Item 6 – Research and Development Annual Report

Gateshead Health
NHS Foundation Trust

The Annual Report of the Research & Development (R&D) Department

April 2022 – March 2023

Contents

Executive Summary

This report presents an overview of research activity and achievements within Gateshead Health NHS Foundation Trust during April 2022 to March 2023.

Over the past year, we have continued to participate in high quality research, demonstrating our commitment to the Government's vision – **Saving and Improving Lives** by trying to create and embed a research positive culture within the Trust. We have encouraged staff from all backgrounds, to get involved either by promoting awareness to their patients or by delivering research as part of a team.

Only through research evidence can healthcare be improved, by identifying the best means to prevent, diagnose and treat conditions, thus ensuring that our patients are given wider access to new treatment options or new and different ways to improve their care.

1. Introduction

In January 2023 Baroness Brown (Chair of the Science and Technology Parliamentary Select Committee) said:

"Clinical research in the NHS is responsible for some of the UK's greatest success stories in science and medicine. The COVID-19 pandemic RECOVERY trial is just one recent example demonstrating the unique capacity the UK has to combine its academic excellence in the life sciences with its healthcare system to change and save lives.

"However, there are alarming reports about the declining state of clinical research in the NHS. There is a 'leaky pipeline' for consultant clinical academics who often drive medical breakthroughs into frontline patient care. If issues in pay and pension inequality are not addressed, we are in danger of permanently eroding the clinical research workforce and it is patients who will suffer.

"For clinicians and healthcare professionals who are not consultants, the picture is no better, with substantial pressure on time that they would like to devote to research and often limited recognition and resources available. Significant regional inequalities persist in the opportunities for clinical researchers, which drive inequalities in health outcomes.

"Against the backdrop of intense pressure on the NHS, clinical research is on a precipice. Clinical research is not a 'nice-to-have' but vital for the healthcare service to become more efficient and effective. Rather than an additional pressure, the ability to engage with research can aid recruitment and retention for staff, and can bring in industry funding."

By fully integrating research into our Trust, we can provide the evidence we need to transform services and improve outcomes, such as in developing new models of care, leading to better quality care, patient safety and improved use of resources.

2. The Research Team

Medical Director
Mr Andy Beeby

Associate Medical Director for R&D
Dr Salman Razvi

Head of R&D
Alison Harvey

Research Nurses & Research Midwives

Amanda Sanderson
Ann Wilson
Bev McClelland
Bryony Storey
Christine Moller-Christensen
Christine Kirkup
Helen Wild
Jenny Ritzema
Lorraine Pearce
Maureen Armstrong
Rachael Grant
Wendy Stoker

Research Coordinators

Marie Greener
Yvonne Marriott

R&D Assistant

Muriel Waine

Clinical Trials Officers

Lucy Blackwell
Maria Bokhari

Senior Data Manager

Wendy McCormick

Data Managers

Kara Willshire
Lesley Butler
Meraud Bird

Research Assistants

Jess Rice
Jacob Douglass
Mandy Grahamslaw

3. Research & Development Council

The R&D Council is Chaired by Dr Salman Razvi (Associate Medical Director for R&D) and Dr Simon Lowes (Vice Chair).

The R&D Council is responsible for supporting research delivery and research training, ensuring appropriate levels of recruitment to NIHR Portfolio studies, ensuring the Trust complies with the UK Policy Framework for Health & Social Research and Good Clinical Practice. The R&D Council also approves Standard Operating Procedures and Policies relevant to Research and Development.

The R&D Council assesses the Trust's capacity and capability to take part in proposed research projects using Trust facilities, patients and staff.

The R&D Council is held monthly via Microsoft Teams. The process is streamlined and works well, enabling research projects to be setup within the 40 day target period.

During April 2022 and March 2023 there were 10 R&D Council Meetings which assessed 26 research projects. Capacity & Capability (C&C) was only confirmed for 25 of these projects as one did not open at the Trust due to not having a Principal Investigator.

R&D Council Membership

Anna Stabler
Non-Exec Director

Mr Andy Beeby
Medical Director

Dr Salman Razvi
R&D Council Chair

Dr Simon Lowes
R&D Council Vice Chair

Alison Harvey
Head of R&D

Members:

Maureen Armstrong
Caitlin Barry
Meraud Bird
Dr Maria Bokhari
Lucy Blackwell
Lesley Butler
Mr Vai Deshpande
Dr Paul Donaghy
Jacob Douglass
Mr Isaac Evbuomwan
Rachael Grant
Marie Greener
Bev McClelland
Wendy McCormick
Dr Claire McDonald
Christine Kirkup
Yvonne Marriott
Christine Moller-Christensen
Lorraine Pearce
Jess Rice
Jenny Ritzema
Amanda Sanderson
Bryony Storey
Wendy Stoker
Helen Wild
Ann Wilson
Kara Willshire

Supporting Department Members:

Mark Thompson (Pharmacy)
David Sproates (Pharmacy)
Dr Mo Korim (Radiology)
Thai Lou (Radiology)
Dianne Ridsdale (IG)
Shona Gillespie (IG)
Rachel Lorraine (IG)
Jon Vernazza (Pathology)

4. The Health & Care Act 2022

The Health and Care Act 2022 sets new legal duties on ICBs (Integrated Care Boards) around the facilitation and promotion of research in matters relevant to the health service, and the use in the health service of evidence obtained from research.

Gateshead Health is part of the North East & North Cumbria ICB created on 1st July 2022.

The ICB is part of the Region's Integrated Care System (ICS) - a way of working that brings together organisations from across the Region including the NHS, councils, the voluntary and community sector, education, and many more.

By combining collective resources, knowledge and skills, both locally and regionally, health and care can be delivered, so that communities can live longer and healthier lives.

ICBs are encouraged to build on existing research initiatives and activities across health and social care to improve sector-wide performance and best practice. NHS England released guidance in March 2023 – Maximising the Benefits of Research: https://www.england.nhs.uk/long-read/maximising-the-benefits-of-research/ which sets out what good research practice looks like:-

- Identifying and addressing local research priorities and needs, and working collaboratively to address national research priorities
- Improve the quality of health and care and outcomes for all through the evidence generated by research
- Increase the quality, quantity and breadth of research undertaken locally
- Extend and expand research in settings such as primary care, community care, mental health services, public health and social care
- Drive the use of research evidence for quality improvement and evidence-based practice
- Influence the national research agenda to better meet local priorities and needs
- Improve co-ordination and standardisation within and between localities for the set up and delivery of research
- Harness the patient and economic benefits of commercial contract research
- Co-ordinate and develop the research workforce across all settings.

5. National Priorities & Strategies

The National Patient Safety Strategy, which incorporated the **Strategic Research Needs** document, was launched in December 2022.

Aidan Fowler, NHS National Director of Patient Safety Research, stated that without research the NHS is:-

- At risk of continuing safety practices that have not been tested
- Continue to failing addressing issues because the details have not been investigated
- Continue treating risks that exist because there are no tested solutions.

There are many knowledge gaps which need to be closed and the aim of the Strategic Research Needs document is to steer researchers towards the most pressing key safety priorities.

The strategy underlines the need for crucial patient safety research and innovation and has identified and categorised (in relation to the priorities of the NHS Patient Safety Strategy the following eight themes:-

1. Reducing inequalities in healthcare safety
2. Improving patient safety intelligence and understanding patient safety challenges
3. Improving organisational patient safety culture and practice
4. Patient safety behaviours
5. Effective patient safety practices
6. Patient safety impacts of alternative service delivery models
7. Ergonomics, design and human factors
8. Clinical risk scores (validation, implementation and outcomes)

Research Nurses Bev McClelland and Lorraine Pearce attended the Patient Safety Conference at the Marriott Hotel in April 2022, to promote the **Strategic Research Needs** document. They also demonstrated how staff could search for specific research relating to patient safety on the NIHR Be Part of Research website https://bepartofresearch.nihr.ac.uk/ in the hope that staff would be encouraged to look for, and engage with, research projects that could be hosted at Gateshead.

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. Research, after all, is **Everyone's Business!**

In September 2022, the R&D Team promoted the new **Allied Health Professions' Research & Innovation Strategy** for England, at their conference at the Marriott Hotel, Gateshead.

Yvonne Marriott gave a presentation at the conference – **Research & Innovation Makes a Difference**. The presentation incorporated how AHPs of all disciplines and at all career stages could get involved in research and provide a valuable contribution to research across the Trust.

The presentation also included how AHPs could gain skills, experience, insights and confidence in research processes, through the **Associate PI (Principal Investigator) Scheme**.

The AHP Research & Innovation 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.

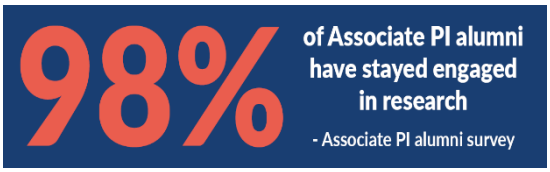
Capability for individuals to undertake and achieve excellence in research and innovation activities, roles, careers and leadership

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".

The **Associate Principal Investigator Scheme** is important in helping Doctors, Nurses and other Allied 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:

In October the R&D Team were invited to attend 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.

Healthcare support workers play a vital role in providing excellent care to patients across all NHS care settings. They can help patients with social and physical activities, personal care, mobility, meal times etc. and are ideally placed to promote and raise research awareness.

HCSW are encouraged to become Research Champions by following a very simple 3 step process:-

1. Learn more about research by taking the Introduction to Research module on ESR
2. Find out and get to know the Research Teams working on their ward or in their area of speciality
3. Find out which research projects are open and actively recruiting on their ward or in their area of speciality

6. Research Activity

The NHS Constitution includes a pledge that everyone has the right to be informed of research studies that they are eligible to take part in.

Only through research can ways be found to improve prevention, diagnosis, care and treatments. Research can also help people living with a condition to have a better quality of life.

In line with National research priorities, Gateshead Health NHS Foundation Trust remains a research active organisation and during April 2022 to March 2023, **1,947** of our patients took part in research.

Our top recruiting studies include:-

INGR1D2 INvestigating Genetic Risk for type 1 Diabetes (2)

Principal Investigator: Research Midwife Christine Moller-Christensen
Research Team: Research Midwife: Rachael Grant | Research Assistant: Jess Rice | Data Manager: Lesley Butler

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.

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

Principal Investigator: Research Midwife: Rachael Grant
Research Team: Research Midwife: Christine Moller-Christensen | Research Assistant: Jess Rice | Data Manager: Lesley Butler

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 North East and North Cumbria: The PoCo Study

Principal Investigator: Research Midwife Christine Moller-Christensen
Research Team: Research Midwife: Rachael Grant | Research Assistant: Jess Rice | Data Manager: Lesley Butler

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 North East and North Cumbria, in both community and maternity settings, to better understand the current provision in relation to National guidelines.

R&D Department
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Evaluation of MCM5 in postmenopausal bleeding patients

Principal Investigator: Mr Iain Cameron
Research Team: Research Nurse: Lorraine Pearce | Senior Data Manager: Wendy McCormick

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 original recruitment target for MCM5 was just 40 participants, but in their first year of opening a staggering 244 participants were recruited to this important study. Gateshead Health NHS Foundation Trust were the highest recruiting Trust within the NENC CRN Region and third highest recruiting Trust, Nationally. In March 2023, the Trust was the highest recruiting site in Europe!

The DETERMIND Study

Principal Investigator: Dr Paul Donaghy
Research Team: Research Nurse: Christine Kirkup | Research Assistants: Mandy Grahamslaw & Jacob Douglass

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

Principal Investigator: Dr Raj Sharma
Research Team: Research Nurse: Bev McClelland | Clinical Trials Officer: Maria Bokhari

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.

7. Urgent Public Health Research Update

Covid-19 may not have dominated the headlines (or day-to-day lives) in the way it did during 2020 and 2021. However, some of the Urgent Public Health studies set up to help us understand it, continue to generate important results.

RECOVERY
Randomised Evaluation of COVID-19 Therapy

RECOVERY Trial
Principal Investigator: Dr Dina Mansour

Lead Research Nurse: Maureen Armstrong | Research Pharmacist: David Sproates

The Medical Research Council Prize Committee awarded the RECOVERY Trial Team the MRC Impact Prize 2022 for Outstanding Team Impact.

The RECOVERY Trial is the world's largest study of Covid-19 therapies. It was launched in UK hospitals at the start of the pandemic, only nine days after the idea was first conceived. Within three months, the trial had delivered the first major breakthrough in the Covid-19 response – the finding that the inexpensive steroid, dexamethasone, reduced deaths by up to a third. In the following nine months, this result saved an estimated million lives worldwide.

Since launching, RECOVERY has identified three other effective Covid-19 treatments, and shown that seven others are ineffective, enabling healthcare services to prioritise their resources and save patients from being exposed to ineffective or harmful treatments.

