quality/validity and, therefore, ensuring that Trust decision making is based on clean and accurate information.

2.4 Learning from Deaths

During 2022/23, there were 1,196 patient deaths within Gateshead Health NHS Foundation Trust. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 267 in the first quarter;
- 257 in the second quarter;
- 347 in the third quarter;
- 325 in the fourth quarter.

Seasonal increases in mortality are seen each winter in England and Wales.

In early April 2023, 891 case record reviews and 52 investigations have been carried out in relation to 1,196 of the deaths included above.

In 28 cases a death was subjected to both a case record review and an investigation.

The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 151 in the first quarter;
- 120 in the second quarter;
- 319* in the third quarter;
- 325* in the fourth quarter.

*increase to due to change in process from 10th October 2022 – Medical Examiner undertaking all 1st level reviews.

Zero deaths representing 0% of the patient deaths during the reporting period were judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of:

- 0 representing 0% for the first quarter;
- 0 representing 0% for the second quarter;
- 0 representing 0% for the third quarter;
- 0 representing 0% for the fourth quarter.

These numbers have been estimated using the Trust's 'Learning from Deaths' policy. Reviewed cases are graded using the Hogan preventability score and National Confidential Enquiry into Patient Outcome and Death (NCEPOD) overall care score following case note review.

179 case record reviews and 83 investigations were completed after 1st April 2022 which related to deaths which took place before the start of the reporting period. 1 death representing 0.6% (1/179) of the patient deaths before the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

This number has been estimated using the Trusts 'Learning from Deaths' policy. Reviewed cases are graded using the Hogan preventability score and NCEPOD overall care score following case note review.

Summary of learning/Description of Actions:

Good practice identified:

- Good practice was identified around obtaining a second opinion from a colleague in complex cases which highlighted effective team working.
- Evidence of joint working with mental health care for patients with severe mental illness
- Collaboration between teams
- Provision of activity co-ordinators on wards
- Continuity of care for patients
- Safety netting advice given appropriately
- Supporting patient to comfort eat at end of life

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 alert 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.
- Learning disability patients being brought to A&E on their own – to target triage team to highlight this with care homes/ care providers
- Learning disability nurse not being alerted of admission of learning disability patients
- Capacity assessments for patients with a learning disability to be documented – even when they have capacity
- DNACPR completion remains an issue in some cases – mock up DNACPR form to be used as good practice

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'.

Caring for patients with a serious mental illness

- Patients can suffer with constipation be mindful of this during assessments
- Smoking cessation/health screening for patients with serious mental illness – work to be done to ensure this group of patients are engaged in health promotion
- Access to EEGs is problematic, good access for critical care patients, however an issue for patients on base wards
- Lithium level monitoring requires pharmacy expertise and JAC prompt to be explored

Care and treatment

- Accessibility of Careflow for out of hours GPs
- Senior clinicians to be involved in NG tube insertion for patients with difficult access
- Lack of earlier senior review for patients when there has been multiple failed attempts at a procedure
- Confirmation bias for patients with decompensated liver failure – they can have other conditions
- Plan B required for treatment for patients who self-discharge
- Pathways required for patients who present with leg weakness to ensure CT scans undertaken when required
- Importance of continuing to manage electrolytes in metastatic breast cancer

Governance

- Reminder to log all inpatient falls on Datix
- Reminder to log all self discharges on Datix
- Improve the process of feeding back outcomes of reviews to junior doctors for learning and educative opportunities
- Civility/ professionalism important in terms of looking after patients who don't always comply with treatment – this could be for various reasons

2.5 Seven Day Hospital Services

The Trust has fully implemented priority standards five (access to diagnostics) and six (access to consultant directed interventions) from the ten clinical standards as identified via the seven-day hospital services NHS England recommendations.

The Covid-19 pandemic delayed further work around this agenda and we had to temporarily adapt our ways of working considerably during this time. As we came out of the pandemic, we reviewed and changed our model of care, concentrating on patient flow especially around non-elective care. The original NHS England recommendations around seven-day hospital services are several years old and need to be reconsidered in light of new models of care (both locally and nationally). The priority for the Trust moving forward will be to improve the quality of care by improving length of stay through better use of clinical pathways. The original NHSE recommendations may need to be revised in this light and the standards redefined.

2.6 Freedom to Speak Up

As a result of Sir Robert Francis QC's follow up report to his Mid Staffs Report, all NHS Trusts are required to have a Freedom to Speak Up Guardian (FTSUG). Gateshead Health NHS Foundation Trust is committed to achieving the highest possible standards/duty of care and the highest possible ethical standards in public life and in all its practices. We are committed to promoting an open and transparent culture to ensure that all members of staff feel safe and confident to speak up. The FTSUG is employed by the Trust but is independent and works alongside Trust leadership teams to support this goal. The FTSUG reports to the Board and the People and Organisational Development Committee twice per year, as well as continuing to report to the National Guardian Office on a quarterly basis. Our FTSUG supports the delivery of the Trust's corporate strategy and vision as encapsulated in our ICORE values. As well as via the FTSUG, staff may also raise concerns with their trade union or professional organisations as per our FTSU Policy. When concerns are raised via the FTSUG, the Guardian commissions an investigation and feeds back outcomes and learning to the person who has spoken up. The FTSUG is actively engaged in profile raising and education in relation to this role. The FTSUG now reports directly to the Chief Executive and has regular meetings with the Director of People and OD and the Non-Executive Director (NED) responsible for FTSU.

2.7 NHS Doctors and Dentists in training – annual report on rota gaps and the plan for improvement to reduce these gaps

The Trust Board via the People and Organisational Development Committee receives quarterly reports from the Guardian of Safe Working summarising identified issues, themes, and trends. The exception report data are scrutinised by the Medical Workforce Group with representation from all business units and actions to support areas and reduce risk/incident levels identified on a quarterly basis. These actions are escalated to the People and Organisational Development by exception when it is deemed necessary due to difficulty in reaching local resolution.

The Trust Board via the People and Organisational Development receives an annual report from the Guardian of Safe Working which includes a consolidated report on rota gaps and actions taken by the Medical Workforce Group. This report is provided to the Local Negotiating

Committee (LNC) by the Guardian of Safe Working and the LNC representation at the Medical Workforce Group.

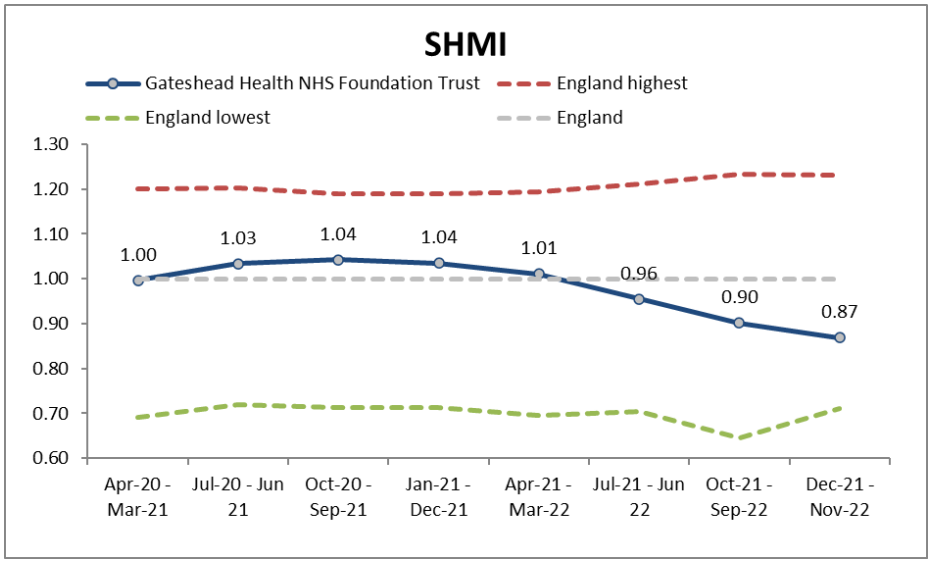
The Medical Workforce Group meets monthly and reviews the recently developed medical workforce dashboard which summarises rota fill rates and staffing absences by service / specialty area and by business unit. The Trust Medical Staffing Team are now established and manage the medical staffing rosters on a day-to-day basis to ensure maximal roster fill rates and medical staffing cover. Gap management is proactive to ensure full rota compliance.

2.8 Mandated Core Quality Indicators

(a) SHMI (Summary Hospital-level Mortality Indicator)

SHMI	Apr-20 - Mar-21	Jul-20 - Jun 21	Oct-20 - Sep-21	Jan-21 - Dec-21	Apr-21 - Mar-22	Jul-21 - Jun 22	Oct-21 - Sep-22	Jan-21 - Dec-22
Gateshead Health NHS Foundation Trust	1.00	1.03	1.04	1.04	1.01	0.96	0.90	0.87
England highest	1.20	1.20	1.19	1.19	1.19	1.21	1.22	1.22
England lowest	0.69	0.72	0.71	0.71	0.70	0.70	0.65	0.71
Banding	2	2	2	2	2	2	2	3

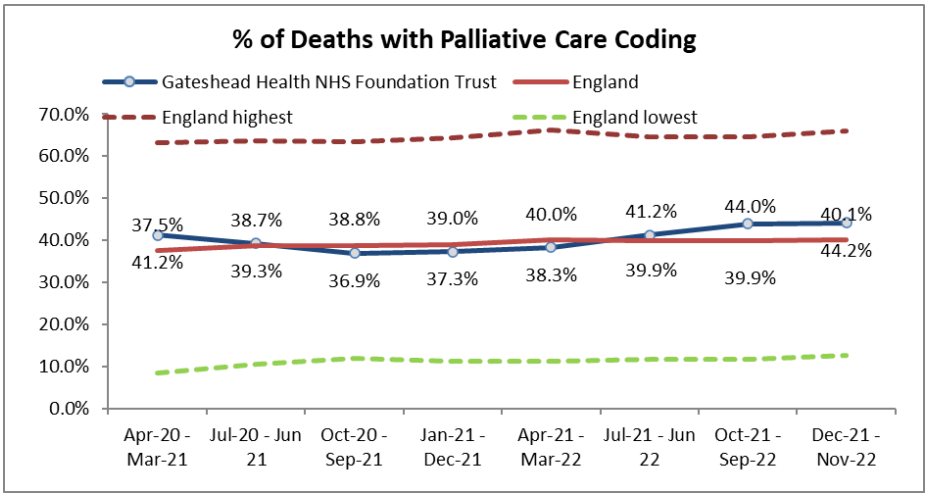
Source: www.digital.nhs.uk/SHMI



(b) The percentage of patient deaths with Palliative Care coded at either diagnosis or specialty level

% Deaths with palliative coding	Apr-20 - Mar-21	Jul-20 - Jun 21	Oct-20 - Sep-21	Jan-21 - Dec-21	Apr-21 - Mar-22	Jul-21 - Jun 22	Oct-21 - Sep-22	Jan-21 - Dec-22
Gateshead Health NHS Foundation Trust	41.2%	39.3%	36.9%	37.3%	38.3%	41.2%	44.0%	44.2%
England highest	63.3%	63.6%	63.3%	64.3%	66.3%	64.6%	64.6%	66.0%
England lowest	8.5%	10.6%	12.0%	11.2%	11.1%	11.7%	11.8%	12.6%
England	37.5%	38.7%	38.8%	39.0%	40.0%	39.9%	39.9%	40.1%

Source: www.digital.nhs.uk/SHMI



Gateshead Health NHS Foundation Trust considers that this data is as described for the following reasons:

- The Summary Hospital-level Mortality Indicator (SHMI) reports death rates (mortality) at a Trust level across the NHS in England and is regarded as the national standard for monitoring of mortality. For all SHMI calculations since October 2011, mortality for the Trust is banded 'as expected' except for the most recent data release banding the Trust as having Lower than expected deaths. The Trust reviews its SHMI monthly at the Mortality and Morbidity Steering group.

Gateshead Health NHS Foundation Trust has taken the following actions to improve the indicator and percentage in (a) and (b), and so the quality of its services, by:

- The Trust reviews cases for individual diagnosis groups where the SHMI & HSMR demonstrates more deaths than expected or an alert is triggered for a diagnosis group. The Trusts mortality review process can be used to review the Hogan preventability score & NCEPOD quality of care score and interrogate the narrative from the review to identify specific learning or learning themes.
- In response to a mortality alerts, and concerns from the medical examiner office, extraordinary Mortality Councils have been set up to review certain patient cohorts, for example heart failures death and frailty / end of life care.
- The Trust reviews the clinical coding for alerting diagnosis groups to determine whether the appropriate diagnosis was assigned and to refine the coding where appropriate.
- The Trust continues to review palliative care coding to ensure palliative care is recorded for all cases where this is appropriate. Palliative care coding is in line with the national level.

Patients on Care Programme Approach (CPA) who were followed up within seven days after discharge from psychiatric inpatient care.

In March 2020, the collection was suspended due to the coronavirus illness (COVID-19) and the need to release capacity across the NHS to support the response. This indicator is not included because of the suspension and has not yet been reinstated.