The trial is delivered by many thousands of doctors, nurses, pharmacists, and research administrators in 200 hospitals. The Outstanding Team Impact prize celebrates an inspiring and successful team of individuals whose collaborative team science approach has made an outstanding contribution in medical research. The prize recognises that complex and pressing human health and research challenges are best tackled by teams with a diverse range of expertise and skills, focussing on a shared goal. It recognises the essential contributions made by all those participating in research.

The RECOVERY trial is a truly collaborative effort that goes far beyond the team at Oxford University. This award recognises the commitment of all those involved, particularly the participants who made it possible at such a difficult time in their lives. The trial would not have been possible without the dedication and support of everyone involved.'

The application of genomic technologies in diagnosis and personalised medicine is becoming even more important and impactful. Using genomics, can provide rare disease and cancer patients with an accurate diagnosis earlier and more quickly, ensuring patients get the right treatments at the right time and at the right dose, improving outcomes for patients and reducing the number of adverse drug reactions and their impact on the NHS.

Using genomics can help to better understand pathogens and how they are spread, as well as the role of a person's genome in their response to infectious diseases. This supports scientists in controlling outbreaks, as well as developing new diagnostics and treatments for infectious diseases.

GenOMICC

In December 2022 the Chief Investigator for the GenOMICC Trial wrote to the Research Team to thank them for their extraordinary efforts to deliver the GenOMICC study and to update them with the latest findings for the trial:-

- Discovery of the TYK2 association with critical Covid-19 that led directly to a new effective drug treatment, baricitinib. This is the first time that host genetics has led to a new drug treatment for infectious disease or critical illness.
- Discovery of a total of 49 genetic variants associated with Covid-19, some of which may have broad implications for ARDS and other types of viral pneumonitis.
- Reported that over 20,000 critically ill patients had been recruited to the GenOMICC Trial, with many ICUs consistently recruiting over 50% of eligible cases. (In November 2022, the Trust was in the top 15 recruiting sites to the GenOMICC Trial, across the whole of the UK).

8. International Clinical Trials Day 2022

A new campaign – Your Path in Research was launched by the NIHR in October 2021 to encourage more Healthcare Professionals to get involved in research.

The campaign was promoted by the Research Team on International Clinical Trials Day, which takes place annually on or near to the 20th May.

The Your Path in Research campaign showcases a range of ways Healthcare Professionals can learn more about the research happening around them every day, as well as how they can take their first steps or next steps to get involved.

9. #Red4Research Event

The annual #Red4Research campaign has gained even more popularity since it began during Covid-19. The event aims to get as many people, children and even pets, wearing red to demonstrate their support and appreciation for all those participating, undertaking and supporting Covid-19 and other research. It is an opportunity to showcase the phenomenal work, and the new innovative research systems and techniques that have arisen. None of which would be possible without all the people involved – people make research happen.

#Red4 RESEARCH





The Medical Director | The Research & Development Team | The R&D Director

All of whom support our highly motivated Research Teams to setup and undertake safe, high quality research, and provide research governance to ensure the interests of our Patients, our Researchers and our Trust are protected.

#RED4RESEARCH

DID YOU KNOW ?

Gateshead Health NHS Foundation Trust is a Research Active Trust and research is happening every day in most clinical areas ?

#RED4RESEARCH

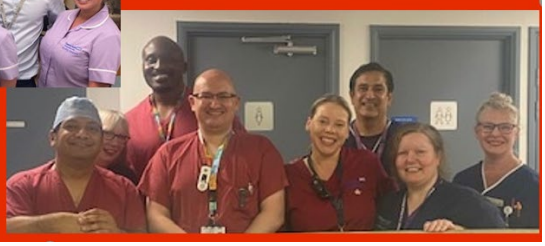
DID YOU KNOW ?

That Research is critical to help discover new treatments for our patients or ensures that existing treatments are used in the best possible way.

#Red4Research 2022

Research continues to offer a beacon of hope for the future, with everybody playing their part.

The Doctors, HCA's and Reception Staff in our Women's Health Clinic

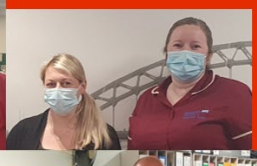


The Labour Ward Team

#Red4Research 2022

Research continues to offer a beacon of hope for the future, with everybody playing their part.






The Hepatology Research Team

PI – Dr Dina Mansour

#RED4RESEARCH

DID YOU KNOW ?

Patients who receive care in research active Trusts like ours, have better health outcomes. They value the opportunity to take part in research, not just for themselves, but to help patients in the future.

DID YOU KNOW ?

That Research comes under the CQC Well-Led Framework and is considered to be central to delivery and the development of good care. Poor research activity and patients not being given the opportunity to participate in research can affect our Trust rating negatively.

DID YOU KNOW ?

That you don't need to be part of a Research Team to be involved in research ?

Being involved can just mean knowing what research projects are happening on your ward / clinical area and being able to signpost patients to the relevant Research Team member.

R&D Department
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10. Research News Roundup

Principal Investigator - Dr Dina Mansour and the Hepatology Research Team were congratulated on their amazing recruitment to the **BOPPP** trial during both March & April 2022, and won a personalised set of BOPPP goodies.

Two trials reached the **100 participants** recruitment milestone:-

The **SMALL** (Open surgery versus minimally invasive vacuum-assisted excision for small screen-detected breast cancer) Trial (Principal Investigator Dr Simon Lowes) recruited their 100th participant in October 2022.

The **Arquer MCM5** study (Principal Investigator Mr Iain Cameron) also recruited their 100th participant in October 2022

Congratulations to both Teams!

In December 2022, Christine Kirkup and Mandy Grahamslaw were nominated by the Executive Team as "Star of the Month" for their outstanding contribution. Christine & Mandy had come to the aid of an injured lady out in the community and had stayed with her until an ambulance arrived. The lady's husband contacted the Trust to thank them both for their kindness.

Congratulations to Dr Simon Lowes, Consultant Breast Radiologist for the Trust, Honorary Senior Clinical Lecturer at Newcastle University and R&D Council Vice Chair, who was appointed as the NENC CRN Regional Research Imaging Lead in July 2022.

The New York Times

An article appeared on the front page of The New York Times in March 2023 regarding the advancements in A.I. and how they are beginning to deliver breakthroughs in breast cancer screening by detecting the signs that doctors miss. So far, the technology is showing an impressive ability to spot cancer at least as well as human radiologists, according to early results. It is one of the most tangible signs to date of how A.I. can improve public health. Gateshead Health Foundation NHS Trust entered into a research agreement with Kheiron Medical Technologies to be part of a multicentre retrospective study of Kheiron's AI tool called Mia™ (Mammography Intelligent Assessment). Mia is designed to empower Radiologists to deliver confident, accurate and timely results. Its goal is to support Radiologists in making the critical "call-back" decision whilst reducing their workload, increasing screening efficiency, and improving the patient experience.

In January 2023 breast cancer specialists, including Specialist Breast Care Nurse Caroline Tweedie and Research Clinical Trials Officer, Lucy Blackwell from the Trust, came together at 8K TV and film studio, to share their knowledge to improve the patient experience by recording a series of cancer patient podcasts.

The podcasts raise the profile of male breast cancer, clinical research trials, Women's Cancer Detection Society (Wcds) Gateshead, rehabilitation and menopause after breast cancer.

11. Reddoor – Public Engagement Event

During February there was great excitement when the R&D Team filmed a research public engagement video with the Reddoor TV and Film Company. All parts were played by members of staff (and extended staff members) from the R&D Team.

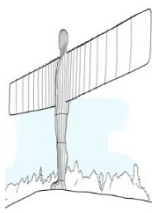
The film would become a commercial for research and used as an ongoing resource to promote local community awareness.






In March 2023, the R&D Team took part in Community Engagement Event organised by Reddoor, at the Metro Centre, Gateshead. It was a great opportunity to showcase the new commercial and promote health and social care research.

The event took place over two days and the R&D Team met and spoke with some fabulous people who were keen to share their positive research experiences. It was a lovely surprise to be visited by The Worshipful the Mayor of Gateshead Councilor Dot Burnett and Non-Executive Director, Anna Stabler, both of whom wanted to show their support.





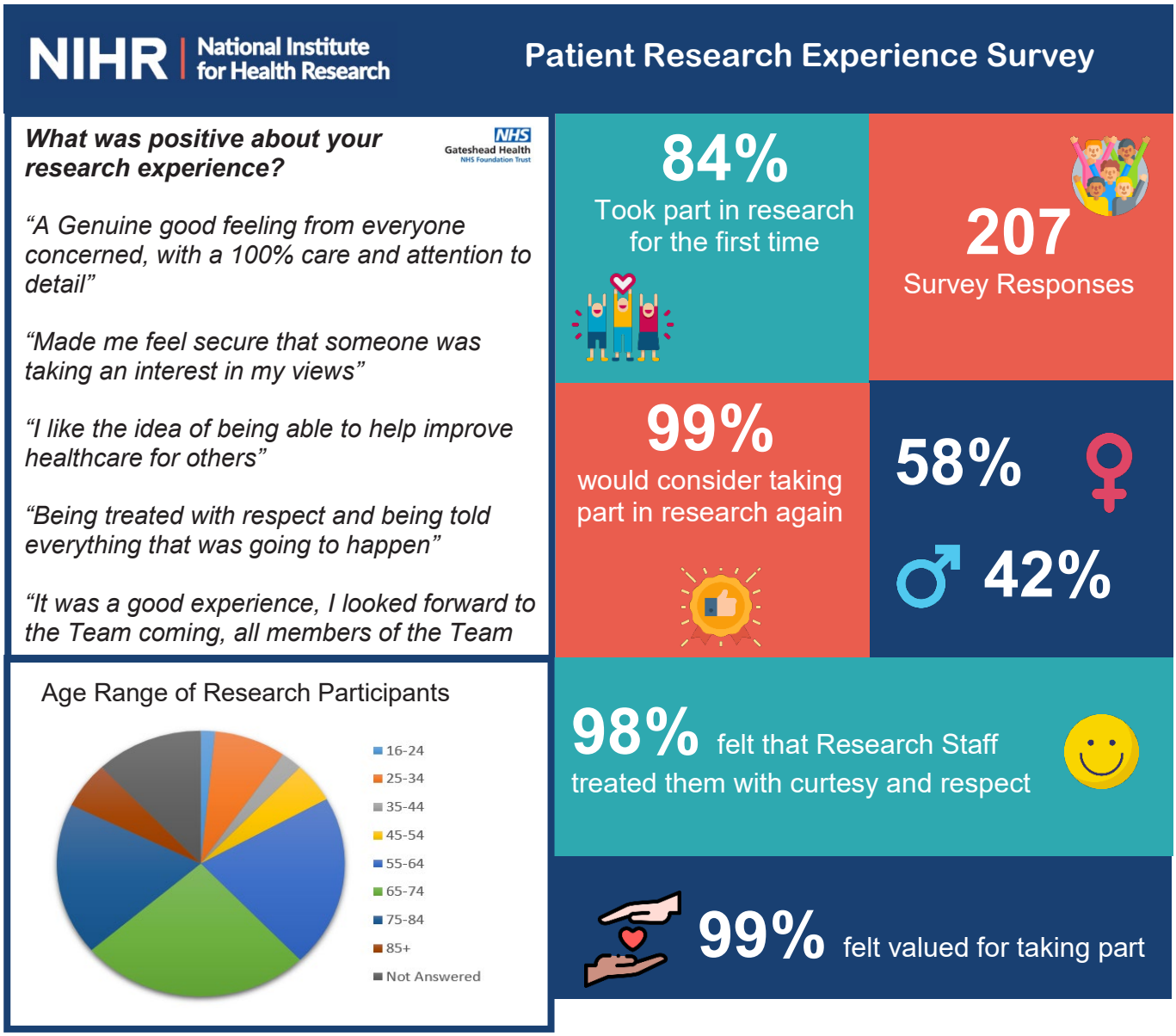
12. Patient Research Experience Survey

The Patient Research Experience Survey (PRES) gives research participants the opportunity to feedback about their research experience via an online survey.

Through PRES, the NIHR aims to put research participant experience at the centre of research delivery by providing an opportunity for as many research participants as possible to share their experience of taking part in research.

Between April 2022 and March 2023, the Trust received **207** survey responses, a massive 113% increase on our target of 99 responses expected.

The PRES survey is supposed to be completed online, but many Gateshead patients found this difficult and asked if they could complete the survey either by telephone or paper questionnaire. By being inclusive and implementing these simple changes, the response rate has been unprecedented.



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13. Research Income

During 2022/2023 Gateshead Health NHS Foundation Trust received **£623,982** from the NENC CRN to provide the infrastructure to support and deliver portfolio research.

This funding was allocated to support the Research Staff, R&D Department, and the relevant Support Departments.

Use of this funding is reported quarterly to the CRN NENC.

£20,000 of NIHR Research Capability Funding (RCF) was awarded to the Trust.

14. Publications 2022/2023

In July 2022, Research & Development were contacted by Sarah Stockton, the Knowledge & Library Services Manager for the Trust.

Sarah had the idea of creating a dedicated repository for staff publications using the Library's Management System and compiling a simple structured list of articles authored by Trust staff, to:-

- Showcase Trust research publications and provide wider accessibility
- Forge stronger links between the Trust's research community and the Knowledge & Library Services.
- Provide a shared central resource for evidence, outcomes and knowledge generated by research

Over the last year, researchers from the Trust have published **124** publications.

The majority of the publications are as a result of our involvement in NIHR research, which shows our commitment to transparency and the desire to improve patient outcomes and experience across the NHS.

15. Key Priorities for Research 2023/2024

The following aims and key priorities for research were published in our Research Strategy 2022-2027.

Research Management

- Achieve NIHR HLOs for efficient study delivery, provider participation and patient experience.
- Appropriately deploy Research Nurses to optimise Team support and research capability.
- Promote research across the Trust and encourage all staff to become research aware, involved in research or actively partake in research.
- Increase the number of hosted commercial studies.
- CQC - Well Led Framework – How is Clinical Research used to improve patient care? Is every patient given the opportunity to take part in research?

Research Delivery

- Increase patient satisfaction with our hosted research portfolio and activities.
- Broaden our hosted research portfolio to offer more of our patients the opportunity to participate in research.
- Attract more commercial studies.
- Embed a culture of research within the Trust and make research everyone's business.
- Invest in our workforce and facilities to increase our ability to deliver the research of the future.
- Make research more visible and accessible to our patients and visitors.

15. Key Priorities for Research 2023/2024

Research Finance

Develop a sustainable and stable staffing model within the constraints of a fragile income stream.
Comply with the financial reporting requirements of the Department of Health & Social Care (DHSC), the NIHR Research Capability Funding (RCF) and the NENC CRN.
Increase the number of hosted commercial studies to utilise the income to build capacity within the Department.
Ensure all Excess Treatment Costs are requested.

16. Conclusion

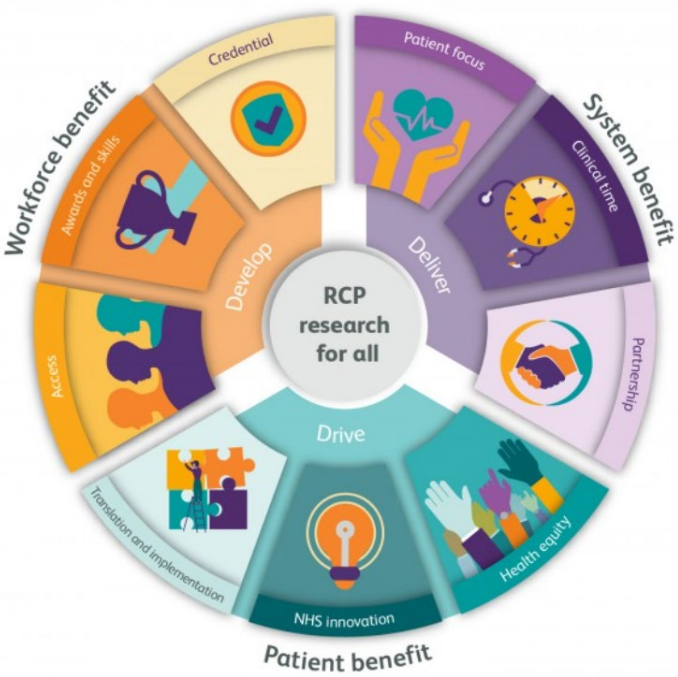
This annual report has outlined the many achievements of the Research and Development Team during 2022/2023.

The value of research is transforming health and care in the NHS as evidence from research influences and shapes clinical practice, as well as informing and underpinning policy.

There is also evidence that clinical research activity improves patient outcomes, which is why the Care Quality Commission (CQC) look for research activity during inspection.

Research involvement is also linked to better staff morale with improved retention and recruitment.

Whilst the R&D Team have continued to drive the promotion of research, focusing their attentions on raising awareness and encouraging clinical staff to get involved and support research, there is a need to identify how best to use research results to actively shape, improve and effectively change current clinical practices and/or services within the Trust, as well as using the National strategies to identify and set the Trust's own areas of research priorities for future clinical and service improvements.



17. Recommendations

The SafeCare/Risk & Patient Safety Council is asked to consider and ratify this report.

Appendix I – Glossary of Terms

Abbreviation	Term
C&C	Capacity and Capability
CRN	Clinical Research Network
CRN NENC	Clinical Research Network: North East and North Cumbria
CTIMP	Clinical Trial of an Investigational Medicinal Product
HLO	High Level Objective
HRA	Health Research Authority
IRAS	Integrated Research Application System
LPMS	Local Portfolio Management System
NIHR	National Institute for Health Research
ODP	Open Data Platform
PRES	Patient Research Experience Survey
R&D	Research and Development
RCF	Research Capability Funding
SOP	Standard Operating Procedure
UPH	Urgent Public Health

Item 8 – Patient Safety Incident Response Plan

Appendix A – Safety Improvement Profile

THEME / Category	Existing work streams / projects (2022 -2023)	Gap identified	Actions Required
Falls/ Slips / Trips	1. Strategic Falls Group	• Time / Resource / Membership. • Strategic Falls Lead • In-Patient falls team.	• TOR • Executive Sponsor • Business Case for Strategic Falls lead • Mapping of current Governance Structures for all meetings / projects / work streams • Proposed governance structure for all work streams to be presented to Safe Care council decision • Explore link with Trust governance review
	2. Introduction of Carefall/Safecare One training	• Monitoring of compliance • Uptake of training • Variation of learning tools • Variation in staff skills and knowledge	• Focused training • POD Support for monitoring
	3. Digital Strategy Group	• Links between work streams and learning panels	• Proposed governance structure for all work streams to be presented to Safe Care council decision.

	4. Quality Account key priority 10	• Links between QA governance and outputs with Strategic falls group.	• Proposed governance structure for all work streams to be presented to Safe Care council decision.
Pressure Damage	1. CQUINN- Pressure Damage: 85% of acute inpatients aged 18+ having a pressure ulcer risk assessment that meets NICE guidance with evidence of actions against all identified risks	• Quality improvement work stream	• Introduction of Pressure Damage work stream – governance / TOR / membership • Identification of executive sponsor • Specialist Lead identified for group
	2. Quality Account Priority 10.	• Links to work streams for quality improvement	• Governance structures - Proposed governance structure for all work streams to be presented to Safe Care council decision.
Medication	1. Medicines Management Group.	• Membership / time /resource	• Review of TOR • Review of membership • Executive Sponsor

	2. CQUINN **:** 40% (or fewer) patients still receiving IV antibiotics past the point at which they meet the switching criteria (excl; ICU/HDU, intravenous antifungals or antivirals) 1.5% of acute trust inpatients having changes to medicines communicated with the patient's chosen community pharmacy within 48 hours following discharge via electronic message (excl: maternity)	• Links to work streams for quality improvement	• Governance structures - Proposed governance structure for all work streams to be presented to Safe Care council decision.
Digital / IT inc pathology/radiology and sample/reporting issues and medication issues and consenting procedures	1. Digital Transformation Group 2. Digital Assurance Group 3. Quality Account Priority 9 &12	• Links to and from other work streams. • Links from patient safety learning panels.	• Governance structures - Proposed governance structure for all work streams to be presented to Safe Care council decision. • Review of membership

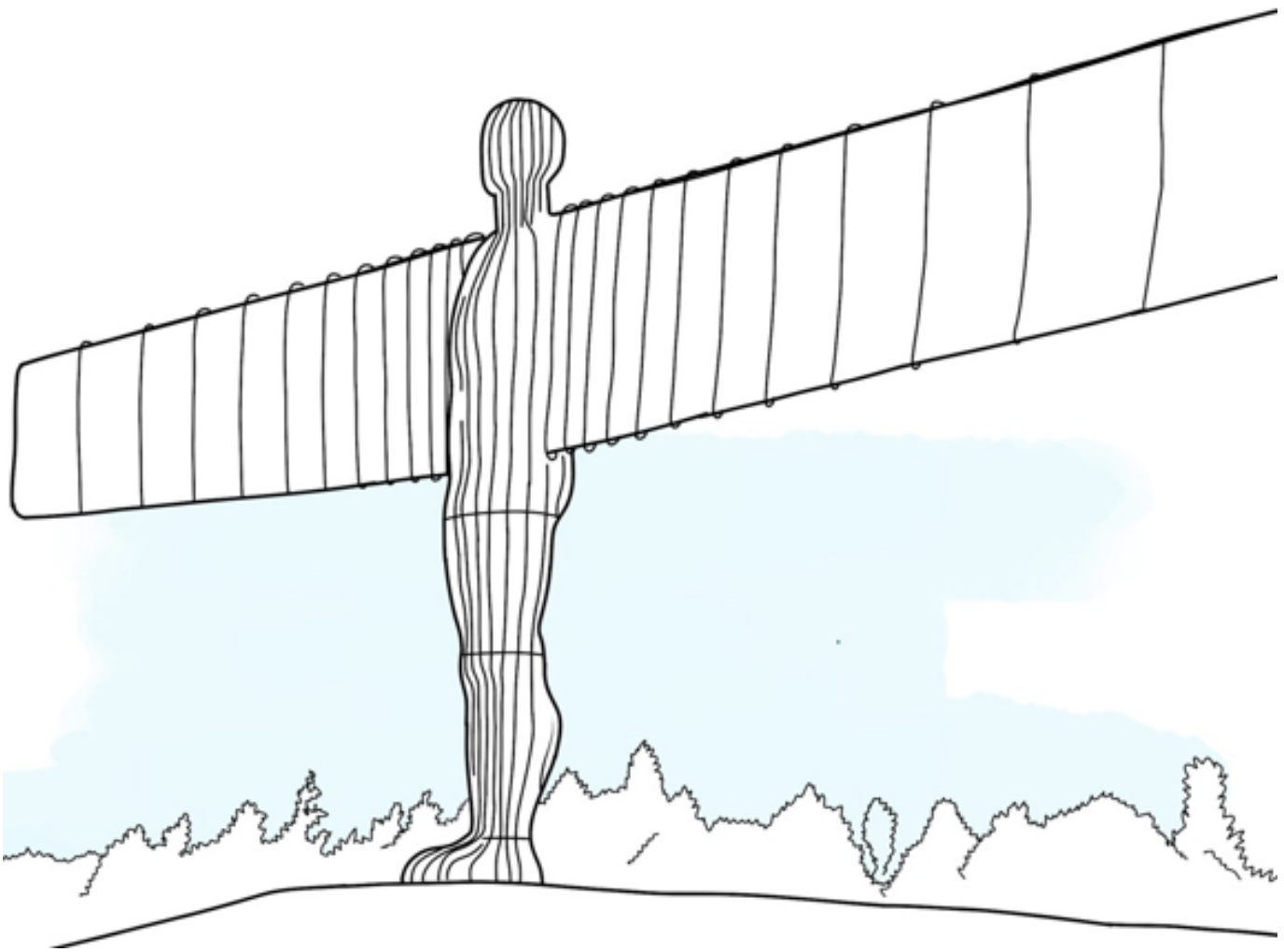
IPC	1. IPC Committee 2. CQUINN - Antibiotic prescribing: 40% (or fewer) patients still receiving IV antibiotics past the point at which they meet the switching criteria (excl; ICU/HDU, intravenous antifungals or antivirals)	• Links to and from other work streams. • Links from patient safety learning panels. • Links to work streams for quality improvement	• Governance structures - Proposed governance structure for all work streams to be presented to Safe Care council decision. • Review of membership • Governance structures - Proposed governance structure for all work streams to be presented to Safe Care council decision.
Maternity	1. Regional Patient Safety Learning Network 2. MatNeo SIP network	• A formalised, local quality improvement workstream to pull together current and planned QI activities/aspirations and feed these into regional networks and bring back from those networks to the local workstream	• Terms of Reference to be established including membership and Executive Sponsor

Item 8 – Patient Safety Incident Response Plan

Appendix B

Quality Account 2023-24

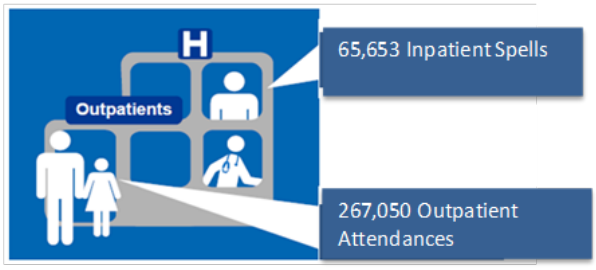
NHS
Gateshead Health
NHS Foundation Trust