PROMs (Patient Reported Outcome Measures) for Hip Replacement and Knee Replacement:

Gateshead Health NHS Foundation Trust considers that the outcome scores are as described for the following reasons:

Gateshead Health NHS Foundation Trust has taken the following actions to improve these outcome scores, and so the quality of its services, by:

Awaiting publication of national data

Emergency Readmissions within 30 Days

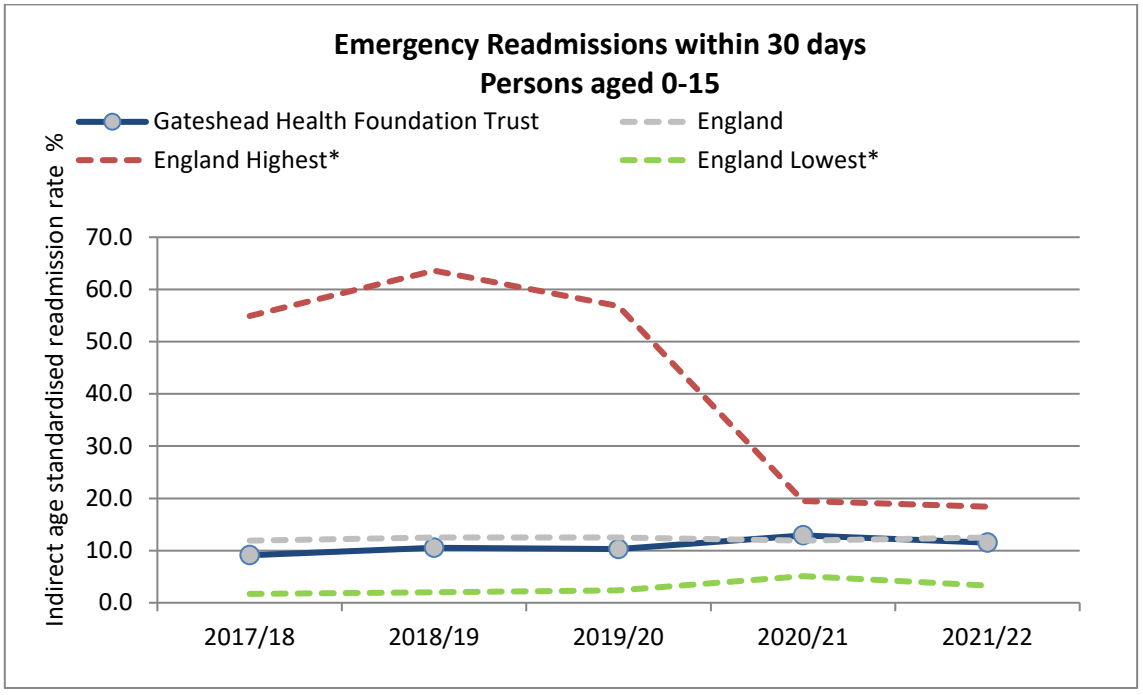
- Aged 0 – 15yrs

Emergency readmissions within 30 days of discharge from hospital Persons aged 0-15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Gateshead Health Foundation Trust	10.9	10.4	9.1	10.5	10.3	12.9
Banding	W	W	B1	B5	B5	W
England	11.5	11.6	11.9	12.5	12.5	11.9
England Highest*	19.3	16	54.9	63.6	56.8	19.5
England Lowest*	1.3	5.1	1.7	2.0	2.4	5.1

B1 = Significantly lower than the national average at the 99.8% level

B5 = Significantly lower than the national average at the 95% level but not at the 99.8% level

W = National average lies within expected variation (95% confidence interval)
*excluding caution in interpretation of data records. Numbers of patients discharged too small for meaningful comparisons (i.e., below 200).



Gateshead Health NHS Foundation Trust considers that the data is as described for the following reasons:

- Whilst Emergency readmission rates have increased slightly in 2020/21, they have broadly remained static over the last five years, tracking 'Significantly lower' or within than the national average in each of the last six years. The increase this year remains within the expected variation from the national average.

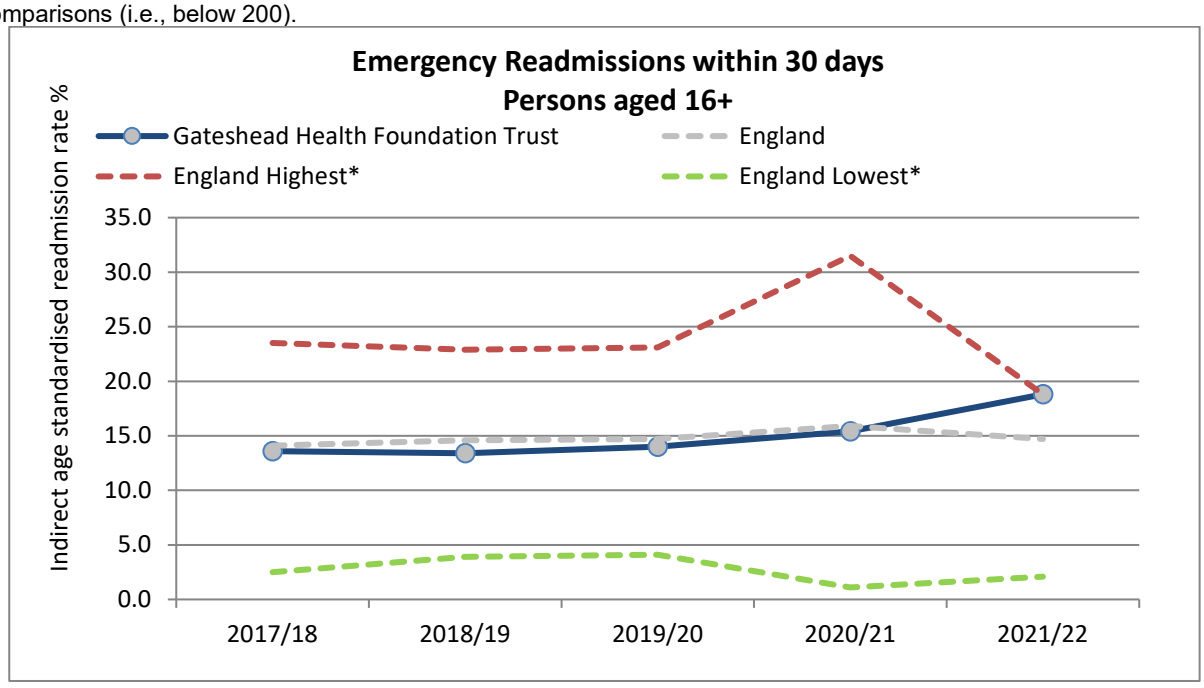
Gateshead Health NHS Foundation Trust has taken the following actions to improve these outcomes, and the quality of its services, by:

- The Trust will continue to monitor performance and undertake further investigations/actions should the increase in rates continue.

- Aged 16 years or over

Emergency readmissions within 30 days of discharge from hospital Persons aged 16+	2017/18	2018/19	2019/20	2020/21	2021/22
Gateshead Health Foundation Trust	13.6	13.4	14.0	15.4	18.8
Banding	W	B1	B5	W	A1
England	14.1	14.6	14.7	15.9	14.7
England Highest*	23.5	22.9	23.1	31.5	18.8
England Lowest*	2.5	3.9	4.1	1.1	2.1

A1 = Significantly higher than the national average at the 99.8% level.
B1 = Significantly lower than the national average at the 99.8% level
B5 = Significantly lower than the national average at the 95% level but not at the 99.8% level
W = National average lies within expected variation (95% confidence interval)
*excluding caution in interpretation of data records. Numbers of patients discharged too small for meaningful comparisons (i.e., below 200).



Gateshead Health NHS Foundation Trust considers that the data is as described for the following reasons:

- Emergency readmission rates look to have risen significantly in 2021/22 and are at a similar level to the highest nationally. However, this is largely due to a change in how we record our SDEC activity following a new operating model. Due to the data capture changes, there now appears to be an increase in readmissions because of the follow-up care onto the unit. A further deep dive into the data reveals that the increase in readmissions is artificially inflated because of the clinical need of the SDEC reattenders. The true shift in average readmissions is circa 6 per month – the impact on percentage readmission rate is therefore minimal, demonstrating a slight drop in the average readmission rate overtime.

Gateshead Health NHS Foundation Trust has taken the following actions to improve these outcomes, and the quality of its services, by:

- Local monitoring of readmissions by ward and speciality to ensure that there is oversight of outlying areas.
- Reviews of readmissions that highlight failed / inappropriate discharges to better understand where practices can be improved and help ensure lessoned are learned.
- Successfully appointed a number of Discharge Coordinators across the Trust to improve discharge arrangements for patients and more robustly ensure patients' needs are met on discharge.

Trust's responsiveness to the personal needs of its patients

Gateshead Health NHS Foundation Trust considers that this data is as described for the following reason:

The Gateshead Health NHS Foundation Trust has taken the following actions to improve these percentages, and so the quality of its services, by:

Awaiting publication of national data

Percentage of staff employed by, or under contract to the Trust who would recommend the Trust as a provider of care to their family or friends

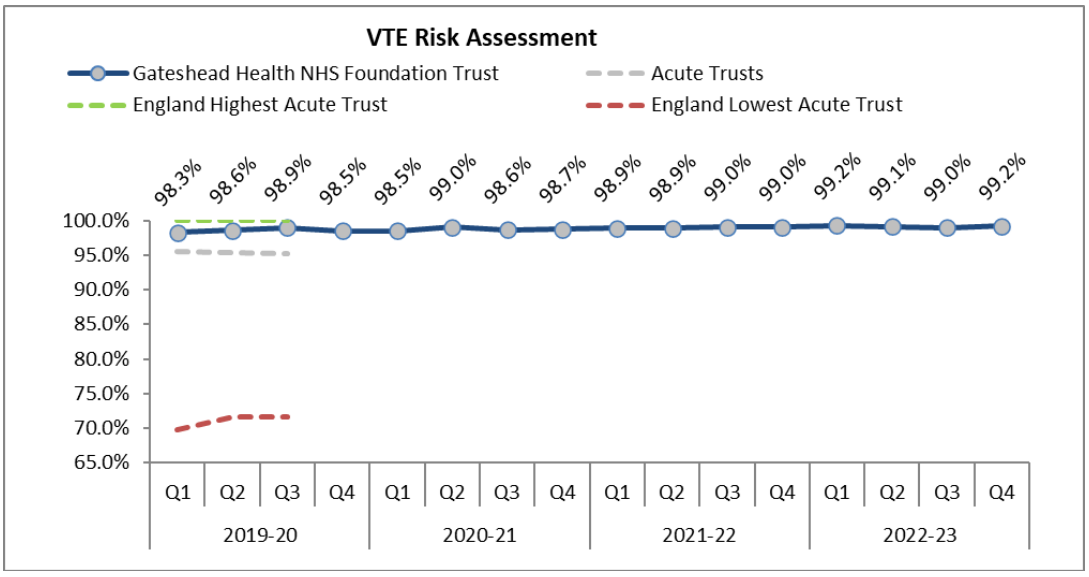
The Gateshead Health NHS Foundation Trust considers that these percentages are as described for the following reasons:

The Gateshead Health NHS Foundation Trust has taken the following actions to improve these percentages, and so the quality of its services, by:

No longer collecting this data – replaced by People's Pulse

Percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism

Year	Quarter	Gateshead Health NHS Foundation Trust	England Highest Acute Trust	England Lowest Acute Trust	Acute Trusts
2019-20	Q1	98.3%	100.0%	69.8%	95.6%
	Q2	98.6%	100.0%	71.7%	95.4%
	Q3	98.9%	100.0%	71.6%	95.3%
	Q4	98.5%	Collection suspended to release capacity to manage COVID-19 and yet to be reinstated		
2020-21	Q1	98.5%			
	Q2	99.0%			
	Q3	98.6%			
	Q4	98.7%			
2021-22	Q1	98.9%			
	Q2	98.9%			
	Q3	99.0%			
	Q4	99.0%			
2022-23	Q1	99.2%			
	Q2	99.1%			
	Q3	99.0%			
	Q4	99.2%			



The Gateshead Health NHS Foundation Trust considers that these percentages are as described for the following reasons:

- Gateshead Health NHS Foundation Trust Compliance with DVT risk assessment has reached 95% in all areas of the hospital which use the JAC prescribing site and reassurance have been gained regarding robust assessment in Critical Care which use a paper documentation. A customised area has been set up on Datix to report cases of Hospital Acquired Thrombosis.

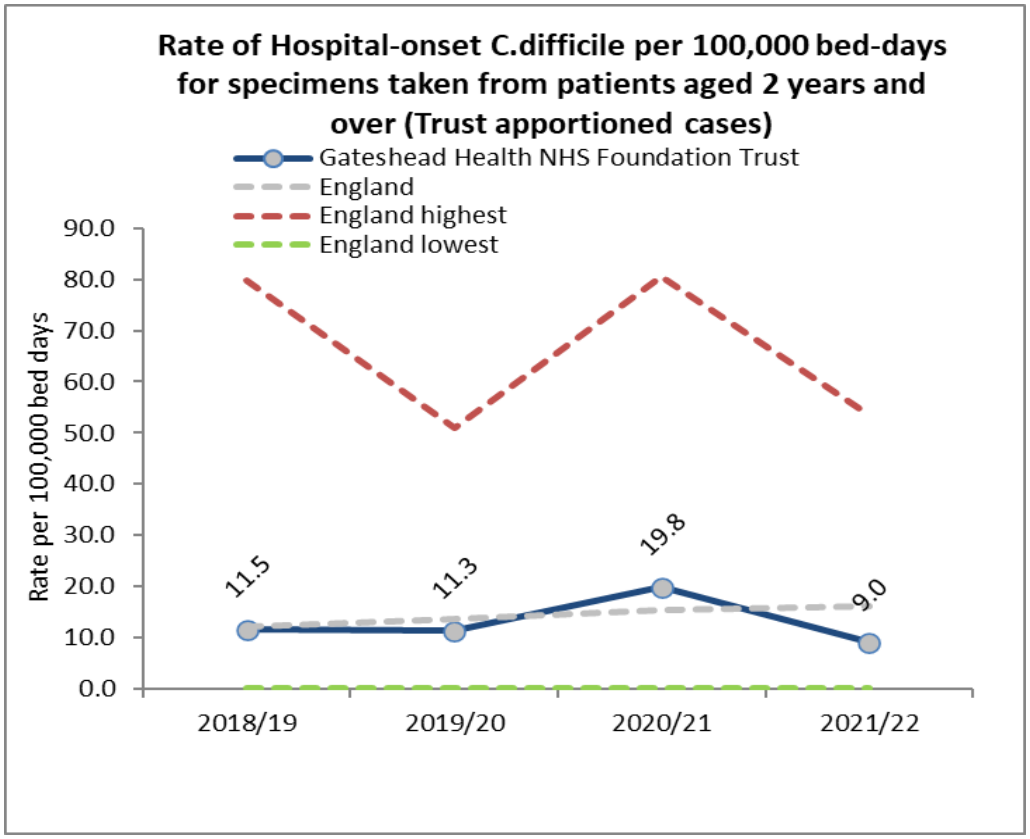
The Gateshead Health NHS Foundation Trust intends to take the following actions to improve these percentages, and so the quality of its services, by:

- A Venous Thromboembolism Committee meet regularly to update all guidelines and raise awareness of deep vein thrombosis and pulmonary embolism and the impact on health. Education of junior doctors and nursing staff have been commenced with regular sessions in the Clinical Leads Nursing meeting and SafeCare meetings. The intranet has been updated with these guidelines and an e-learning module for this has been set up with the help of the Practice and Development Team.
- All new NICE guidelines are monitored on a monthly basis and the relevant updates sent to the respective teams.
- An abstract of the Trust's three-year audit on hospital acquired thrombosis has been accepted for presentation at the Thrombosis UK Conference and a poster has been submitted. This study has shown results which are at par with nationally agreed standards.
- The Trust hospital acquired thrombosis data is also shared with GIRFT.