Quality Account

Gateshead Health NHS Foundation Trust 2022/23

Gateshead Health NHS Foundation Trust at a glance…



Contents

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

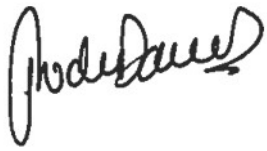
response to this, we have made a significant investment in staff wellbeing, with a dedicated health and wellbeing team and a comprehensive range of support for our people. These include wellbeing and financial advice, menopause support, wellbeing check-ins, therapy sessions in collaboration with Gateshead 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



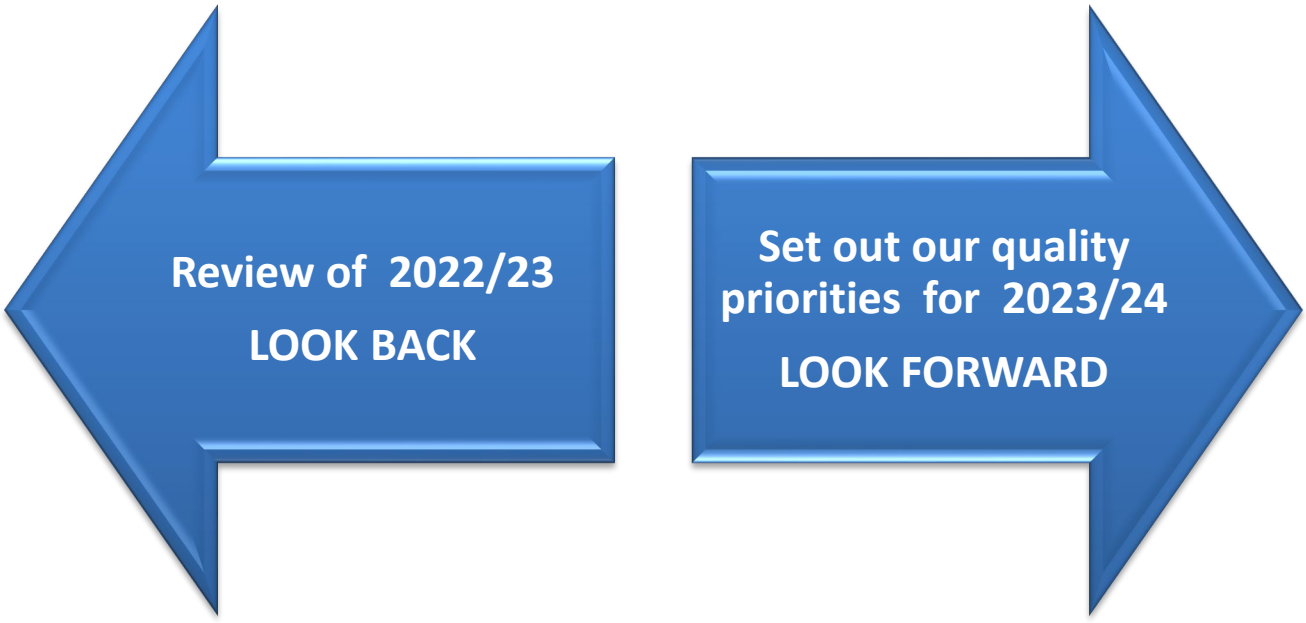
Chief Executive

What is a Quality Account?

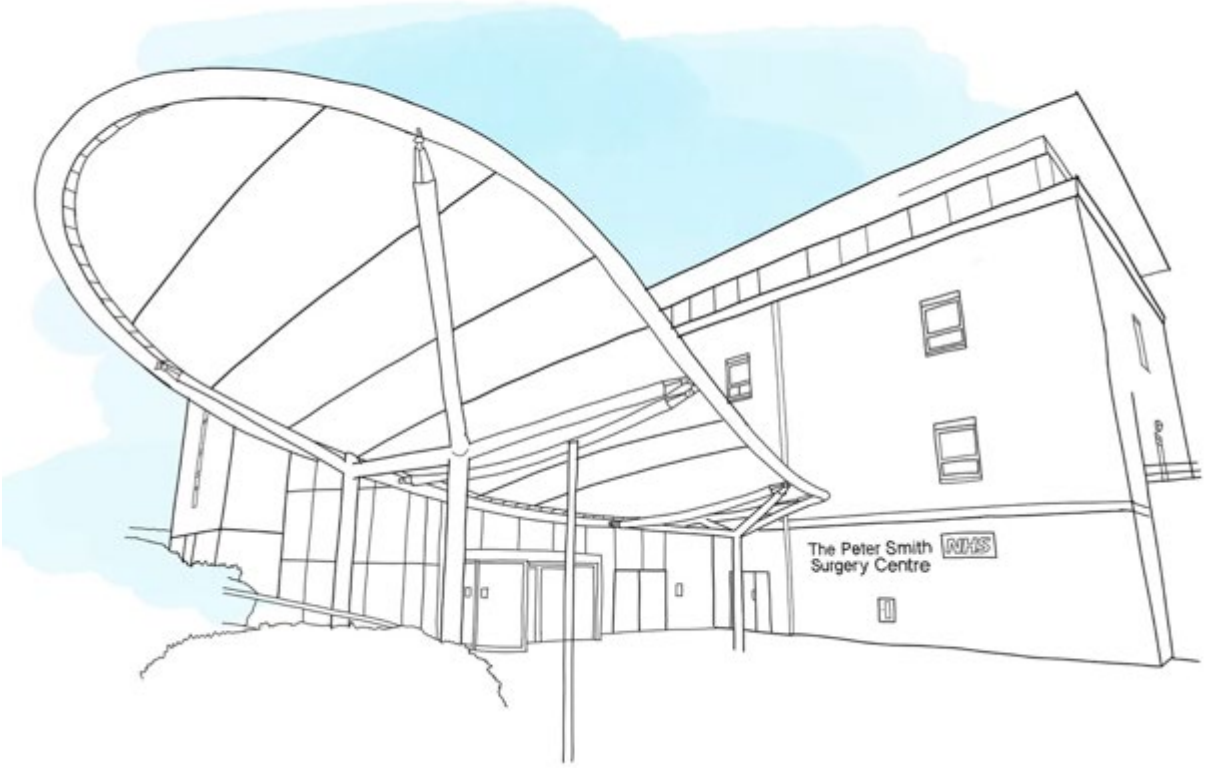
The NHS is required to be open and transparent about the quality of services provided to the public. As part of this process all NHS hospitals are required to publish a Quality Account (The Health Act 2009). Staff at the Trust can use the Quality Account to assess the quality of the care we provide. 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?

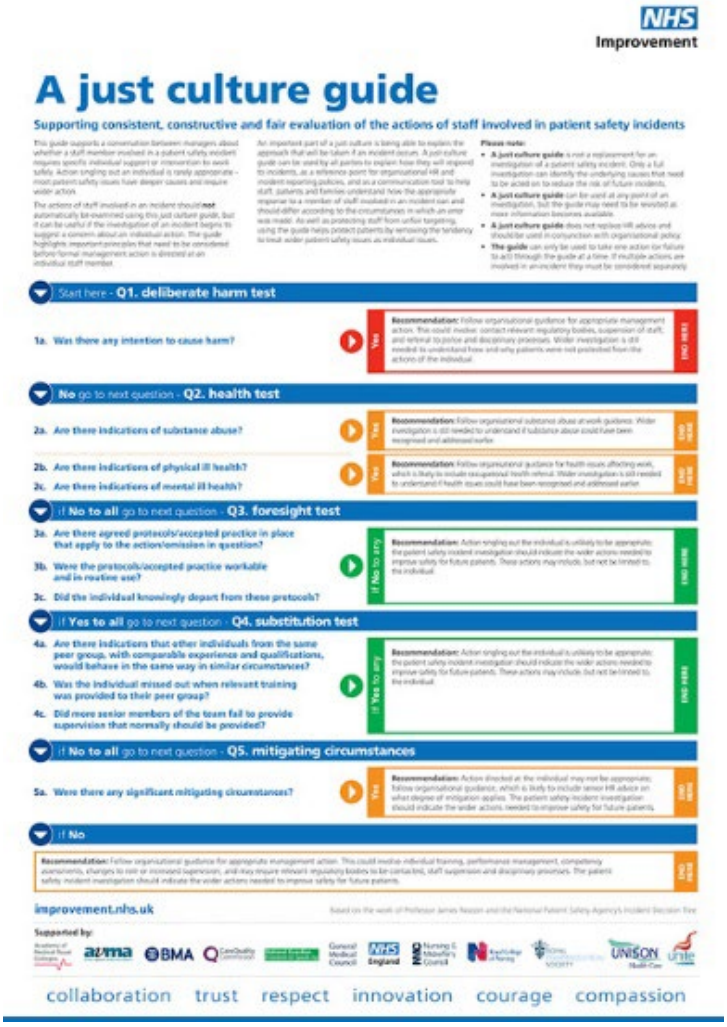
- We partially achieved this.

➢ 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:

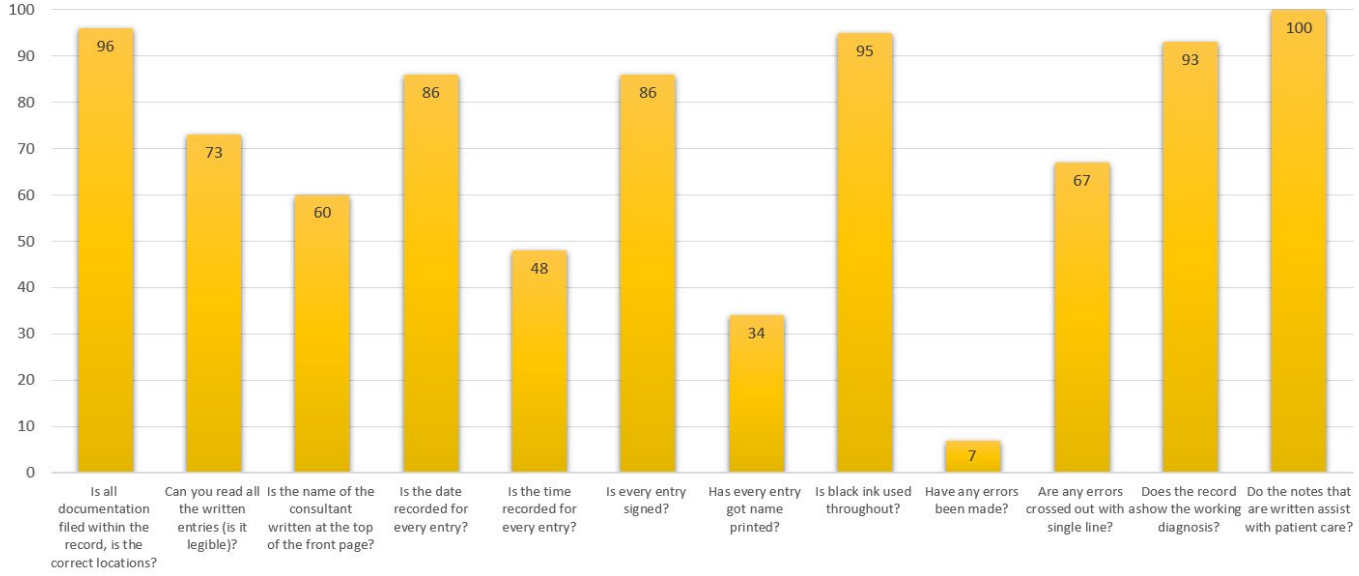


Chart 2 - Overview of compliance with risk assessments:

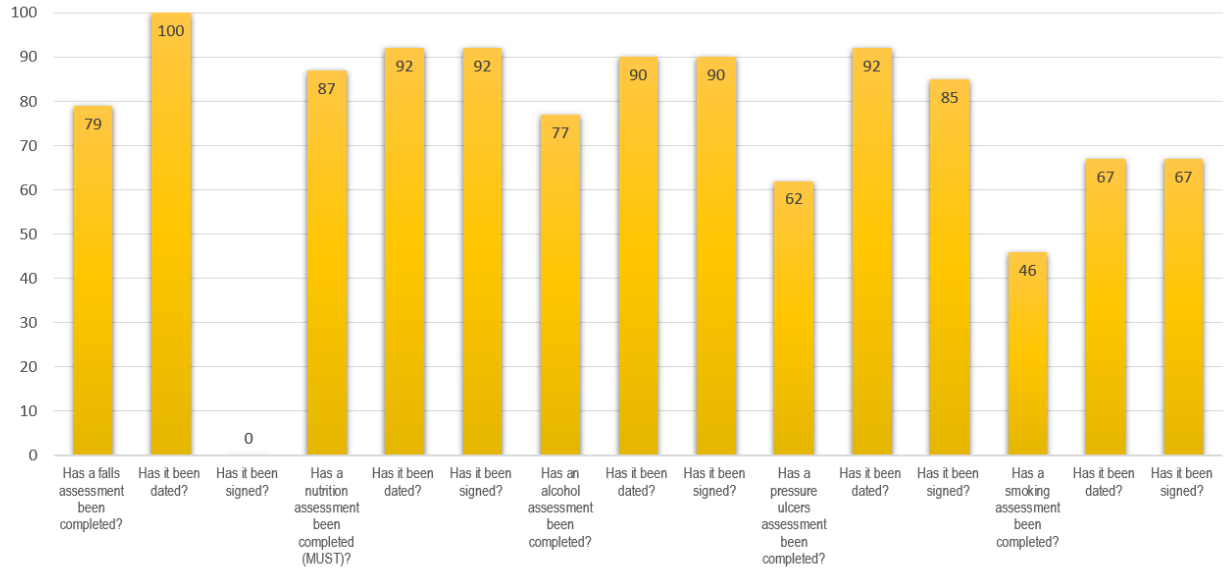


Chart 3 – Overview of compliance with discharge criteria

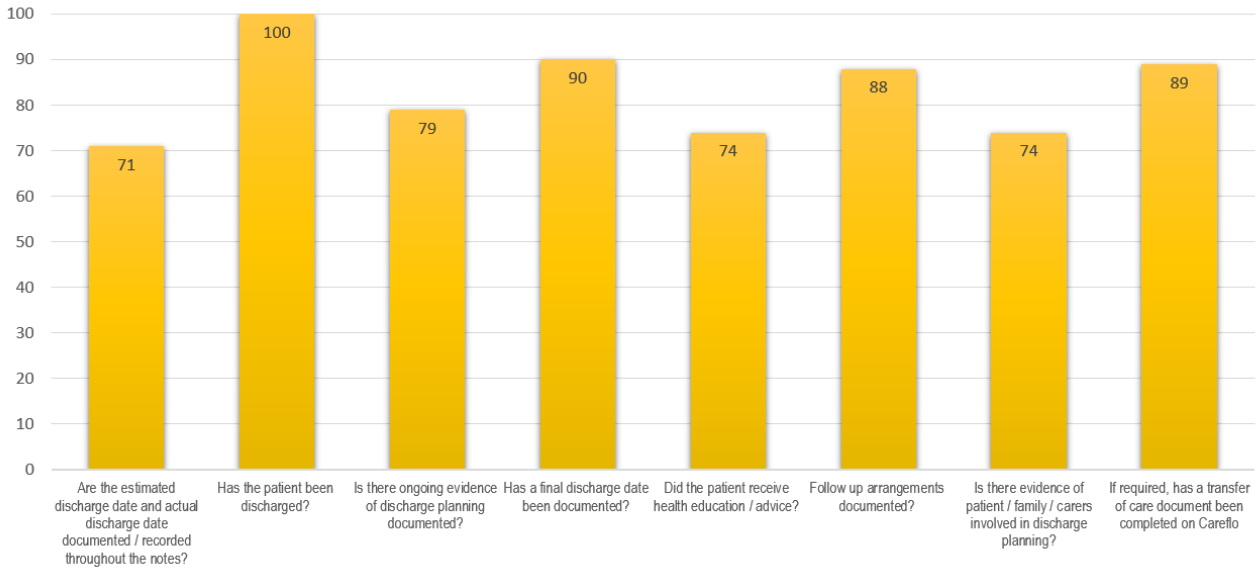


Chart 4 - Overall compliance with each section

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.

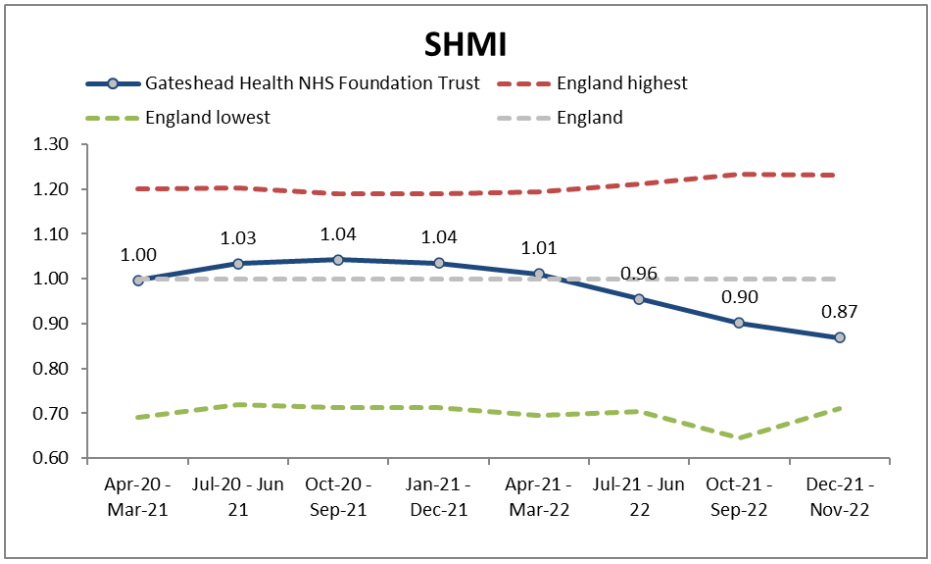
The Medical Workforce Group meets monthly and reviews the recently developed medical workforce dashboard which summarises rota fill rates and staffing absences by service / specialty area and by business unit. The Trust Medical Staffing Team are now established and manage the medical staffing rosters 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

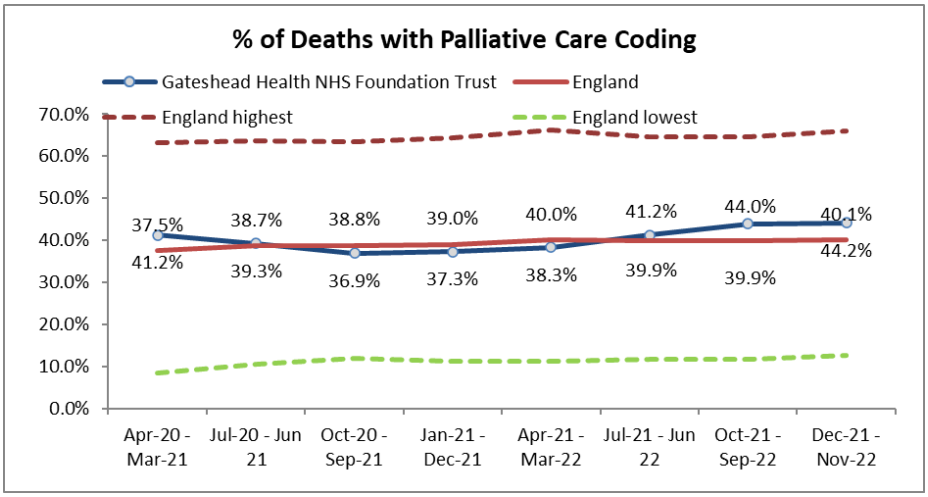
Source: www.digital.nhs.uk/SHMI



(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

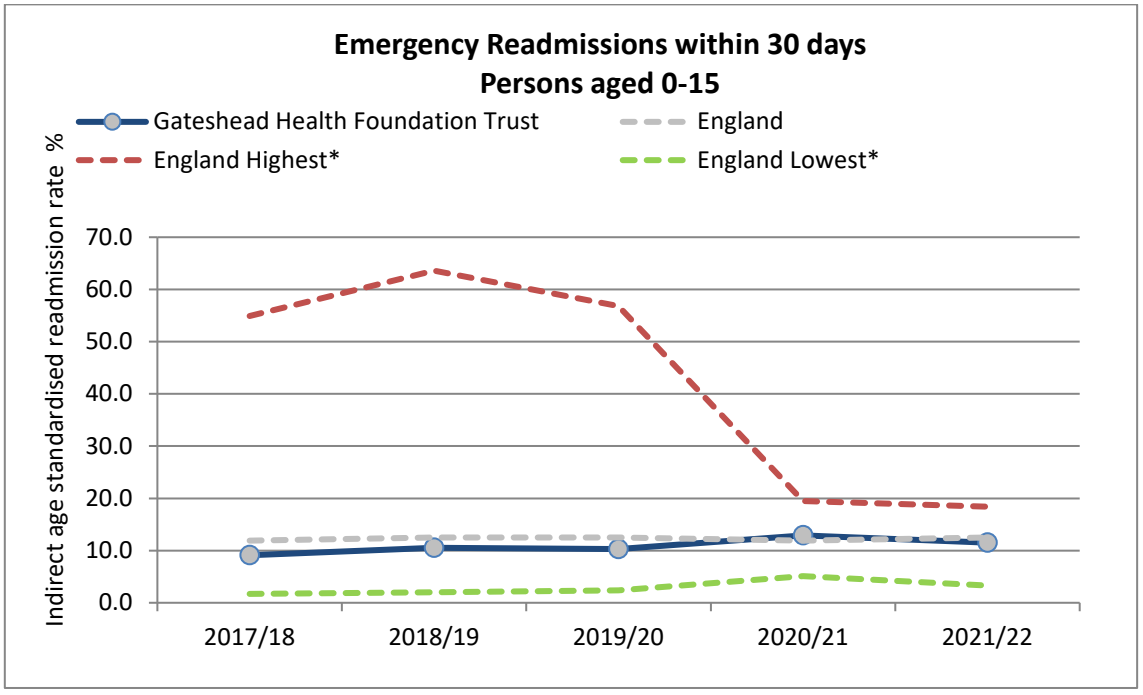
- Aged 0 – 15yrs

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.

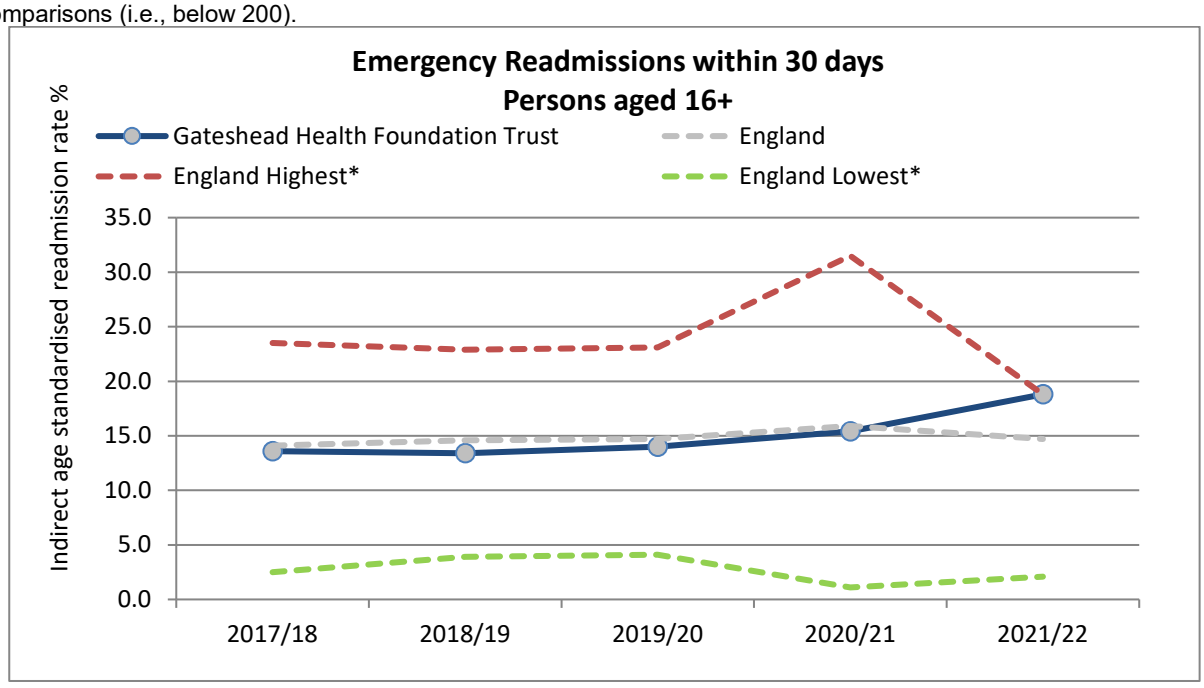
Gateshead Health NHS Foundation Trust has taken the following actions to improve these outcomes, and the quality of its services, by:

- 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

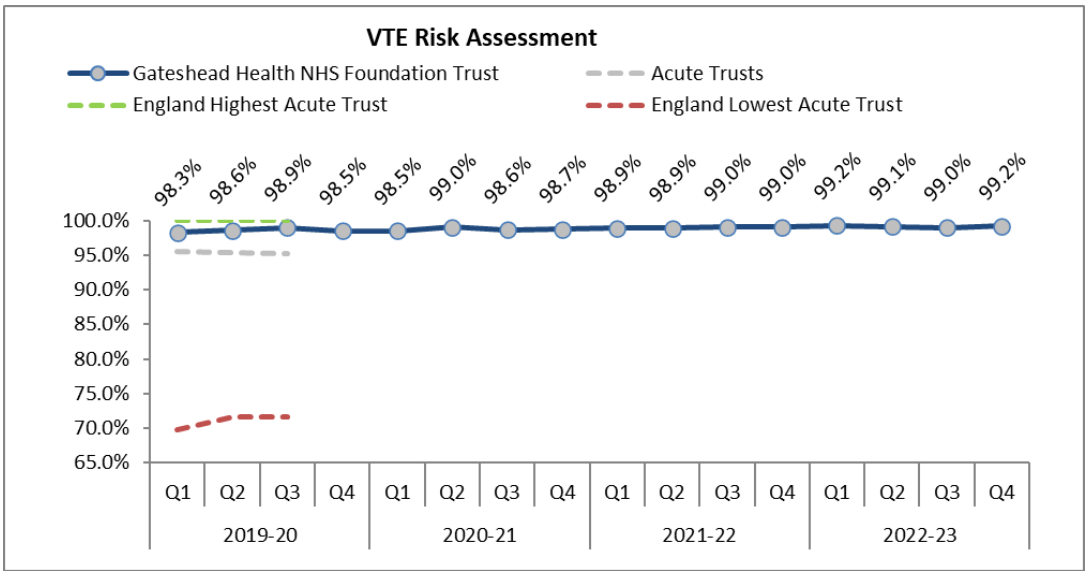
The Gateshead Health NHS Foundation Trust considers that these percentages are as described for the following reasons:

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.