The rate per 100,000 bed days of cases of *Clostridium difficile* infection (CDI) reported within the Trust amongst patients aged 2 or over.

Rate of Hospital-onset C.difficile per 100,000 bed-days for specimens taken from patients aged 2 years and over (Trust apportioned cases)	2018/19	2019/20	2020/21	2021/22
Gateshead Health NHS Foundation Trust	11.5	11.3	19.8	9.0
England highest	79.8	51.0	80.6	53.6
England lowest	0.0	0.0	0.0	0.0
England	12.2	13.6	15.4	16.2

https://www.gov.uk/government/statistics/clostridium-difficile-infection-annual-data



Gateshead Health NHS Foundation Trust considers that these percentages are as described for the following reasons:

- Clostridium difficile infection (CDI) remains an unpleasant, and potentially severe or even fatal infection that occurs mainly in elderly and other vulnerable patient groups, especially those who have been exposed to antibiotic treatment. Reduction of CDI continues to present a key challenge to patient safety across the Trust, therefore ensuring preventative measures and reducing infection is very important to the high quality of patient care we deliver.
- The Trust reports Healthcare associated CDI cases to Public Health England via the national data capture system against the following categories:
    - Hospital onset healthcare associated (HOHA): cases that are detected in the hospital 2 or more days after admission (where day of admission is day 1)
    - Community onset healthcare associated (COHA): cases that occur in the community (or within 2 days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 4 weeks.
- Nationally the financial sanctions for CDI have been removed and the 'appeals' process no longer in use, and the expectation that organisations will perform local review of cases.
- The Trust is required under the NHS Standard Contract 2022/23 to minimise rates of Clostridioides difficile (C. difficile) so that it is no higher than the threshold level set by NHS England and Improvement.
- For 2022/23 we reported forty (40) cases of healthcare associated CDI against the threshold of thirty-two (32). Twenty-seven (27) hospital onset healthcare associated, and thirteen (13) community onset healthcare associated cases.
- The Trust has reported an increase of eight (8) cases in CDI cases for 2022/23.

Gateshead Health NHS Foundation Trust will continue to take the following actions to improve these percentages, and so the quality of its services by using the following approaches:

- An internal review is held for all healthcare associated CDI cases, supported by root cause/human factors review as necessary, where good practice and lessons learnt can be identified. The learning is then linked, if appropriate, to the key themes of sample submission, antimicrobial prescribing, documentation, patient management and human factors. The good practice and lessons learnt are then cascaded back to through the internal safe care mechanisms.
- Where there is an increased incidence of CDI associated with a particular clinical area, a multidisciplinary meeting will review all the cases collectively, consider if any cross infection may have occurred then formulate and enable an action plan to address any shortcomings identified.
- A weekly C-Difficile review round on the relevant clinical areas takes place with the Consultant microbiologist, Infection Prevention and Control practitioner and pharmacist to ensure that patients have timely reviews and specialist clinical intervention if required.
- Validation hand hygiene audits of the clinical areas are undertaken by the IPC team.
- When there is an increased incidence of CDI cases associated with a particular clinical area Ribotyping is arranged with the Clostridium difficile Ribotyping Network (CDRN) to determine if cross infection has taken place.
- Appropriate cleaning of the clinical area where CDI is identified.
- The Diarrhoea Assessment Management Pathway (DAMP) tool provides guidance for clinical staff managing those patients experiencing loose stools, and has been assimilated into the suite of electronic documents available on Nerve Centre
- Enhanced personal protective equipment is worn when caring for patients with suspected infective diarrhoea.

- Patients are risk assessed and prioritised, ensuring those patients requiring a level of isolation are identified.
- To enhance antimicrobial stewardship Trust guidelines are developed to reflect the national five-year antimicrobial resistance strategy.

The number and rate of patient safety incidents per 1,000 bed days reported within the Trust.

Patient Safety Incidents per 1,000 bed days	Oct 19 - Mar 20		Apr 20 – Mar 21*		Apr 21 – Mar 22*	
Organisation	Gateshead Health NHS Foundation Trust	Acute (non specialist) Organisations	Gateshead Health NHS Foundation Trust	Acute (non specialist) Organisations	Gateshead Health NHS Foundation Trust	Acute (non specialist) Organisations
Total number of incidents occurring	2,929	838,722	4,638	1,550,306	4,886	1,767,264
Rate of all incidents per 1,000 bed days	34.8	N/A	35.3	N/A	31.4	N/A
Number of incidents resulting in Severe harm or Death	19	2,536	75	6,828	67	7,116
Percentage of total incidents that resulted in Severe harm or Death	0.23%	0.30%	1.62%	0.44%	1.37%	0.40%

Source: www.england.nhs.uk/patient-safety/organisation-patient-safety-incident-reports/
*NRLS Organisational workbooks now published annually whereas previously these were six-monthly

The Gateshead Health NHS Foundation Trust considers that these percentages are as described for the following reasons:

** NB The last two periods relate to a 12-month period, reporting was previously based on 6 months periods.

- The table above demonstrates a small increase in the overall reporting of patient safety incidents to the NRLS in 2021-2022. Though set against the increased number of beds open due to increased pressures this percentage has dropped slightly. The shortened capture tool was implemented several times throughout the year during periods of pressure, and staff feedback in relation to the current DATIX system, has been a significant driver in the procurement of a new system Inphase Oversight due to be implemented Q1 2023-24.

This system has many organisational benefits but from a reporting perspective it is SMART enabled, though will not affect the figures for the next reporting period of 2022-2023.

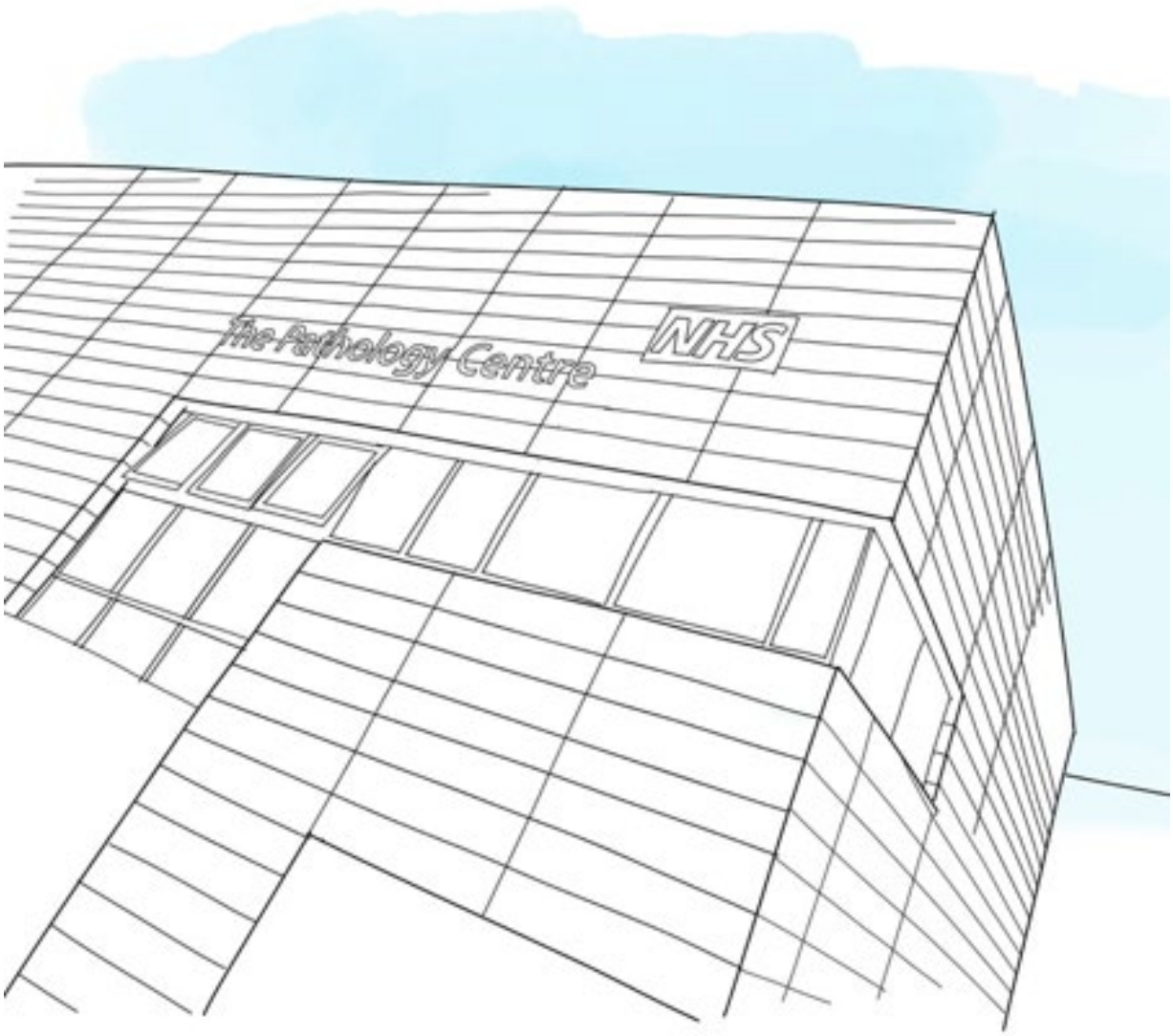
- Figures for this 2021-2022 period related to severe and death level reviews are broadly congruent with the previous 12-month period, and in line with national percentages for these areas.

The Gateshead Health NHS Foundation Trust has taken the following actions to improve these percentages, and so the quality of its services:

- Training continues to be offered to meet the needs of the Trust in relation to incident and risk management, duty of candour and just and restorative culture. It is anticipated that the just and restorative culture work ongoing will improve reporting going forward.
- Alongside the implementation of a new incident management system, the weekly multi-disciplinary meeting (Safety Triangulation Group) continues to review all incidents reported as moderate or above. The impact of this won't be apparent until next year's figures are produced, though the years figures may be from two systems with the anticipated national shift to Learn from patient safety events (LFPSE) in September 2023. The patient safety team in anticipation of Patient Safety Incident Response Framework (PSIRF) have produced and had Trust approval for a suite of new learning response templates that are rooted in safety science and just culture principles.
- A gap analysis was undertaken following the re launch of the National Patient Safety Strategy in September 2022 and work towards compliance continues at pace to compliance by September 2023
- A business intelligence report was developed to assist all areas of the Trust to see their incident trends including no harm/low harm incidents. Following this the patient safety team have worked across the business units to help area devise and address these themes and trends.
- The Trusts Falls prevention group have rolled out the Think Yellow initiative and have undertaken a concurrent pilot of the AFLOAT tool with the Trusts current falls risk assessment tool. The results showed a change to AFLOAT was required, and this has been agreed at Risk and Patient SafeCare Council for Trust wide roll out within Nervecentre.

Part 3

Review of Quality Performance



Review of quality performance

2022/23 has been a successful year in relation to the three domains of quality:

- Patient Safety
- Clinical Effectiveness
- Patient Experience

The Council of Governors has a key role in our assurance processes – both representing the interests of members, the public, staff and stakeholders, as well as holding our Non-Executive Directors to account for the performance of the Board. As part of the Council of Governors' meetings, our Chief Executive delivers an overview of our performance against key quality metrics, with opportunities to question our Board Members on this. Two Governors are also nominated observers of our Quality Governance Committee and we have put in place new structures to support representatives to share feedback on the quality of debate and contributions with the rest of the Council. This provides further opportunities for Governors to seek assurance and hold our Non-Executive Directors to account in respect of quality.

The following sections provide details on the Trust's performance on a range of quality indicators. The indicators themselves have been extracted from NHS nationally mandated indicators, and locally determined measures. Trust performance is measured against a mixture of locally and nationally agreed targets. The key below provides an explanation of the colour coding used within the data tables.

	Target achieved
	Although the target was not achieved, it shows either an improvement on previous year or performance is above the national benchmark
	Target not achieved but action plans are in place

Where applicable, benchmarking has been applied to the indicators using a range of data sources which are detailed in the relevant sections. The Trust recognises that benchmarking is an important tool that allows the reader to place the Trust performance into context against national and local performance. Where benchmarking has not been possible due to timing and availability of data, the Trust will continue to work with external agencies to develop these in the coming year.