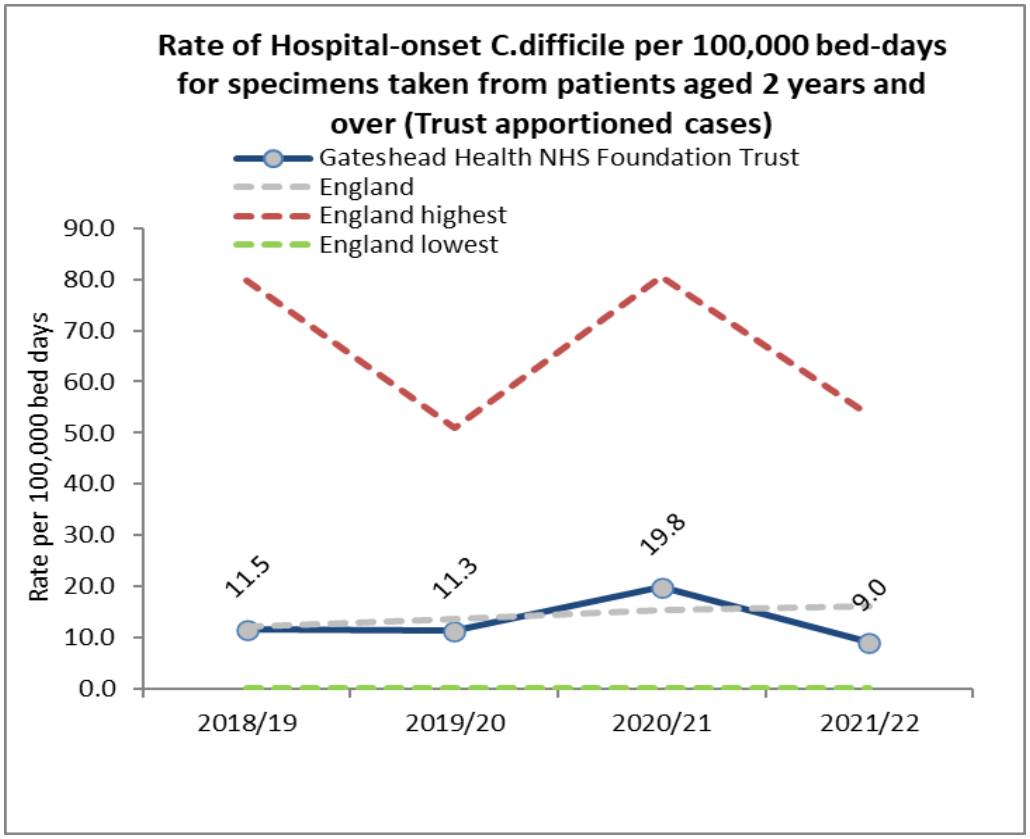
The Gateshead Health NHS Foundation Trust intends to take the following actions to improve these percentages, and so the quality of its services, by:

- 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.

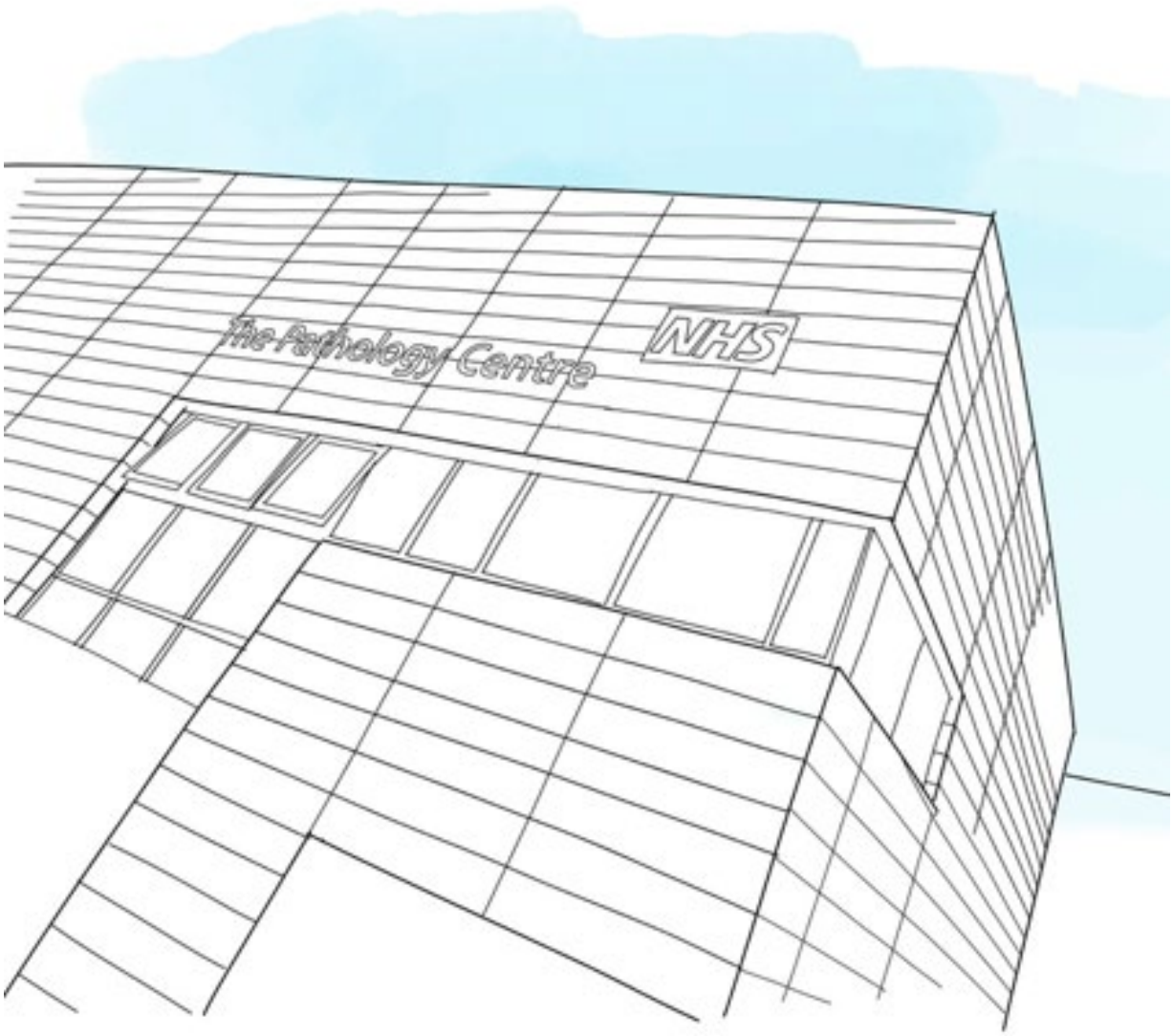
- Figures for this 2021-2022 period related to severe and death level reviews are broadly congruent with the previous 12-month period, and in line with national percentages for these areas.

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.

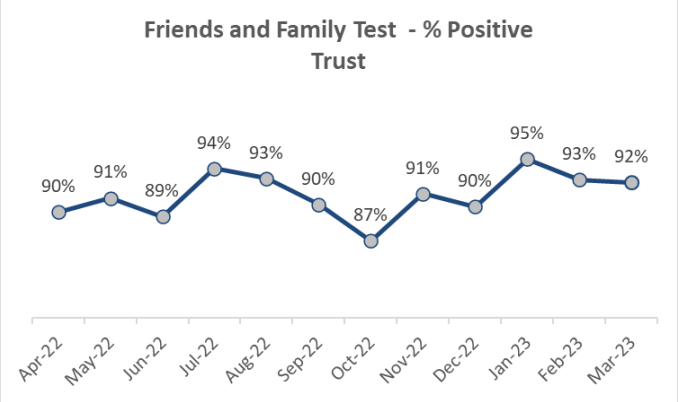
During 2022/23 there has been one 'deep dive' visit:

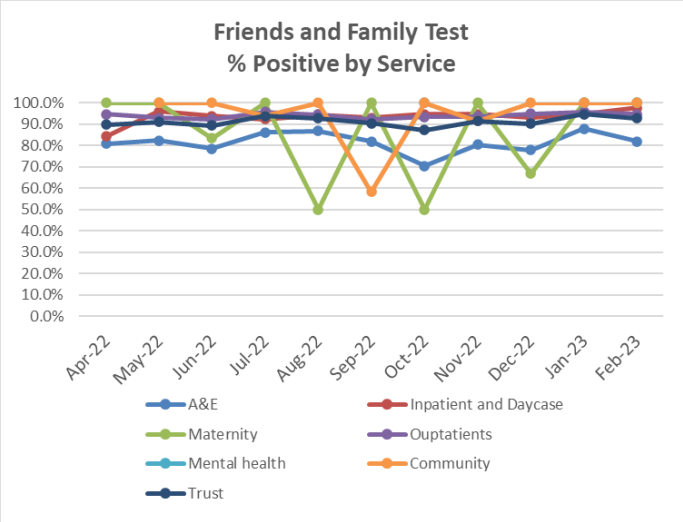
Speciality	Good practice/opportunities for improvement identified
Critical Care May 2022	Although this visit took place in May 2022 the formal feedback was not available for inclusion in the last six monthly report, hence the reason for inclusion here. The team identified the rehab nurses taking patients 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





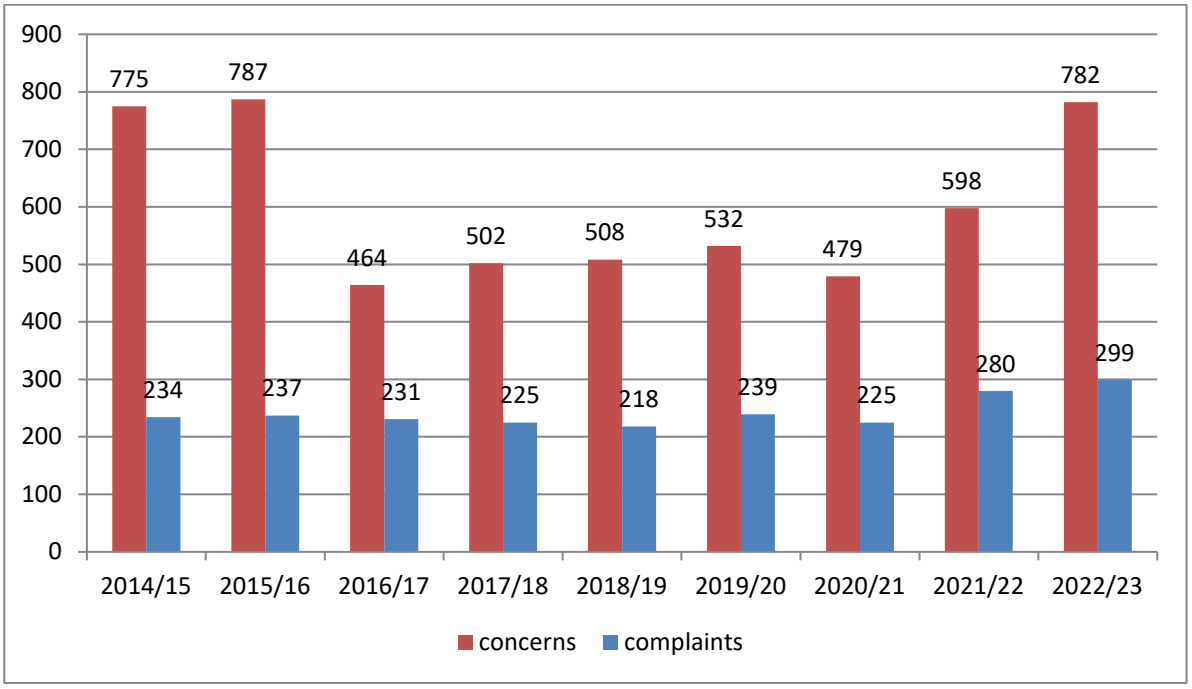
Listening to Concerns and Complaints, Compliments

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.