3.1 PATIENT SAFETY

Reducing Harm from Deterioration:

Safe Reliable care	2020-21	2021-22	2022.23	Target
HSMR	107.9	114.4	100.1*	<100
SHMI Period	Apr-20 to Mar-21	Apr-21 to Mar-22	Dec-21 to Nov-22	
SHMI	1.00	1.01	0.87	<=1
SHMI Banding	As Expected	As Expected	Lower than expected	As expected or lower than expected

SHMI - Percentage of provider spells with palliative care coding(contextual indicator)	2.7%	2.1%	2.1%	N/A
Crude mortality rate taken from CDS	2.32%	1.83%	1.71%	<1.99%
Number of calls to the CRASH team	113	164	176	N/A
Of the calls to the arrest team what percentage were actual cardiac arrests	38.1%	40.2%	34.7%	N/A
Cardiac arrest rate (number of cardiac arrests per 1000 bed days)	0.83	0.41	0.35	N/A
Hospital Acquired Pressure Damage (grade 2 and above)	115	87	127	Year on year Reduction
Community Acquired Pressure Damage (grade 2 and above)	1565	1451	1469	N/A
Number of Patient Slips, Trips and Falls	1415	1525	1589	N/A
Rate of Falls per 1000 bed days	10.36	9.51	9.03	Reduction (<8.5)
Number of Patient Slips, Trips and Falls Resulting in Harm	318	335	382	N/A
Rate of Harm Falls per 1000 bed days	2.33	2.09	2.17	Reduction (Less than <2.25)
Harm Falls Rate Change	23.6% Increase	10.3% Reduction	3.8% Increase	N/A
Ratio of Harm to No Harm Falls (i.e. what percentage of falls resulted in Harm being caused to the patient)	22.5%	22.0%	24.0%	Year on Year reduction

*HSMR figures are February 2022 to January 2023

Reducing Avoidable Harm:

Reducing Avoidable Harm		2020-21	2021-22	2022-23	Target
Medication Errors	No Harm	529	620	738	N/A
	Minimal Harm	75	84	129	N/A
	Moderate Harm	4	4	8	<8
	Severe	2	1	3	0
	Death	1	0	0	0
	Total	611	709	878	N/A
Never Events		2	0	0	0
Patient Incidents per 1,000 bed days		46.52	38.92	38.3	N/A
Rate of patient safety incidents resulting in severe harm or death per 100 admissions		0.19	0.15	0.13	N/A

Infection Prevention and Control:

Infection Prevention & Control	2020-21	2021-22	2022-23	2022-23 Objective
MRSA bacteraemia apportioned to acute trust post 48hrs	0	0	0	0
MRSA bacteraemia rate per 100,000 bed days	0	0	0	0
NB: *Clostridium difficile* Infections (CDI) post 72hr cases	40	32	40	<=32
Clostridium difficile Infections (CDI) rate per 100,000 bed days	29.28	20.58	22.74	-

Infection Prevention & Control	2020-21	2021-22	2023-23
Hospital Onset Healthcare Associated C.difficile per 100,000 occupied overnight beds	17.72	14.15	17.37

Other Indicators:

Other Indicators	2020-21	2021-22	2022-23	Target	Benchmark
Percentage of Cancelled Operations from FFCE's†	0.24%	0.55%	0.41%	0.80%	1.00%**
Percentage of Patients who return to Theatre within 30 days (Unplanned / Planned / Unrelated)	4.40%	4.89%	5.00%	Improve Year on Year	N/A
Fragility Fracture Neck of Femur operated on within 48hrs of admission / diagnosis	93.9%	92.7%	90.1%	90%	N/A
Proportion of patients who are readmitted within 28 days across the Trust*	10.43%	14.33%	14.06%	Improve year on year	N/A
Proportion of patients undergoing knee replacement who are readmitted within 30 days*	5.66% 6 Patients readmitted	6.21% 10 Patients readmitted	8.43% 15 Patients readmitted	Improve Year on Year	N/A
Proportion of patients undergoing hip replacement who are readmitted within 30 days*	7.34% 8 patients readmitted	9.83% 17 patients readmitted	8.49% 18 patients readmitted	Improve Year on Year	N/A

Safeguarding Children and Adults

- The Safeguarding of children and vulnerable adults has remained a priority across the Trust. There has been a national picture of increased safeguarding in particular mental health issues for children and adults and an increase in incidents of domestic violence. These figures are reflected in the numbers of cause for concerns and referrals coming through to the safeguarding teams and in response to this we have undertaking various pieces of work.

- We continue to provide monthly updates within the Gateshead Health Weekly and Safeguarding newsletter providing valuable updates on current safeguarding issues and promotes training opportunities.
- The Adult and Children Safeguarding teams provide monthly safeguarding link meetings where up to date safeguarding information and any significant learning can be shared with the safeguarding link representatives from each ward or practice area within the trust.
- Within the quarterly Safeguarding Committee, we bring the lived experiences of service users by sharing patient stories at every meeting.
- The children's safeguarding team offer opportunities to staff for restorative supervision and debrief after difficult cases. Regular supervision is provided by both teams to appropriate staff teams across the Trust.
- There is up to date guidance and links available on the safeguarding staff zone pages for staff who have experienced any challenging or distressing safeguarding cases.
- Safeguarding adults and children's training is provided via e-learning and face to face across the Trust. The teams have listened to staff preferences for onsite training.
- The Adult Safeguarding team work with the Local Authority and Community Services in relation to provider concerns.
- The safeguarding teams and charitable funds team continue to work together to provide grab bags which include essential items for people who are fleeing domestic abuse situations.
- The children and adult teams continue to promote the use of the Safeguarding Exploitation Grooming and Risk Identifier tool (SEGRI) to include both vulnerable adults and children at risk sexual exploitation, criminal exploitation, and modern-day slavery. County lines training is included in Level 3 training across the Trust.
- Young people who are care experienced have an increased likelihood of an unplanned teenage pregnancy therefore, the Looked After Children's team have linked up with Gateshead sexual health service to look at ways of improving access to sexual health services for young people.
- The Adults team are continuing to roll out training on capacity assessments in line with Mental Capacity Act legislation for staff awareness and in preparation for the potential change in legislation in relation to Deprivation of Liberties.
- As part of safeguarding week, the children's' and adult's team raise awareness across the Trust of relevant safeguarding issues in Gateshead.
- The children's safeguarding team work closely with the Gateshead Safeguarding Children Partnership to learn from cases and improve practice across the area. The team disseminate that learning across the Trust via various forums.
- The adults safeguarding team work closely with partner agencies to ensure best practice is incorporated across the Trust and any learning is disseminated.
- The teams work together to deliver a joint adult and children safeguarding conference. The next conference is planned for the 19th September 2023.

3.2 CLINICAL EFFECTIVENESS

Getting it Right First Time (GIRFT)

GIRFT is a national programme designed to improve the treatment and care of patients through in-depth review of services, benchmarking, and presenting a data-driven evidence base to support change. The programme undertakes clinically led reviews of specialties, combining wide-ranging data analysis with the input and professional knowledge of senior clinicians to examine how things are currently being done and how they could be improved.

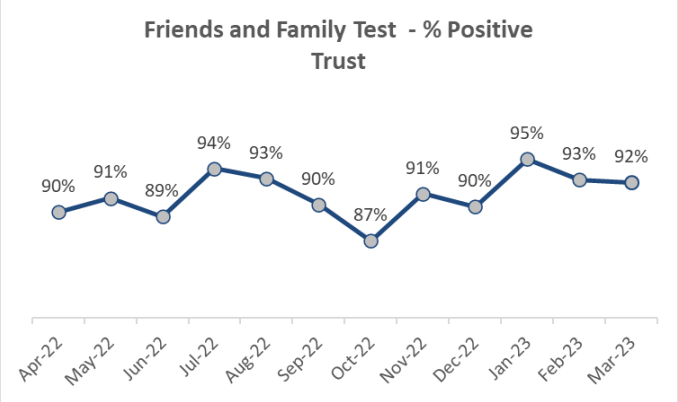
During 2022/23 there has been one 'deep dive' visit:

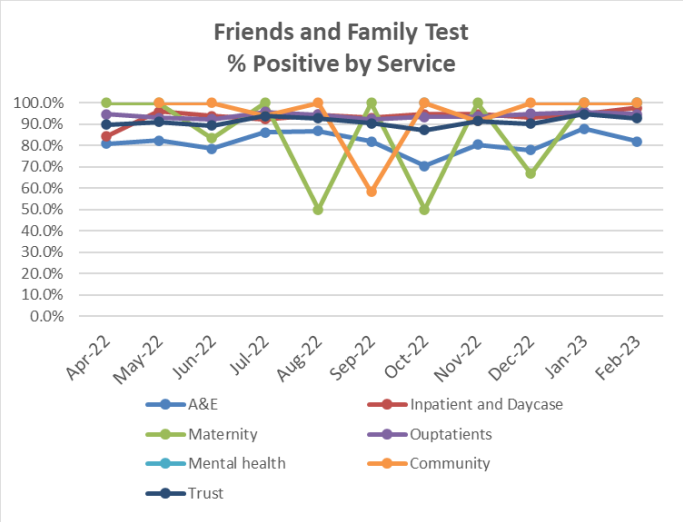
Speciality	Good practice/opportunities for improvement identified
Critical Care May 2022	Although this visit took place in May 2022 the formal feedback was not available for inclusion in the last six monthly report, hence the reason for inclusion here. The team identified the rehab nurses taking patients out into the garden as an area of good practice. In terms of opportunities for improvement, the following were identified: - 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

A deep dive was scheduled for Acute Medicine in November 2022, however, this was stood down by the GIRFT national team. This is currently being rearranged.

3.3 PATIENT EXPERIENCE

Friends & Family Test





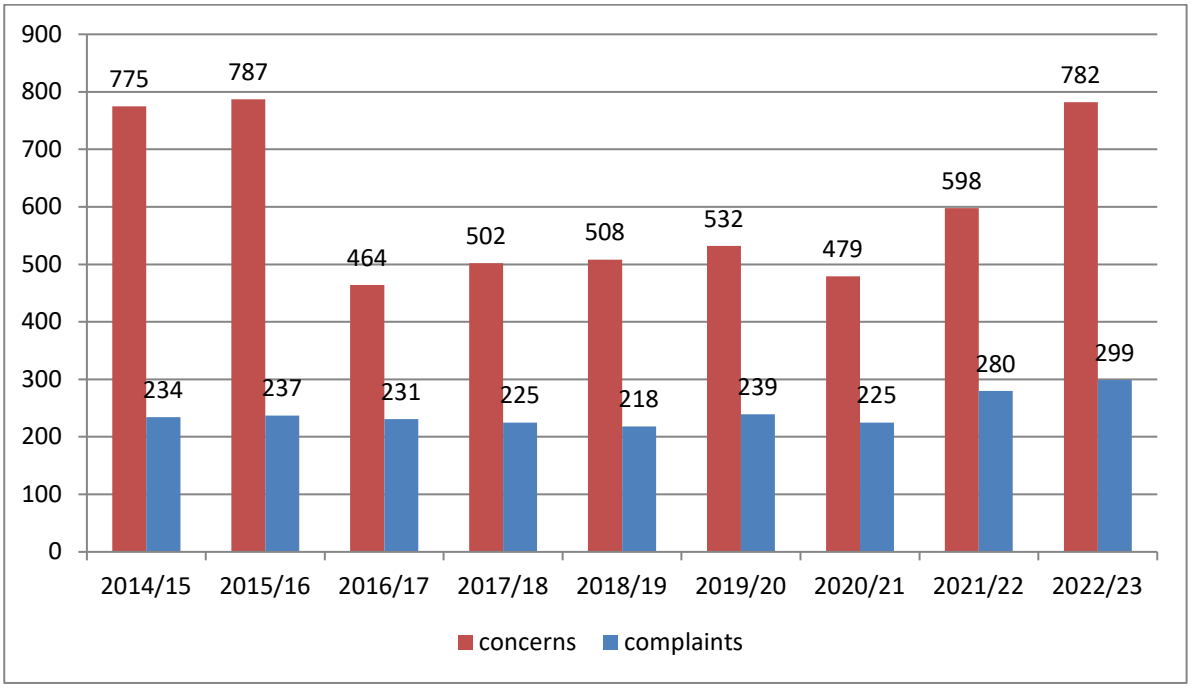
Listening to Concerns and Complaints, Compliments

The Trust acknowledges the value of feedback from patients and visitors and continues to encourage the sharing of personal experiences. This type of feedback is invaluable in helping us ensure that the service provided meets the expectations and needs of our patients through a constructive review.

For the year 2022/23 we received a total of 299 formal complaints. Promoting a culture of openness and truthfulness is a prerequisite to improving the safety of patients, staff and visitors as well as the quality of healthcare systems. It involves apologising and explaining what happened to patients who have been harmed as a result of their healthcare treatment when inpatients or outpatients of the Trust. It also involves apologising and explaining what happened to staff or visitors who have suffered harm. It encompasses communication between healthcare organisations, healthcare teams and patients and/or their carers, staff and visitors and makes sure that openness, honesty and timeliness underpins responses to such incidents.

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 carers.

Complaints and Concerns 2014 to 2023



During 2022/23 the top five main reasons to raise a formal complaint were in relation to:

- Communications (59 complaints).
- Clinical Treatment – General Medical Group (56 complaints).
- Clinical Treatment – Surgical Group (46 complaints).
- Clinical Treatment – Accident & Emergency (42 complaints).
- Values & Behaviours (Staff) (25 complaints).

Complaints Performance Indicators	Total 2022/23
Complaints received	299
Acknowledged within three working days	299
Complaints closed	311
Closed within agreed timescale (eight weeks)	117
Number of complaints upheld	238
Concerns received by PALS	782

Complaints Indicators	Total 2022/23
Number of closed complaints reopened	34*
Number of closed complaints referred to Parliamentary & Health Service Ombudsman	13

Outcome of complaints referred to Parliamentary & Health Service Ombudsman (PHSO)	Total 2022/23
Considering whether to investigate	5

Currently investigating	1
Complaints upheld	0
Part upheld	0
Declined to be investigated	3
Agreed actions with Trust (incl as a result of learning)	4

***Number of closed complaints reopened.**
In the year 2022/23 34 closed complaints were reopened. This compares to 40 in 2021/22. Reasons for reopening cases include where the complainant has additional questions/concerns.

As a result of complaints and concerns raised over the past year several initiatives have been implemented.

The provision for and experience of male breast patients has been identified as an area for investigation by the Breast Team and patients concerns provided supporting evidence for this work.

- A questionnaire has been designed and completed by male patients to highlight issues and identify areas for improvement.
- This feedback acted upon to display male breast cancer posters in the Breast Unit waiting areas with the aim of increasing awareness and reducing any uncomfortable feelings for those in attendance.
- A male specific information folder has been created for male breast cancer patients.
- A podcast discussing male breast cancer has been recorded.

Red tabards now in use worn by staff when giving out medication to patients, to tell staff not to interrupt. This is as a direct result of an incident/complaint.

In response to a complaint regarding cancellation of surgery, we have since taken steps to ensure that if a patient is cancelled at short notice, we ask the team who are handling our theatre cancellations to ensure that a patients covid status is checked and the patient informed by a suitable individual in a timely way to ensure they do not attend for the original appointment.

In response to an A&E complaint, Consultant in Emergency Medicine has reviewed the patient's medical notes and recognises that although a fracture was identified on the initial x-ray, the fracture was underappreciated and has used this as an opportunity to provide further teaching to the Advanced Clinical Practitioner involved regarding these types of fractures to prevent a similar event happening in the future. Consultant has reviewed the pathways in the department and ensured that a thorough mobility assessment in now carried out within the department, prior to discharge.

In response to a complaint relating to Radiology, the department has reviewed their processes to ensure there is now a robust patient checking process in place. Radiology now has a process in place whereby the Radiology Support Workers will ask every patient in the waiting area on a regular basis (every 30mins) if they are warm enough. Radiology has also purchased a blanket warmer to use for the blankets of any patient who is particularly cold or in the waiting area for any length of time.

In response to a complain regarding Ultrasound signage, the signage the patient on the chair should have been made visible from the outside of the Tranwell Unit when the Sonographer

and Radiology Support Worker leave the building. This had not happened on this occasion. To prevent this type of incident reoccurring all the ultrasound staff have been reminded to place the signage in a prominent position when they leave the Tranwell Unit. The ultrasound department has also ordered a weatherproof blue and white signage which will be attached externally near the entrance to the Tranwell Unit. The signage will advise patients to go to, or ring, the main ultrasound department if there is no response from the buzzer.

3.4 Good News Stories

Trust staff participated in a number of promotional, awareness raising and celebration events throughout the year.

Teams recognised with awards

Breast care nurse wins Innovation Champion Award at Bright Ideas in Health Awards 2023 ceremony.

Our Gynaecological Oncology centre was recognised as a centre for excellent for advanced ovarian cancer surgery by the European Society for Gynaecological Oncology

Medicines Optimisation service rated ‘Good’ by CQC

Maternity staff received chief nursing officer awards including CMO silver award and MSW awards

Chief Nursing Officer presented silver awards for outstanding dedication to nursing and the NHS for Jane Ramms, Allison Grapes and Chris Fawcett

Breast services were finalists for the Performance Recovery Award at the HSJ awards

New initiatives implemented

Pilot of recovery navigator service launched in the emergency care department to support people with substance abuse towards a safer, healthier and more productive lifestyle.

Cancer prehabilitation project launched to support patients providing advice on a healthy diet, physical activity and mental wellbeing.

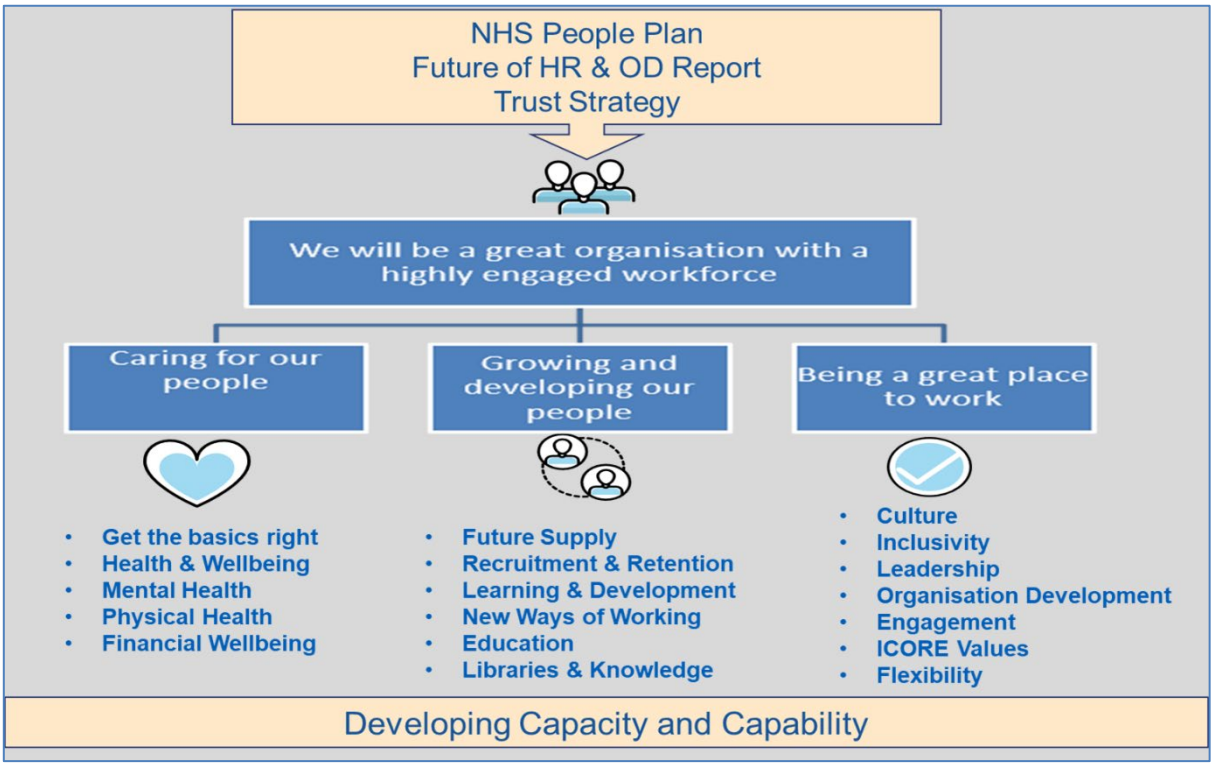
A new state of the art maternity theatre opening, due to increasing numbers of operations required, the new theatre allows more capacity for planned and emergency operations to take place.

3.5 Focus on staff

Our People Strategy

There is no denying, over the past couple of years it has been a challenging time to work in the NHS with each one of our people's experiences shaping the way they continue to do the jobs they love. The world of work has also changed at a pace none of us could have ever imagined, and we have all had the opportunity to begin to think about what matters to us. We know that the future of health services is also changing – there is rising demand, a need to integrate services and a shift towards prevention and addressing health inequalities. We simply cannot keep doing the same things and hope that it will be enough. In order for us to deliver outstanding and compassionate care to our patients and communities, we must first focus on our people.

Our people are key to achieving our vision for our patients and communities and this year has seen us embark on an exciting journey to develop a People Strategy that is fit for 2023 and beyond. A strategy that takes us to 2026. A strategy for our people, across all professions and in all areas. A strategy that outlines how the Trust will care for our people, provide opportunities for their development and growth, and continue to make Gateshead a great place to work which in turn builds both capacity and capability.



We have developed this strategy collaboratively by drawing on the huge wealth of information relating to people that we have access to, both within the Trust, across the wider NHS and within our people profession. Taking the opportunity to engage with both our People and OD teams and the Trust's Senior Management teams about the draft from September 2022 onwards, which has enabled us to produce a strategy that means something to all of us at Gateshead. Being presented and discussed in Board Development days as well as our People and OD Committee in early 2023, leading to final Board sign off in March 2023. We are confident that this strategy will mean something to all our People at Gateshead, providing a

framework for us to concentrate on our people priorities, supporting the delivery of care to our local population.

The strategy underpins our current strategic people aim of being a great organisation and aligns to each of our three 2022-23 strategic objectives, of which there are many key achievements to celebrate over the course of the past 12 months;

1. Protect and understand the health and wellbeing of our staff by looking after our workforce;
2. Growing and developing the Workforce;
3. Development and Implementation of a Culture Programme.

Health and Wellbeing

As a Trust, Gateshead Health is committed to the health and wellbeing of its people, recognising the impact of both short and long-term absence on the workforce, and therefore as part of our commitment to addressing our supply issues a new, ***focused absence management approach*** has been adopted this year. The aim of which is to support staff to remain at work, wherever possible and where this is unavoidable, provide effective solutions to assist a timely return to work. In time this has been operational gradual improvements have been reported in the absence figures across all clinical business units. Seasonal variations have affecting some of the month-on-month comparison, but this is not unusual. This is a success definitely worth celebrating given the well-recognised evidence base that suggests work is generally good for physical and mental health and wellbeing, as well as maximising the workforce availability to provide direct patient care.

Launched in June 2022, Gateshead Health's dedicated Occupational Health and Wellbeing website ***balancegateshead.com*** provides all colleagues with anytime access to self-care as well as physical, mental, financial, social and environmental wellbeing support resources. Previously, such support had only been available through the organisation's intranet and on trust devices, limiting the ability of the organisation to effectively signpost and support colleagues.

Since its launch, 7,600 unique users have visited the website over 34,000 times with the website now clearly established as the 'go-to' place for all things health and wellbeing. The website continues to expand month on month and is regularly updated with the latest wellbeing news, acting as an effective means of promoting wellbeing support, offers, resources and more.

In July 2022, the Trust opened its very own ***Listening Space***, a dedicated health and wellbeing area, available for any member of staff to use at any time, it is designed to offer our colleagues with an identified space to decompress. Staff might visit to meet a mental health first aider for a chat, find out where to access targeted support from a member of the health and wellbeing team or chat with one of our colleagues around a work-related issue that is troubling them.

The Listening Space is also used to host various health and wellbeing events activities and the organisation's Carer's Circle and its Menopause Warriors support group and staff network groups meet their regularly. It also provides a space for the weekly drop-in sessions provide by Citizens Advice and weekly free salon treatments delivered to staff with the aid of Gateshead College.

2022 also saw the introduction of ***Schwartz Rounds*** at Gateshead Health; with the aim of helping colleagues better understand the challenges and rewards of providing care, bringing

these to life through their experiences. The focus of Schwartz Rounds is very much on reflection, with evidence showing that staff who attend feel less stressed and less isolated. All staff regardless of their role in the Trust are encouraged and welcomed to attend these events.

Throughout the year, approximately 150 colleagues have participated in a Schwartz Round session and feedback has been overwhelmingly positive from attendees, with:

- 93% agreeing that they gained insights which would help them to meet the needs of patients;
- 94% sharing that Schwartz Round helped them to work more effectively with colleagues and that the group discussion was useful to them;
- 99% agreeing that they had a better understanding of how colleagues felt about work and;
- 99% indicating that they would recommend Schwartz rounds to their colleagues.

Supporting people within mental health and wellbeing has also extended to ***financial wellbeing***. In recognition of the financial pressures many colleagues are facing, and which have been and continue to be well reported in the media, a concerted campaign was launched in early 2023 to support staff with financial wellbeing matters. Titled #GHMoneyMatters, the start of the campaign was marked with the launch of the #GHMoneyMatters Guide to Financial Wellbeing, bringing together all of the financial support available to colleagues. With the aim of offering something for everyone, the campaign continues to promote financial wellbeing support for all colleagues across the Trust – whether this be due to them struggling financially, looking to purchase a home, planning for the future and/or retirement, looking to get the most from their money or otherwise. As part of this work, we have seen the introduction and review of partnerships with external organisations, such as the likes of Citizens Advice Gateshead, Schroders, Barclays and others to provide training, expert advice and much more.

A grant was secured this year to fund the launch of the ***Leg-Up Project***. An initiative aimed to provide colleagues in financial hardship with access to hot meals at work, in recognition of the social, physical and mental benefits of ensuring colleagues can access quality food and drink while at work as well as the positive effect this then in turn has on patient care. Following a successful introduction which enabled the provision of 500 meals, further funding was provided to extend the project into 2023 and distribute vouchers for a further 564 meals. A targeted approach has been taken throughout the project with the support of Chaplaincy, who led distribution and worked to ensure those more likely to be experiencing financial pressures were aware of voucher availability. Adding to the 1,064 meals provided, a number of festive meal vouchers provided as a gift from the organisation to colleagues were donated to the Leg-Up Project and redistributed to those in need.

Through the fantastic work and investment, we have put into developing our Health and Wellbeing Offer, 2022 has seen Gateshead Health achieve the ***Better Health at Work Silver Award*** – this award provides a Health and Wellbeing framework to work to and benchmark ourselves against, all with the aim of improving the colleague experience at Gateshead. In 2023 we are aiming high and plan to go for Gold.

Finally, more recently, in March 2023, the Occupational Health and Wellbeing Team completed a ***Rapid Process Improvement Workshop*** with the primary aim of reducing the time between a management referral and a patient's first appointment.

In addition to a reduction of 66% in waiting times, the workshop also led to a number of other positive outcomes. Included amongst these are patient experience improvements such as the reintroduction of an always-staffed reception area, the Occupational Health and Wellbeing

phone line and a visible board to help direct visitors to the correct room. In addition, drop-in clinics, were reintroduced, providing colleagues with more flexibility, while new follow-up letters help provide patients with appropriate signposting during any waiting times.

Elsewhere, a new referral form streamlines the colleague referral process and brings all types of referrals in one place. This feeds into a new and improved triage process, which has made processing a much quicker task and ultimately helps the team support colleagues more efficiently. Furthermore, a review of estates helped lead to the introduction of a further clinical room – helping to increase capacity by a further 29 appointments per month and tackle a growing backlog. A new physiotherapy room was also sourced, providing a more suitable space to deliver appointments.

Growing and Developing the Workforce

Nationally, there are significant staff shortages, which are well reported, with an urgent need to focus on nurse supply. 2022 saw the appointment of a ***People Analyst*** a new role and the first of its kind for the People and OD team at Gateshead Health. The introduction of this role has really supported the Trust to better understand our local people picture in Gateshead, through effective analytics. Our People Analyst has supported with the production of high-quality analysis and interpretation of a wide range of data sources, providing expert advice on interpretation of data and visualisation. They have begun to develop strong Trust wide relationships to translate complex information into actionable insight, helping the Trust track performance, monitor delivery, and plan for the future workforce through the supply and analysis of robust, reliable, and useful data.

With the aim of addressing some of the supply challenges mentioned this year as a Trust, we have grown our nursing workforce through an ***international recruitment programme***, appointing international nurses and supporting them to become registered Nurses across Gateshead Health. Our dedicated international nursing team have established and embedded a 10-week programme to support international recruits through their training, Objective Structured Clinical Examination (OSCE) and NMC registration as well as a 2-week pastoral programme incorporating language support and ward readiness. To date, as a Trust our OSCE first time pass rate is 60% increasing to 94% at second attempt and all of our international recruits to date have passed by their third attempt. We are delighted with the high standard of international recruits we have welcomed to the Trust and the feedback received from those who have joined us to date has been extremely positive.

As we reflect on the year, ***industrial action*** has also presented additional and unique challenges around workforce supply and availability. Locally and nationally industrial action has been and continues to take place and for some unions this is the first time they have ever balloted their member for strike action. As a Trust we have deeply aware of how complicated this issue is for many colleagues, and that that they may be feeling conflicted or torn in the decisions that they and their colleagues are making. Gateshead Health recognise that our people have a legal right to take industrial action, respecting the decision each and every one of our colleagues make. Our priority throughout each period of industrial action has been and continues to be to deliver high quality and safe care.

To date, the trust has continued to manage the impact of the industrial action and mitigate the risk to ensure there is minimal disruption to patient care and emergency services can continue to operate as normal through a robust, multi-disciplinary planning framework. Strong partnerships between the trust's Senior Management Team, People at OD and both

operational and clinical colleagues, the Emergency Preparedness, Resilience and Response team and Trade Unions have been key.

We have now been through a number of periods of industrial action and through them all we have pulled together to support each other and patients, at what has been a really challenging time. We know that each period of industrial action brings knock on effects and that the cumulative pressures continue to build up. We are continually impressed by our people's resilience and appreciative of their ongoing commitment to our patients and service users. We know that at times, this has not been easy. Continuous improvement is a key part of what we are about at Gateshead and have developed a strong debrief process that enables us to reflect on the positive outcomes from any action and associated planning in addition to giving consideration of any learning points.