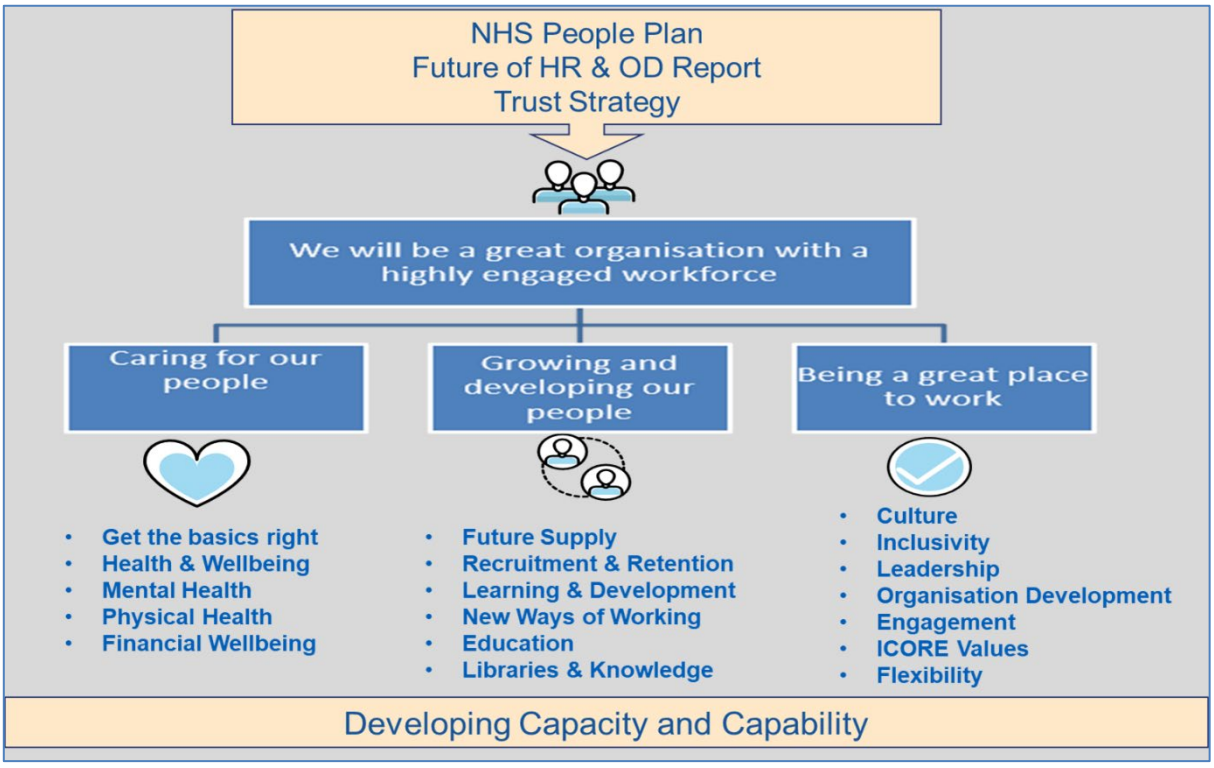
A new state of the art maternity theatre opening, due to increasing numbers of operations required, the new theatre allows more capacity for planned and emergency operations to take place.

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

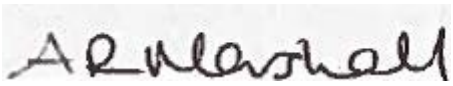
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and

- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts

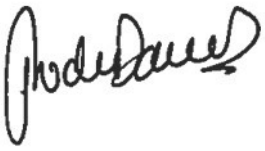
regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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.

Item 8 – Patient Safety Incident Response Plan

Appendix C

Learning Response Methods Tools

NHS
Gateshead Health
NHS Foundation Trust

Patient Safety Incident
After Action Review (AAR)

Incident Reference Number:	
Incident Description:	
Incident Date:	
AAR Date and Time:	
AAR Facilitator(s):	
Attendees:	
Glossary of Abbreviations/Acronyms:	

Rationale and Specific issues to be addressed by the AAR (Terms of Reference):	

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What is it: *A structured, facilitated discussion on an incident or event to identify a group's strengths, weaknesses and areas for improvement by understanding the expectations and perspectives of all those involved and capturing learning to share more widely. Safe space, invitees only (those involved in incident, agreed prior to discussion).* **When to use it:** *AARs can be used after any activity or event that has been particularly successful or unsuccessful. It is also often used at the end of a project to help populate a lessons learnt log. It is important to disseminate learning widely so that good practice and learning can be shared.*

Creating a common understanding of the experience under review:	
What happened that we can learn from?	
What did we set out to do?	
What actually happened?	
Why were there differences?	
What went well? Why?	

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Reflecting on the successes and issues:	
What could have gone better? Why?	
What would you do differently next time?	
What learning has been identified?	
How will the learning be shared within your service?	
Agree as a group on any actions that need to be taken	
How you are going to share the learning more widely?	

NHS
Gateshead Health
NHS Foundation Trust

System Improvement Plan

Incident Reference Number:

Identified Learning	Action	Lead(s)	Timescale

Item 8 – Patient Safety Incident Response Plan

Appendix C.1

Case Review

NHS
Gateshead Health
NHS Foundation Trust

Patient Safety Incident Case Review

Incident Reference Number:	
Date Incident Occurred:	
Date Incident Reported:	
Report Author(s):	
Final Approval Date:	
Final Approval Name/Position/Panel:	
Version Number:	

Distribution List

(*List who will receive the final report, including those involved in review/incident and the patient/family*)

Name	Position

N.B. Names should be redacted before report shared external to Organisation, leaving Positions only

About Patient Safety Incident Case Reviews

Patient Safety Incident Case Reviews are conducted to identify new opportunities for learning and improvement. Case Reviews focus on improving healthcare systems not individuals; they do not determine or apportion blame. Other specialist organisations and investigation types have been established to consider issues such as criminality, culpability, or cause of death. Including blame or determinations of preventability within an investigation designed for learning can drive a culture of fear and concealment, resulting in missed opportunities for improvement.

The key objective of a Case Review is to identify underlying system factors that contributed to an incident. These findings are then used to identify effective, sustainable improvements.

Case Reviews begin as soon as possible after the incident and are normally completed within three months of the review start date. The duration of the review may be extended and where applicable with the agreement of the patient/family/carers.

If a Case Review reveals significant risks that require immediate action to improve patient safety, these actions will be made as soon as possible. Recommendations for system improvement may not be made immediately after a single review however a realistic timescale should be outlined in the Improvement Plan at the end of the report. If this forms part of a wider review/local or national safety priority, this report should be shared with the Patient Safety Team for that purpose.

Where applicable, the review team follow the Duty of Candour and Being Open principles, in their collaboration with the patient/family/carers and staff, to help them identify what happened and why this resulted in a patient safety review. HR teams are encouraged to follow the Just Culture Guide in the minority of cases when staff may be referred to them.

Case Reviews are led by a reviewer/review team trained to conduct investigations for learning, and follow guidance set out in the Patient Safety Incident Response Framework and in the national standards for Patient Safety Incident Investigation.

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Contents

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Incident Summary

(Brief description of what happened)

Review Approach

Case Review ☐

Peer Review ☐

Other (p*lease state below)* ☐

Scope (Terms of Reference)

(Any specific areas that will be explored)

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Patient/Family Questions to be included

(List)

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Findings

(Can be structured as preferred however sub-headings may be useful to outline main findings and in order of significance to incident. Can also include incidental findings that may require action, as well as positive findings/good practice. ***Abbreviations/acronyms should be avoided and written out in full, or an explanation given directly after of meaning****)*

Learning

(List in order of significance)

Recommendations

(List in order of priority)

Appendices

(Delete if there are none)

References

(Include references to national and local policy/procedure/guidance, and other data sources as required – delete if there are none)

NHS
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NHS Foundation Trust

System Improvement Plan

(To be agreed by the department(s)/area(s) concerned if Peer Review)

Incident Reference Number:

Identified Learning	Action	Lead(s)	Timescale

Item 8 – Patient Safety Incident Response Plan

Appendix C.2

Patient Safety Learning Team

Learning Team Template, V1.3, May 2023

NHS
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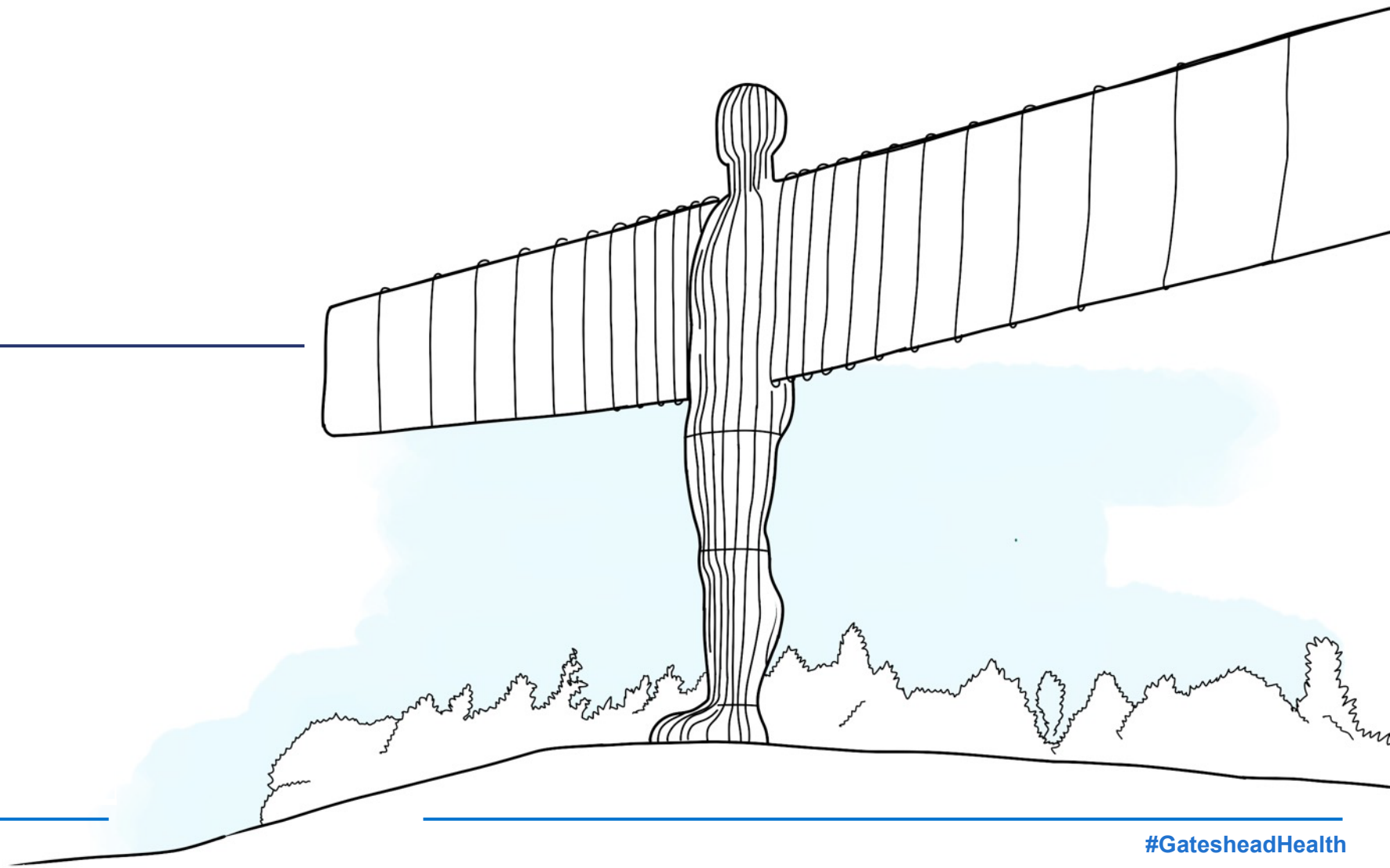
NHS Foundation Trust

Patient Safety Learning Team



Title of Learning Team:

Date of Learning Team:

Date of Final Report Approval:

Approving Body/Position:

Version:
Approving Body:
Date:

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Team

Name	Job Role/Department

Gateshead Health NHS Foundation Trust

What is a Learning Team?