Continuing with the theme of supply, in order to support our supply challenges in an ever challenging and equally competitive job market we continue to focus on ***recruitment***, ensuring that applicants have a positive, seamless and timely candidate experiencing when applying for roles at Gateshead Health. Over the course of the past two years our in-house recruitment team have been on an intensive improvement journey in order to deliver, a high functioning, efficient and effective recruitment service which recruits staff to the Trust as quickly and as safely as possible. This has included investment in a new recruitment system to support the management of recruitment activity, implementation of a series of recommendation and a number of improvement workshops in 2022, which provided the tools to significantly improve our service offering. As such, we have seen our time to hire reduce considerably and the team are regularly outperforming the target.

As part of our longer-term supply pipeline in April 2022, as a Trust we began to open our doors, post pandemic, taking small steps towards a "new normal" and progressing our ***widening participation*** agenda. An agenda that involves increasing not only the number of young people entering higher education, but also the proportion of under-represented groups. As a result, we have looked to adopt a more strategic approach to engaging with schools and colleges in addition to both internal and external stakeholders that support the Trust (and our partner's) workforce pipeline and recruitment. This involves supporting work experience placements and both T Level and Project Choice students. T Levels, offer students practical learning via on-the-job, industry placement experience. On the other hand, Project Choice is a supported internship course that promotes employment opportunities for individuals with learning difficulties, disabilities and/or Autism. Since April 2022, we have supported 74 work experience placements, 22 T Level Students and 25 Project Choice internships.

Over the course of the last six months in particular we have actively attended events with local schools and Gateshead college in particular, educating students that we have over 1,200 different job roles in the Trust alone. We have showcased job roles from entry level and outlined progression pathways, emphasising that there is a place for everyone regardless of skill set, ability, interests or background, with the aim of opening up different supply pipeline into the Trust.

Going forward we commit to continue to offer a robust work experience programme, including medical shadowing. Project Choice also continues to go from strength to strength. It not only supports students across Gateshead with learning difficulties but also looks at the potential of the students joining the workforce in entry-level roles.

We also continue to be part of Gateshead College's Employer Skills Board with other partners in the local area, reviewing the current college curriculum, mapping and sharing ideas on how we can input into the offer they provide to help shape a future-ready workforce.

As part of our continued commitment to education, learning and development, 2022 saw us begin to develop the ***Gateshead Health and Care Academy***. The academy is an approach and branding of our workforce development offer and is a partnership with the local authority and college. The long-term strategic aim of which is to provide a sustainable workforce within the Gateshead area – local jobs, for local people. Within the next 12 months the Health and Care Academy is looking to open up new apprenticeship routes within the Trust but also in a joint approach with the local authority, host joint events with our local partners and support the Step into Work programme. Step into Work being an employability programme for adults aged 19+ supporting them to develop employability skills and qualities in order to secure health and social care roles, through a blended approach of work placements and training, which takes place over a 6-to-12-week period.

As part of the Trust's objective to grow and develop our workforce Gateshead Health officially launched its internal ***Managing Well*** Programme in May 2022 and what a success it has been.

This was designed in response to the Executive Team's aspiration to be a value led organisation where managers are compassionate, kind and inclusive, a commitment to the NHS People Promises, the need to strengthen leadership and management across health in addition to the requirement to reinvest in management development following the pandemic.

The programme provides a balance between management theory and a practical overview of support available to managers within the Trust, supporting them to be the best people manager they can be. Designed to support managers at all levels of the organisation the programme provides experienced managers with the opportunity to reflect refresh and refocus on the key principals of effective management and less experienced managers with a foundation in the principals of effective management but most importantly the allows all participants to become part of a supportive network of managers across the Trust.

With over 25 cohorts to date, and over 300 managers attending, the programme has evaluated very positively, with 100% of participants being likely or highly likely to recommend this programme to another manager in the organisation.

Following on from Managing Well, we have also ***Leading Well.*** Leading Well is our flagship Leadership Development programme and builds upon the NHS 'Our Leadership Way' principals, providing clarity around expectations of a leader. The programme takes participants through a journey of self-reflection through to understanding their impact, the responsibility that they carry and the importance of taking a broader, strategic approach to their leadership practice. The course has attracted participants from across the organisation, in all professions and the feedback continues to be extremely positive. Plans for the coming year are to build on from Leading Well with a focus on clinical leadership development, collective clinical leadership and profession specific development pathways including, for example, matron development.

Over the last 18 months, we have also worked closely with an external provider to deliver a programme of ***development for our senior leadership team***. This began with an opportunity to pause and reflect on the impact of the pandemic and those lessons learned and over the course of 2022-23 supported the senior team to create clarity around the roles and responsibilities of the team. With an ongoing focus on collective leadership, the programme allows time and space for strategic thinking and provides an operating framework that can be

shared with new members, ensuring consistency of approach moving forward. In 2023 development has focused more closely on 1:1 support, preparing for the change that a change in leadership will inevitably bring, whilst collectively addressing some of the larger organisational challenges currently being faced, including staffing and finances.

Finally, as a Trust, we are delighted that this year we have had six colleagues accepted onto the regional ***Executive Director Pathway***, an inclusive talent scheme which aims to support aspiring executive leaders progress in their careers through a series of targeted development opportunities. The pathway, which takes between 12 and 24 months to complete, provides a clear development journey to senior executive leadership, combining best practice in both talent management and leadership development.

Culture Programme

2021-22 saw the People and OD department embark on a journey to strive towards Delivering Excellence in People Practice, with capacity creation and a high-quality customer focused service underpinning this delivered by people experts, providing specialist people advice. The new model of service delivery saw investment in and the introduction of a new ***OD offer and team***, which we have seen fully embed throughout 2022. The structure allows our teams to closely partner with each of our Business Units, through a matrix model of working, and provide bespoke support to both our corporate and operational teams and to date we have received positive feedback on this offer from across the organisation. In addition, the team also lead on key people projects including the Annual Staff Survey, People Pulse Survey, Talent Management, Leadership Development, Team Engagement and Culture, providing a cohesive and centralised OD service to the Trust.

As we mention ***staff survey***, this year's staff survey results are in and as Trust, we are thrilled to see our response has again increased, with 51% of our people responding to in 2022, meaning that one in every two of our staff have taken the time to pause, reflect and tell us how they are feeling, and as such the results are more representative than ever.

The past year has been incredibly challenging, but our people have all pulled together to support each other and our patients. This is reflected in the results, which show that 88% of people feeling that they can make a difference to patients in their role and 80% of people agreeing that caring for our patients remains our top priority.

Many of the responses demonstrate that our people embody and appreciate our compassionate culture, with 72% of staff saying that they feel valued by their team, that the people they work with are kind and considerate, and that colleagues are polite and treat each other with respect. While around three quarters of people agree that the organisation respects individual differences, and feel that their manager values their work, and cares about their concerns. This really echoes the 'team Gateshead' ethos we have – working together to overcome the challenges that are thrown our way. We are thrilled that our people continue to recommend Gateshead as a place to work, an area where our average score is significantly higher than the national average.

Engagement and more specifically, ***team engagement***, has been a focus of activity this year and will continue into 2023. This builds on the work of Professor Michael West in the area of Home Teams and the importance of these for patient safety. This has resulted in a number of team development initiatives including the launch of department level staff survey results dashboards, Building an Effective Team training, Managing Conflict guidance, pilot of TED, which is a team engagement diagnostic tool and a series of team focused communications that

will launch in May 2023. Teams and the importance of team leadership, management and membership will be a primary focus for us through 2023-24.

Building on our culture and engagement work, at Gateshead Health we encourage a working environment where we can all speak up and speak out about issues that concern us. Along with our Freedom to Speak Up Guardian, as part of the Trust's commitment to ***Freedom to Speak Up***, we are currently looking to build a support network of Freedom to Speak Up Champions who will play an important role in positively promoting the key messages about speaking up and widening the reach of the freedom to speak up agenda. We are pleased to have recently recruited five champions who are all about to embark on their training.

As part of the wider cultural piece, finally, we are delighted to share that the Gateshead Health ***Culture Programme*** will launch in April 2023, it is anticipated this will be a programme of work over the next two to three years and focuses on six key workstreams including Vision, Values & Behaviours; Just and Restorative Culture; Compassionate & Inclusive Leadership; Psychological Safety; Colleague Experience; and Colleague Engagement. These themes emerged as part of the large colleague engagement exercise took place this year, which was used to shape the Trust's vision, values and behaviours.

3.6 National targets and regulatory requirements

The following indicators are all governed by standard national definitions

Indicator		2020/21	2021/22	2022/23	Target
Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway		69.0%	78.6%	73.0%	92.0%
A&E – maximum waiting time of four hours from arrival to admission / transfer / discharge		91.4%	81.6%	73.3%	95.0%
All cancers: 62 day wait for first treatment from: urgent GP referral for suspected cancer		68.1%	64.4%	**59.9%**	85.0%
NHS Cancer Screening Service referral		76.4%	85.9%	90.2%	90.0%
All cancers: 31 day wait for second or subsequent treatment, comprising:	Surgery	95.8%	86.5%	93.4%	94.0%
	Anti-cancer drug treatments	98.9%	96.9%	98.4%	98.0%
All cancers: 31 day wait from diagnosis to first treatment		97.9%	96.3%	97.2%	96.0%
Cancer: two week wait from referral to date first seen, comprising:	All urgent referrals (cancer suspected)	67.3%	83.2%	84.7%	93.0%
	Symptomatic breast patients (cancer not initially suspected)	91.8%	96.2%	95.6%	93.0%
Cancer Faster Diagnosis Standard	Faster diagnosis standard (FDS): Maximum 28-day wait to communication of definitive cancer/not cancer diagnosis for patients referred urgently (including those with breast symptoms) and from NHS cancer screening	N/A	N/A	76.4%	75.0%
	Maximum two-month (62-day) wait to first treatment from urgent GP referral (including for breast symptoms) and NHS cancer screening	N/A	N/A	98.8%	75.0%
	Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients	N/A	N/A	**61.4%**	75.0%
Maximum 6-week wait for diagnostic procedures		55.8%	70.6%	81.3%	99.0%

Annex 1: Feedback on our 2022/23 Quality Account

4.1 Gateshead Overview and Scrutiny Committee

Based on Gateshead Care, Health and Wellbeing OSC's knowledge of the work of the Trust during 2022-23 we feel able to comment as follows:-

Quality Priorities for 2023-24

OSC is supportive of the Trust's proposed Quality Priorities for Improvement.

Progress Against Quality Priorities for 2022-23

OSC expressed its thanks to all the Trust's staff and volunteers for its excellent work in continuing to make some real improvements in quality and safety whilst still facing significant challenges. Areas to particularly note were around the increase in the number of nursing staff and overseas nurses as well as an increase in volunteer numbers. Although there is further work continuing in this area, progress was good.

The Trust has carried out some good work around patients as partners in improvement, holding co-design improvement workshops and working collaboratively with ISB / Gateshead Place to establish a Patient Forum. The Trust has maintained its focus on the health and wellbeing of staff particularly focusing on enhanced staff offers during very busy periods and achieved the Better Health at Work Silver Award during the year. OSC also noted it is working towards the Gold award.

In addition, the Trust has in place an overarching Equality and Diversity Objections action plan for Workforce Disability Equality Standard (WDES) and Workforce Race Equality Standard (WRES) and has trained 9 Cultural Ambassadors to be utilised during disciplinary processes where BME members of staff are involved.

The Trust has taken forward work to maximise safety in maternity services and has a fully staffed maternity unit. The Trust has made good progress in terms of improving the experiences of service users with Learning Disabilities and Mental Health needs and acknowledged that further work is continuing around clinical coding.

The Trust has worked towards, and will continue to promote, a just, open and restorative culture across the organisation. There has been dedicated Patient Safety Incident Response Framework (PSIRF) sessions held and work will continue in this area as part of the 2023/24 priorities.

Maternity Service
OSC sought clarification as to the reasons why an improvement plan was being developed for the Trust's Maternity Services. OSC was informed that this was following Maternity Services generally coming under a lot of scrutiny across the country with various reports being published in relation to other Trusts that contained a number of actions to be taken forward. A new three-year plan was produced therefore and the Trust has recognised the need to have these pieces of work in one place to

facilitate good strategic oversight and to demonstrate what the Trust is doing in this area.

OSC also enquired about the CQC inspection carried out in February 2023 and it was noted that the Trust is awaiting the outcome of the inspection. OSC asked to be updated on the outcome in due course as part of its work programme.

Volunteers
OSC queried to what extent the growth in volunteers reflected staff shortages and cuts in funding. OSC was informed that, in times of pressure, the Trust recognises that there would not be enough resources to offer additional support to patients and staff without the help and input of volunteers. The OSC was also informed that volunteers can help in terms of recruitment and retention with some people coming into a career in nursing through the volunteering route.

Working with patients as partners in improvement
OSC queried how the Trust is ensuring it hears the voice of those with the most difficult of circumstances and those unlikely to attend engagement workshops. OSC was informed that this is included within wider health inequality work, where Trust representatives are proactively going out to meet patients in their own communities. There are also a number of mechanisms for patient and family feedback which is used to inform service change.

Health and Wellbeing of Staff
OSC sought to understand how the cost of living crisis has been taken into account in terms of the wellbeing of staff at the Trust. The Trust continues to support its staff and is aiming to tailor its staff health and wellbeing initiatives further so that staff can get the most from them.

CQC Inspection Outcomes

OSC noted that the Care Quality Commission has not taken enforcement action against Gateshead Health NHS Foundation Trust during 2022-23.

4.2 Northeast and North Cumbria Newcastle Gateshead Integrated Care Board

NHS
North East and
North Cumbria

Commissioner Statement from
North East and North Cumbria Integrated Care Board (NENC ICB)
Gateshead Health NHS Foundation Trust
Quality Account 2022/23

As commissioners, North East and North Cumbria Integrated Care Board (NENC ICB), is committed to commissioning high quality services from Gateshead Health NHS Foundation Trust (GHFT) and take seriously the responsibility to ensure that patients' needs are met by the provision of safe high-quality services and that the views and expectations of patients and the public are listened to and acted upon. The ICB

welcomes the opportunity to review and comment on the 2022/23 Quality Account for GHFT.

Firstly, like many organisations across the country, GHFT has faced another challenging year, as the NHS continued its recovery from the pandemic and the impact of unprecedented industrial action. The ICB would like to commend the Trust and all its staff for the excellent commitment and dedication demonstrated throughout these difficult times and for ensuring that patient care continued to be delivered to an extremely high standard.

The quality of services delivered, and associated performance measures are the subject of discussion and challenge at the Quality Review Group (QRG) meetings. The QRG meetings provide an opportunity to gain assurance that there are robust systems in place to support the delivery of safe, effective and high-quality care. These meetings have continued to be held on a virtual basis during 2022/23 which created significant efficiencies in terms of staff time. The ICB would like to take this opportunity to thank the Trust for continuing to engage in the QRG meetings at a time of heightened operational pressures.

The Trust's Quality Account provides an honest, comprehensive and transparent appraisal of both the quality achievements and challenges faced by the Trust over the past year and its aspirations for the coming twelve months. The ICB welcomes that safe and high quality-care has remained a priority and progression has been made towards achieving the 2022/23 quality priorities.

It is positive to note that the quality priority to reinvigorate the volunteers service has been achieved. It is fully acknowledged that the support volunteers provide to patients, relatives and staff is invaluable and the ICB would like to commend them for their fantastic contribution. The ICB look forward to hearing the outcome of the evaluation of the Patient Experience and Response Volunteer Programme via the QRG meeting. The ICB fully supports the continuation of this quality priority to further develop volunteer roles in 2023/24 across the organisation.

The ICB recognises the progress made with the quality priority to improve the experiences of services users with learning disabilities and mental health needs. It is positive to see that a wide range of easy read leaflets have been produced, which were reviewed by a service user group. The workshop ran by the learning disabilities theatre production group Lawnmowers was an excellent initiative and it was disappointing that more staff were unable to attend this training. It is noted that further work is needed to ensure patients with a learning disability are appropriately flagged and plans are in place to progress this. The ICB acknowledges the Trust's continued commitment to ensuring patients with a learning disability, mental health or autism have access to services that will help to improve their health and wellbeing, providing a positive and safe patient experience. The ICB therefore fully supports the Trust's plans to build further on this important work in 2023/24.

The Trust is to be congratulated on the excellent progress made with the working with patients as partners in improvements quality priority, which included working collaboratively with the ICB to establish a joint patient forum. It is also positive to note that patient representatives now sit on key groups across the Trust, and they have also participated in the 'Your time to shine' ward visits. The ICB fully supports the

quality priority for 2023/24 to strengthen partnership working with collaborative patients forums to enhance patient engagement and involvement.

It is acknowledged that the pandemic has had a significant effect on staff and the ICB commends the Trust for their comprehensive approach in supporting staff and promoting their health and wellbeing. Whilst it is noted that the Trust did not fully achieve all of its aims with this quality priority it was very encouraging to see the breadth of work that has taken place over the past year. The Trust is also to be congratulated for achieving the Better Health at Work Silver Award in December 2022, which is an excellent achievement. The ICB fully supports the Trust's ongoing commitment to promoting the health and wellbeing of its staff and the next steps outlined in the report.

The Trust has made good progress with the quality priority to advocate for equality, diversity and inclusion for all staff. The D-Ability Staff Network which includes all levels of disabled employees, with many diverse and hidden disabilities represented, is an excellent initiative and it is positive to see that they continue to raise awareness and provide education to staff. Allied Health Professionals (AHPs) are the third largest clinical workforce in the NHS and are recognised in the NHS Long-Term Plan as having an essential role in supporting services to meet current and future demands. The ICB therefore commends the Trust for the work they have undertaken with regards to their AHP workforce, including an annual conference, establishing a leads forum and the work planned to compile the AHP five-year strategy.

It is noted that the Trust partially achieved the quality priority to promote a just, open and restorative culture across the organisation. It is positive to see that a dedicated session on the new Patient Safety incident Response Framework (PSIRF) and Learn from Patient Safety Events was delivered to the Board in February 2023. We look forward to working in partnership with the Trust on their transition to phase one of the PSIRF by Autumn 2023 and fully support that this is taken forward as a quality priority in 2023/24.

In light of the Ockenden and East Kent Maternity Reports there has been considerable attention nationally on all maternity services across England therefore, the QRG meetings have maintained a strong focus on maternity safety. It is very reassuring to note that the Trust has fully achieved their quality priority to maximise safety in maternity services and are compliant with all the immediate and essential actions of the Ockenden report. The ICB recognises the Trust's continued commitment to improve the quality and safety of care for pregnant women and fully supports this important work continuing in 2023/24 to implement a maternal and neonatal improvement plan.

Whilst it is acknowledged that the staffing quality priority was partially achieved, there has been good progress made. Overseas staff make a significant contribution to the care of patients in the NHS and organisations benefit greatly from their expertise and the new knowledge and skills they bring. It was therefore positive to note the Trust has been successful in their first international recruitment campaign and welcomed 38 overseas nurses. The ICB supports the 2023/24 quality priority to focus on safe staffing, including reducing the movement of staff between clinical areas.

Due to operational pressures the Trust were unable to achieve all of its aims in their quality priority to undertake improvement work to agree a safe method of processing

clinical results. It is noted that a rapid process improvement workshop (RPIW) took place in March 2023 to map out the process for requesting and managing blood tests, with a number of agreed actions. The ICB fully supports that this quality priority is carried forward in 2023/24 with a further RPIW event to be held in July 2023 to review the process for radiology and histology requests. The ICB look forward to learning the outcomes from these two RPIW events at a future QRG meeting.

The ICB recognises the good progress made with the quality priority to revisit the core fundamental standards of care. It is particularly positive to see that a revised programme of environmental audits was implemented, and improved compliance levels are being achieved. The ICB recognises that phases one to three of the Trust's CQC monitoring approach have now been implemented and supports the plans in place to progress this work further over the coming year.

The commissioners acknowledge that progress has been made with the quality priority to encourage, help and support staff to engage with research. Clinical Research is a major driver of innovation and is central to NHS practice for maintaining and developing high standards of patient care. Therefore, the ICB fully supports the Trusts plans in 2023/24 to embed a culture of research and make everyone's business. The ICB would also like to congratulate the Trust for achieving the quality priority to support the continual improvement of clinical record keeping by reviewing and reinstating a revised programme of documentation audits, which will be undertaken on a quarterly basis.

The emphasis that the Trust gives to national clinical audits and confidential enquiries demonstrates that they are focussed on delivering evidence-based best practice, noting participation in 89% of national clinical audits and 100% of national confidential enquiries. The ICB commends the Trust for their continued commitment to clinical research and for remaining a research active organisation to ensure patients have access to the latest treatments and technologies.

It is noted that there has been a reduction in the rate of falls per 1000 bed days however there has been an increase in the ratio of patient harm. It is positive to see that the Falls Prevention Group has rolled out the Think Yellow initiative and the AFLOAT tool has been rolled out trust wide following a successful pilot. The ICB supports the plans in place as part of the implementation of PSIRF in 2023/24 to strengthen the falls prevention work to reduce inpatient falls, particularly those resulting in a fractured neck of femur and head injury.

The ICB would like to commend the Trust for their strong performance in the National Patient Surveys and for the positive results they received, in particular the CQC Maternity Survey, which ranked the Trust as one of the top providers of maternity care in England, which is an excellent achievement.

It is fully acknowledged that the NHS faced huge pressures due to the COVID-19 pandemic and this significantly impacted on the Trust's performance across a number of the key national priorities. The ICB is fully cited on the ongoing challenges with the cancer and referral to treatment targets and the diagnostic pressures. Commissioners will continue to work in partnership with the Trust and fully support the ongoing work to reduce waiting lists and the cancer improvement plans, which will support recovery, and improve performance and patient experience.

The ICB was impressed by the good news stories and quality improvements initiatives the Trust has implemented over the past year, as set out in the report. These are all fantastic achievements, and the ICB would again like to thank the Trust and all its staff for their continued hard work and commitment in delivering high quality, effective and compassionate care to patients.

The ICB congratulates the Trust for the positive results received in the NHS Staff Survey; with 80% of staff agreeing that caring for patients remains a top priority and 88% agreeing that their role makes a difference to patients. Although some scores were lower than the previous year, the ICB recognises that this is consistent with the national decline in staff satisfaction across the whole NHS. It is acknowledged that where improvement areas have been identified appropriate action is taken to address these.

The Quality Account clearly defines the key priorities for 2023/24, which are aligned to the four domains of clinical effectiveness, patient safety, patient experience and staff experience. They include detailed explanation of how progress will be measured to deliver safe, clinically effective services and to improve peoples' experience. The ICB welcomes and fully supports these quality priorities as appropriate areas to target for continuous evidence-based quality improvement, which link well with the commissioning priorities.

The ICB can confirm that to the best of their ability the information provided within the Annual Quality Account is an accurate and fair reflection of the Trust's performance for 2022/23. It is clearly presented in the format required and contains information that accurately represents the Trust's quality profile and is reflective of quality activity and aspirations across the organisation for the forthcoming year.

The commissioners look forward to continuing to work in partnership with the Trust to assure the quality of services commissioned in 2023/24.

Richard Scott
Director of Nursing (North)
NENC ICB
May 2023

4.3 Gateshead Healthwatch

Response from Healthwatch Gateshead
Gateshead Health NHS Foundation Trust
Annual Quality Account 2022/23

30th May 2023

Healthwatch Gateshead comments and feedback on the Quality Account are under the following headings –

1. Feedback on progress on 2022/23 Quality Priorities
2. Feedback on 2023/24 proposed Quality Priorities
3. Any other feedback

Healthwatch Gateshead welcome this year's Quality Account as it shows that Gateshead Health NHS Foundation Trust (GHFT) have continued to focus their approach and they are working to achieve their ambitions. We welcome the continual review they are undertaking to ensure that resources are used effectively, and we support their continued vision to deliver outstanding and compassionate care to our patients and communities.

1. Feedback on progress on 2022/23 Quality Priorities

Healthwatch Gateshead acknowledge the continue impact of the Covid 19 pandemic and the aftereffects it has had on GHFT services throughout 2022/23.

We welcome the endeavours taken by GHFT to achieve its twelve priorities it set for 2022/23. Healthwatch Gateshead especially welcomes the work done following the loss of volunteers due to Covid 19 restrictions and the priority to address this through further recruitment. We also appreciate the work done on trying to improve the patients experience through the development of a collaborative forum for long term conditions which is wider than just the Trust and the delivery of the patients' voice workshops.

Overall, Healthwatch Gateshead feel GHFT has performed positively in trying to achieve in its priorities in 2022/23, in the context of added pressures put upon the service during the aftereffects of the pandemic and the ongoing staff industrial actions.

Healthwatch Gateshead would like to commend GHFT for their work in this year on improvements to maternity services which has seen the Trust ranked eighth in England by the CQC in March 2023.

2. Feedback on 2023/24 proposed Quality Priorities

Healthwatch Gateshead welcomes the priorities chosen by GHFT for 2023/24 that cut across all the four quality domains.

- Patient experience

Healthwatch Gateshead supports the continued development of the volunteer offer within GHFT and the introduction of a new volunteering programme. We also support the GHFT aim to learning from delivery and the investment in the collaborative patient's forum, as well as continuing with wider engagement.

- Staff experience

Healthwatch Gateshead supports GHFT priority to listen and learn from staff, and we especially welcome the introduction of speak up champions. Staff training/events to reduce waste within GHFT and hence improving environmental impact by having less waste is a priority we endorse too.

- Patient safety

Healthwatch Gateshead supports the priorities to improve patient safety with the implementing of the Patient Safety Incident Response Framework (PSIRF) and the improvement work around the safe processing of clinical results, as well as the Implement a maternity and neonatal improvement plan.

- Clinical effectiveness

Healthwatch Gateshead welcomes the activities that GHFT are developing to embed a culture of research. We also endorse the priority for learning from deaths. Also the aim to improve the experiences of people with a learning disability, mental health, or autism.

3. Any other feedback

Throughout 2022/23 Healthwatch Gateshead and Healthwatch Newcastle have been engaging with the public across the two areas. The feedback received from local people suggested that hospital experiences varied from person-to-person with some sharing positive stories and others sharing less positive experiences.

- Where experiences were positive, local people tended to focus on medical staff carrying out their roles in a transparent way through fulfilment of their duties and keeping the patient informed. People often felt that they were treated with respect and dignity.

- Where experiences were less positive, people focused on waiting times, both at initial consultation and waiting lists further into their hospital journey. Staff attitudes and poor service, due to a lack of resources and organisation, were highlighted as issues by a small number of people.

Healthwatch Gateshead welcomes the continued commitment from GHFT towards improving the patient experience and their willingness to address the issues. We appreciate the energy GHFT put into maintaining strong relationships with the Healthwatch network in the North East and we also offer our support to GHFT for their delivery in 2023/24.

Finally, we recognise that 2022/23 was a difficult year for NHS Hospital Trusts and we understand why GHFT have not been able to achieve all the key actions as planned due to prioritising patient care in response to unprecedented demands.

Healthwatch Gateshead thank everyone at GHFT for their continuing commitment to provide a quality and safe service to the communities and we look forward to further working in partnership with GHFT over the next twelve months.

Michael Brown
Chair of Healthwatch Gateshead

The role of Healthwatch Gateshead.

Healthwatch Gateshead is an independent, not-for-profit service. We help people of all ages and from all backgrounds have their say about social care and health services in Gateshead. This includes every part of the community, so we give a voice to people who sometimes struggle to be heard. We also offer free, confidential and independent information about social care and health services in the area.

Healthwatch Gateshead is one of 153 Healthwatch groups in England and each local authority is linked to a Healthwatch for their area. We have statutory powers under the Health and Social Care Act 2012, including the ability to:

• Request information from commissioners and service providers (they have to respond within 20 days).
• Visit publicly funded health or social care services to see how they are working (known as 'enter and view' visits).
• Represent the views of the public on the Gateshead Health and Wellbeing Board.

Healthwatch Gateshead work to make sure that the people who plan and run social care and health services are listening to their service users. When people's voices can be heard, we can make positive change. Together, we can create services that cater to what real people actually need and want.

4.4 Council of Governors

The Council of Governors had the opportunity to partake in two dedicated workshops on the development of the Quality Account and quality priorities on 30th January 2023 and 19th April 2023. In addition, the completed draft of the Quality Account was shared with all Governors as part of the consultation process. We have used our knowledge of the Trust gained through attendance at meetings and other engagement opportunities during 2022/23 to determine whether the content of the document presents a fair reflection of the achievements, challenges, risks and opportunities experienced during the year, as well as whether the quality priorities for 2023/24 are focussed on what we feel are the key areas.

In general, we believe the document is well presented, concise, comprehensive and informative. It demonstrates the work which has been achieved during the year and is a positive reflection on the quality work completed by the Trust.

We also shared a number of specific points for consideration:

- How the Trust is preparing for the possibility of another pandemic;
- How the actions taken during the year can be measured in respect of the impact on outcomes for patients and staff;
- How further examples can be shared regarding transformational and rapid process improvement workshops undertaken in respect of their benefits to patients, staff and the organisation;
- The inclusion of safe staffing levels assessments and intention to enhance freedom to speak up are particularly welcomed; and
- Further information on the Trust's intention on the 'zero tolerance of bullying campaign' would also be welcomed.

We did raise some further points of operational significance which are important and assurance received that they would be addressed and responded to through appropriate governance and communication channels.

Annex 2: Statement of directors' responsibilities in respect of the quality account

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS Foundation Trust Boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation Trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2021/22 and supporting guidance.
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
    - board minutes and papers for the period April 2022 to March 2023
    - papers relating to quality reported to the board over the period April 2022 to March 2023
    - feedback from Northeast and North Cumbria Newcastle Gateshead Integrated Care Board dated – 30/05/2023
    - feedback from governors dated - 17/05/2023
    - feedback from local Healthwatch organisations dated – 30/05/2023
    - feedback from Overview and Scrutiny Committee dated – 16/05/2023
    - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 – 05/2022
    - the 2022 national patient survey – 02/2023
    - the 2022 national staff survey – 02/2023
    - the Head of Internal Audit's annual opinion of the Trust's control environment dated – TBC
    - CQC inspection report dated CQC Inspections and rating of specific services dated – 14/08/2019

- the Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered

- the performance information reported in the Quality Report is reliable and accurate

- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice

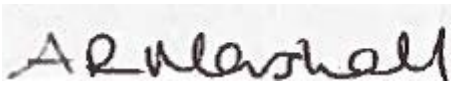
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and

- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts

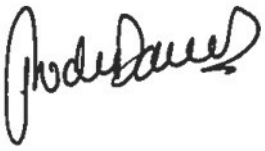
regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the board



Date: 21/06/2023 Chairman:



Date: 21/06/2023 Chief Executive:

Glossary of Terms

'Always Events®'
'Always Events®' are aspects of the patient experience that are so important to patients and family members that health care providers must aim to perform them consistently for every individual, every time. These can only be developed with the patient firmly being a partner in the development of the event, and the co-production is key to ensuring organisations meet the patients' needs and what matters to them.

Care Quality Assurance Framework (CQAF)
CQAF provides wards and departments with a coordinated set of standards that will provide information in relation to quality and safety.

Care Quality Commission (CQC)
The CQC is the independent regulator of all health and adult social care in England. The CQC aim is to make sure better care is provided for everyone, whether that's in hospital, in care homes, in people own homes, or elsewhere.

Clinical Audit
Clinical audit measures the quality of care and service against agreed standards and suggests or makes improvements where necessary.

***Clostridium difficile infection* (CDI)**
Clostridium difficile is a bacterium that occurs naturally in the gut of two-thirds of children and 3% of adults. It does not cause any harm in healthy people; however, some antibiotics can lead to an imbalance of bacteria in the gut and then the Clostridium difficile can multiply and produce toxins that may cause symptoms including diarrhoea and fever. This is most likely to happen to patients over 65 years of age. The majority of patients make a full recovery however, in rare occasions it can become life threatening.

Commissioning for Quality and Innovation (CQUIN)
The CQUIN framework was introduced in April 2009 as a national framework for locally agreed quality improvement schemes. It enables commissioners to reward excellence by linking a proportion of English healthcare provider's income to achievement of local quality improvement goals.

Commissioners
Commissioners are responsible for ensuring that adequate services are available for their local population by assessing need and purchasing services.

Datix
Datix is an electronic risk management software system which promotes the reporting of incidents by allowing anyone with access to the Trust Intranet to report directly into the software on easy-to-use web pages. The system allows incident forms to be completed electronically by all staff.

Foundation Trust
A Foundation Trust is a type of NHS organisation with greater accountability and freedom to manage themselves. They remain within the NHS overall, and provide the same services as traditional Trusts, but have more freedom to set local goals. Staff and members of the public can join the board or become members.

Friends and Family Test (F&FT)

The Friends and Family Test is an important feedback tool that supports the principle that people who use NHS services should have the opportunity to provide feedback on their experience. It asks people if they would recommend the services they have used and offers a range of responses.

Getting It Right First Time (GIRFT)

Getting It Right First Time is a national programme designed to improve the quality of care within the NHS by reducing unwarranted variations. By tackling variations in the way services are delivered across the NHS, and by sharing best practice between trusts, GIRFT identifies changes that will help improve care and patient outcomes, as well as delivering efficiencies such as the reduction of unnecessary procedures and cost savings.

Hospital Standard Mortality Ratio (HSMR)

The HMSR is an indicator of healthcare quality that measure whether the death rate at a hospital is higher or lower than would be expected.

Healthwatch

Healthwatch is an independent arm of the CQC who share a commitment to improvement and learning and a desire to improve services for local people.

Healthcare Evaluation Data (HED)

HED is an online benchmarking solution designed for healthcare organisations. It allows healthcare organisations to utilise analytics which harness Hospital Episode Statistics (HES) national inpatient and outpatient and Office of National Statistics (ONS) Mortality data sets.

Hospital Episode Statistics (HES)

HES is a data warehouse containing a vast amount of information on the NHS, including details of all admissions to NHS hospitals and outpatient appointments in England. HES is an authoritative source used for healthcare analysis by the NHS, Government, and many other organisations.

Integrated Care Board (ICB)

A statutory NHS organisation responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in the Integrated Care System (ICS) area.

Integrated Care System (ICS)

Integrated care systems are partnerships of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area.

Joint Consultative Committee (JCC)

JCC is a group of people who represent the management and employees of an organisation, and who meet for formal discussions before decisions are taken which affect the employees.

Just Culture

The fair treatment of staff supports a culture of fairness, openness and learning in the NHS by making staff feel confident to speak up when things go wrong, rather than fearing blame. Supporting staff to be open about mistakes allows valuable lessons to be learnt so the same errors can be prevented from being repeated.

Methicillin Resistant *Staphylococcus aureus* (MRSA)

MRSA is a bacterium responsible for several difficult to treat infections in humans. MRSA is, by definition, any strain of *Staphylococcus aureus* bacteria that has developed resistance to antibiotics. It is especially prevalent in hospitals, as patients with open wounds, invasive devices and weakened immune systems are at greater risk of infection than the general public.

National Confidential Enquiries
These are enquiries which seek to improve health and healthcare by collecting evidence on aspects of care, identifying any shortfalls in this, and disseminating recommendations based on these findings. Examples include Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries in the UK (MMBRACE) and the National Confidential Enquiry into Patient Outcome and Death (NCEPOD).

National Confidential Enquiry into Patient Outcome and Death (NCEPOD)
NCEPOD's purpose is to assist in maintaining and improving standards of medical and surgical care for the benefit of the public by reviewing the management of patients. This is done by undertaking confidential surveys and research, and by maintaining and improving the quality of patient care and by publishing the results.

National Patient Survey
The NHS patient survey programme systematically gathers the views of patients about the care they have recently received because listening to patients' views is essential to providing a patient-centred health service.

National Reporting and Learning System (NRLS)
The National Reporting and Learning System is a central database of all patient safety incident reports. Since the NRLS was set up in 2003, over four million incident reports have been submitted.

Nervecentre
Nervecentre is an electronic clinical application used to record a variety of patient observations and assessments.

NHS England (NHSE)
NHS England leads the National Health Service (NHS) in England. They set the priorities and direction of the NHS and encourage and inform the national debate to improve health and care.

Overview and Scrutiny Committee
The Overview and Scrutiny Committees in local authorities have statutory roles and powers to review local health services. They have been instrumental in helping to plan services and bring about change. They bring democratic accountability into healthcare decision-making and make the NHS more responsive to local communities.

Patient Advice and Liaison Service (PALS)
PALS is an impartial service designed to ensure that the NHS listens to patients, their relatives, their carers, and friends answering their questions and resolving their concerns as quickly as possible.

Pressure Ulcers
Pressure ulcers are also known as pressure sores or bed sores. They occur when the skin and underlying tissue becomes damaged. In very serious cases the underlying muscle and bone can also be damaged.

Research
Clinical research and clinical trials are an everyday part of the NHS and are often conducted by medical professionals who see patients. A clinical trial is a particular type of research that tests one treatment against another. It may involve people in poor health, people in good health or both.

Risk
The potential that a chosen action or activity (including the choice of inaction) will lead to a loss or an undesirable outcome.

Special Review
A special review is carried out by the Care Quality Commission. Each special review looks at themes in health and social care. They focus on services, pathways, and care groups of people. A review will usually result in assessments by the CQC of local health and social care organisations as well as supporting the identification of national findings.

Staff Advice and Liaison Service
Brings together a range of support services that are available to staff.

Standard Operating Procedure
A Standard Operating Procedure is a set of step-by-step instructions compiled to help workers carry out complex routine processes.

Trust Board
The Trust Board is accountable for setting the strategic direction of the Trust, monitoring performance against objectives, ensuring high standards of corporate governance, and helping to promote links between the Trust and the community. The Chair and Non-Executive Directors are lay people drawn from the local community and are accountable to the Secretary of State. The Chief Executive is responsible for ensuring that the Board is empowered to govern the organisation and to deliver its objectives.

Meeting:	Trust Board
Chair:	Alison Marshall
Financial year:	2023/24

	Lead	Type of item	Public/Private	May-23	June 23 (year end only)	Jul-23	Sep-23	Nov-23	Jan-24	Mar-24
Standing Items			Part 1 & Part 2							
Apologies	Chair	Standing Item	Part 1 & Part 2	√	√	√	√	√	√	√
Declaration of interests	Chair	Standing Item	Part 1 & Part 2	√	√	√	√	√	√	√
Minutes	Chair	Standing Item	Part 1 & Part 2	√		√	√	√	√	√
Action log	Chair	Standing Item	Part 1 & Part 2	√		√	√	√	√	√
Matters arising	Chair	Standing Item	Part 1 & Part 2	√		√	√	√	√	√
Chief Executive's Update Report	Chief Executive	Standing Item	Part 1 & Part 2	√		√	√	√	√	√
Cycle of Business	Company Secretary	Standing Item	Part 1 & Part 2	√		√	√	√	√	√
Patient & Staff Story	Company Secretary	Standing Item	Part 1	√		√	√	√	√	√
Questions from Governors	Chair	Standing Item	Part 1	√		√	√	√	√	√
Items for Decision			Part 1 & Part 2							
Annual Declarations of Interest	Company Secretary	Item for Decision	Part 1							√
Approval of new Strategic Objectives	Deputy Director of Corporate Services & Transformation	Item for Decision	Part 1	√						
Board Assurance Framework - quarterly updates	Company Secretary	Item for Assurance	Part 1			√		√		
Board Assurance Framework - approval of closing and opening position	Company Secretary	Item for Decision	Part 1							√
Standing Financial Instructions, Delegation of Powers, Constitution and Standing Orders - annual review	Company Secretary / Group Director of Finance	Item for Decision	Part 1				√			
Calendar of Board Meetings	Company Secretary	Item for Decision	Part 1					√		
Winter Plan	Chief Operating Officer	Item for Decision	Part 1				√			
Board Committee Annual Reviews of Effectiveness and Terms of Reference Update	Company Secretary	Item for Decision	Part 1	√						
CQC Statement of Purpose and Registration	Chief Nurse	Item for Decision	Part 1						√	
Items for Assurance			Part 1 & Part 2							
Board Committee Assurance Reports	Committee Chairs	Item for Assurance	Part 1	√		√	√	√	√	√
Trust Strategic Objectives - quarterly updates	Director of Strategy, Planning and Partnerships	Item for Decision	Part 1			√		√		√
Board Assurance Framework - quarterly updates	Company Secretary	Item for Assurance	Part 1			√		√		
Organisational Risk Register	Chief Nurse	Item for Assurance	Part 1	√		√	√	√	√	√
Annual Staff Survey Results	Exec Director of People & OD	Item for Assurance	Part 1							√
Finance Report	Group Director of Finance	Item for Assurance	Part 1	√		√	√	√	√	√
Integrated Oversight Report	Chief Operating Officer	Item for Assurance	Part 1	√		√	√	√	√	√
Maternity Integrated Oversight Report	Chief Nurse	Item for Assurance	Part 1	√		√	√	√	√	√
Nurse Staffing Exception Report	Chief Nurse	Item for Assurance	Part 1	√		√	√	√	√	√
Nurse Staffing Annual Capacity & Capability Report	Chief Nurse	Item for Assurance	Part 1	√						
Learning from Deaths (6 monthly report)	Medical Director	Item for Assurance	Part 1	√				√		
SIRO Report & Digital Update	Group Director of Finance	Item for Assurance	Part 1	√				√		
EPRR Core Standards Self-Assessment Report	Chief Operating Officer	Item for Assurance	Part 1				√			
CNST Maternity Compliance Report	Chief Nurse	Item for Assurance	Part 1						√	
Green Plan (formally Sustainable Development Management Plan)	QEF Managing Director	Item for Assurance	Part 1				√			√
QEF 6 monthly update report	QEF Managing Director	Item for Assurance	Part 1	√				√		
Freedom to Speak Up Guardian Report	Exec Director of People & OD	Item for Assurance	Part 1				√			√
WRES and WDES Report	Exec Director of People & OD	Item for Assurance	Part 1				√			√
Quality Accounts Priorities 6 monthly update	Chief Nurse	Item for Assurance	Part 1					√		
Items for Information			Part 1 & Part 2							
Register of Official Seal	Company Secretary	Item for Information	Part 1				√			
Ad Hoc Items (i.e. items emerging during the year)			Part 1 & Part 2							
Staff survey results action plan update	Exec Director of People & OD	Item for Assurance	Part 1				√			
Thematic review updates	Chief Executive	Item for Assurance	Part 1					√		