Engaging with staff to drive change; fixing systems rather than people

A Learning Team is a multi-disciplinary review of a systemic safety issue (theme/recurring issue) or a complex problem. The intention is to understand what needs to happen for it to go well (which is probably most of the time), and what gets in the way of that sometimes (barriers), so as to direct improvement work in the right places but also acknowledge what we can learn from good practice/excellence as well as adversity and incidents (known as Safety II).

The Learning Team uses the SEIPS (Systems Engineering Initiative for Patient Safety) Framework to support a human factors approach, which focuses on the system humans work within, rather than the humans. It not only prompts us to consider the different variables at play, but also how they might interact and have implications on patients and processes (positive and negative).

When something goes 'wrong' for a patient, the conditions are usually the same as when it goes right, but it's what needed to happen for the system to adapt to cope with the conditions, that wasn't present when it went wrong.

The Learning Team focuses on the 'Work as Done', as opposed to the work as we imagine it to be, how it is prescribed in policies or as it's disclosed to us following an incident. This is to aid understanding of the 'real work' in order to make real improvements.

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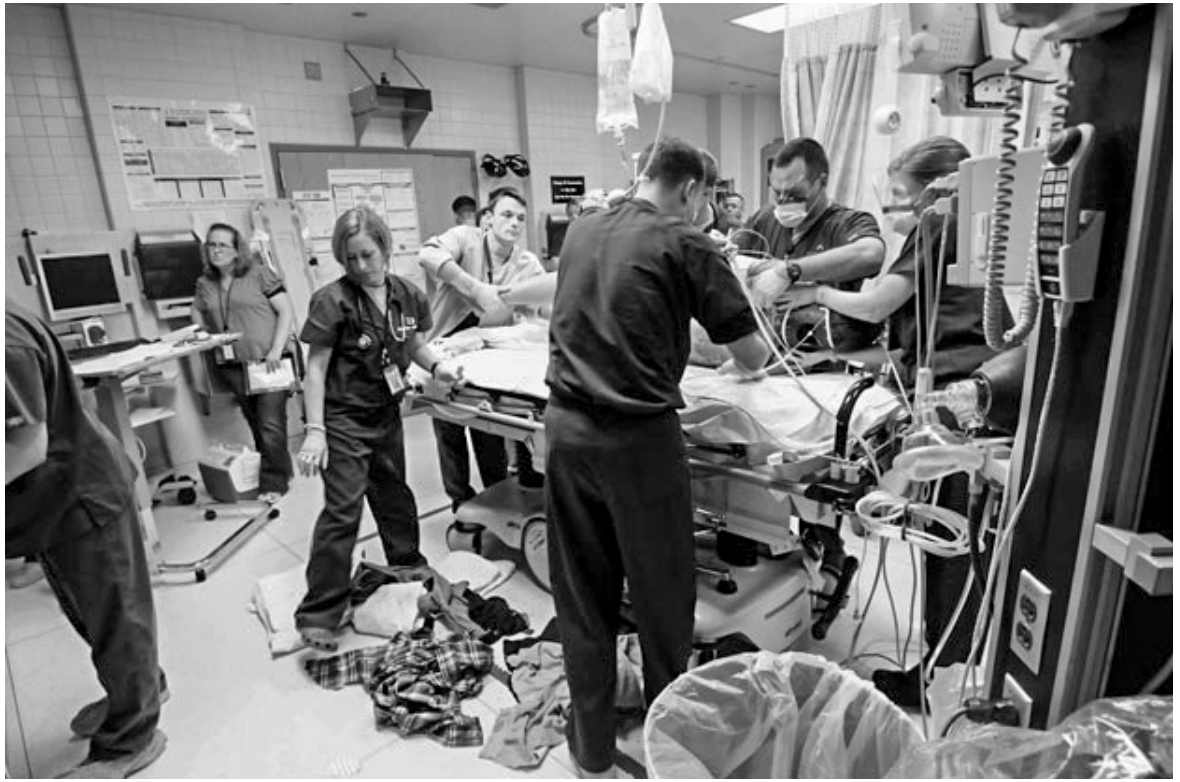
SEIPS

Systems Engineering Initiative for Patient Safety

Can these people, with this training and this equipment, carry out all their tasks to the requisite standard in this organisation and environment?



Reference Event(s)

Incident number(s) & Description

Patient Safety Incident:

System Issues Identified/Indication for Learning Team Response

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Technology & Tools

NOTE

It is important to note the ‘Work as Done’, rather than how we imagine it is done, or how it is prescribed in policies, and any notable differences.

What happens when it goes well	What gets in the way	Impact (processes and patient)	Current mitigations	What else could we do

Organisation of Work (influences can be internal or external)

Gateshead Health NHS Foundation Trust

NOTE

It is important to note the ‘Work as Done’, rather than how we imagine it is done, or how it is prescribed in policies, and any notable differences.

What happens when it goes well	What gets in the way	Impact (processes and patient)	Current mitigations	What else could we do?

Gateshead Health NHS Foundation Trust

Person(s)

NOTE

It is important to note the ‘Work as Done’, rather than how we imagine it is done, or how it is prescribed in policies, and any notable differences.

What happens when it goes well	What gets in the way	Impact (processes and patient)	Current mitigations	What else could we do?

Gateshead Health NHS Foundation Trust

Tasks

NOTE

It is important to note the ‘Work as Done’, rather than how we imagine it is done, or how it is prescribed in policies, and any notable differences.

What happens when it goes well	What gets in the way	Impact (processes and patient)	Current mitigations	What else could we do?

Gateshead Health NHS Foundation Trust

Environment

NOTE

It is important to note the ‘Work as Done’, rather than how we imagine it is done, or how it is prescribed in policies, and any notable differences.

What happens when it goes well	What gets in the way	Impact (processes and patient)	Current mitigations	What else could we do?

Gateshead Health NHS Foundation Trust

System Improvement Plan

Issue	Action	Lead	Timescale

System Improvement Plan

Gateshead Health NHS Foundation Trust

Issue	Action	Lead	Timescale

Gateshead Health NHS Foundation Trust

SEIPS Interaction Map

Technology & Tools

Person(s)

Organisation of Work

Tasks

Environment

Item 8 – Patient Safety Incident Response Plan

Appendix C.3

Report Template

Gateshead Health NHS Foundation Trust

Patient Safety Incident Investigation (PSII) Report

On completion of your final report, please ensure you have deleted all the blue information boxes and green text.

Notes on the PSII template

This national template is designed to improve the recording and standardisation of PSII reports and facilitate national collection of findings for learning purposes. This format will continue to be evaluated and developed by the National Patient Safety Team.

General writing tips

A PSII report must be accessible to a wide audience and make sense when read on its own. The report should:

- use clear and simple everyday English whenever possible
- explain or avoid technical language
- use lists where appropriate
- keep sentences short.

PSII file name: **Use local naming convention. Always include the version number and/or document status**

Incident ID number:	
Date incident occurred:	
Report approved date:	
Approved by:	

Distribution list

List who will receive the final draft and the final report (eg patients/relatives/staff involved¸ board). Remove names prior to distribution.

Name	Position

Contents

To update this contents table, click on the body of the table; select ‘update field’; and then ‘update page numbers only’; and then click ‘ok’.

About patient safety incident investigations

Patient safety incident investigations (PSIIs) are undertaken to identify new opportunities for learning and improvement. PSIIs focus on improving healthcare systems; they do not look to blame individuals. Other organisations and investigation types consider issues such as criminality, culpability or cause of death. Including blame or trying to determine whether an incident was preventable within an investigation designed for learning can lead to a culture of fear, resulting in missed opportunities for improvement.

The key aim of a PSII is to provide a clear explanation of how an organisation's systems and processes contributed to a patient safety incident. Recognising that mistakes are human, PSIIs examine 'system factors' such as the tools, technologies, environments, tasks and work processes involved. Findings from a PSII are then used to identify actions that will lead to improvements in the safety of the care patients receive.

PSIIs begin as soon as possible after the incident and are normally completed within three months. This timeframe may be extended with the agreement of those affected, including patients, families, carers and staff.

If a PSII finds significant risks that require immediate action to improve patient safety, this action will be taken as soon as possible. Some safety actions for system improvement may not follow until later, according to a safety improvement plan that is based on the findings from several investigations or other learning responses.

The investigation team follow the Duty of Candour and the Engaging and involving patients, families and staff after a patient safety guidance in their collaboration with those affected, to help them identify what happened and how this resulted in a patient safety incident. Investigators encourage human resources teams to follow the Just Culture guide in the minority of cases when staff may be referred to them.

PSIIs are led by a senior lead investigator who is trained to conduct investigations for learning. The investigators follow the guidance set out in the Patient Safety Incident Response Framework and in the national patient safety incident response standards.

A note of acknowledgement

Notes on writing a note of acknowledgement

In this brief section you should thank the patient whose experience is documented in the report along with contributions from their family and others (including carers, etc) who gave time and shared their thoughts.

You could consider referring to the patient by name or as ‘the patient’ according to their wishes.

Also thank the healthcare staff who engaged with the investigation for their openness and willingness to support improvements.

Executive summary

Notes on writing the executive summary

To be completed **after the main report has been written**.

Incident overview

Notes on writing the incident overview for the executive summary

Add a brief, plain English description of the incident here.

Summary of key findings

Notes on writing the summary of key findings for the executive summary

Add a brief overview of the main findings here (potentially in bullet point form).

Summary of areas for improvement and safety actions

Notes on writing about areas for improvement and safety actions for the executive summary

Add a bullet point list of the areas for improvement highlighted by the investigation and list any safety actions. Note whether the area for improvement will be addressed by development of a safety improvement plan.

Some actions to address identified areas for improvement may already have been designed in existing an organisational safety improvement plan. Note that here.

Areas for improvement and safety actions must be written to stand alone, in plain English and without abbreviations.

Refer to the Safety action development guide for further details on how to write safety actions.

NB: The term ‘lesson learned’ is no longer recommended for use in PSIIs.

Background and context

Notes on writing about background and context

The purpose of this section, where appropriate, is to provide a short, plain English explanation of the subject under investigation – in essence, essential pre-reading to assist understanding of the incident. It might be a description of a pulmonary embolism, aortic dissection, cognitive behavioural therapy, NEWS, etc.

It may also be worth using this section to summarise any key national standards or local policies/guidelines that are central to the investigation.

Description of the patient safety incident

Notes on writing a description of the event

The purpose of this section is to describe the patient safety incident. It should not include any analysis of the incident or findings – these come later.

Think about how best to structure the information – eg by day or by contact with different services on the care pathway.

It should be written in neutral language, eg ‘XX asked YY’ not ‘YY did not listen to XX’. Avoid language such as ‘failure’, ‘delay’ and ‘lapse’ that can prompt blame.

If the patient or family/carer has agreed, you could personalise the title of this section to ‘[NAME]’s story/experience’.

Investigation approach

Investigation team

Role	Initials	Job title	Dept/directorate and organisation
Investigation commissioner/convenor:			
Investigation lead:			

Summary of investigation process

Notes on writing about the investigation process

If useful, you should include a short paragraph outlining the investigation process:

- how the incident was reported (eg via trust reporting system)
- how agreement was reached to investigate (eg review of patient safety incident response plan, panel review, including titles of panel members)
- what happened when the investigation was complete (eg final report approved by whom)?
- how actions will be monitored.

Terms or reference

Notes on writing about scope

In this section you should describe any agreed boundaries (that is, what is in and out of scope) for the investigation. For example, you might want to note:

- the aspects of care to be covered by the investigation
- questions raised by the those affected that will be addressed by the investigation

If those affected by the patient safety incident (patients, families, carers and staff) agree, they should be involved in setting the terms of reference as described in the Engaging and involving patients, families and staff after a patient safety incident guidance.

A template is available in the learning response toolkit to help develop terms of reference.

Information gathering

Notes on writing about information gathering

The purpose of this section is to provide a short overview of your investigation approach. You should include a brief overview of your methods including:

- investigation framework and any analysis methods used. Remember to keep jargon to a minimum (eg the investigation considered how factors such as the environment, equipment, tasks and policies influenced the decisions and actions of staff)
- interviews with key participants (including the patient/family/carer)
- observations of work as done
- documentation reviews, eg medical records, staff rosters, guidelines, SOPs
- any other methods.

Recorded reflections, eg those used for learning portfolios, revalidation or continuing professional development purposes, are **not suitable** sources of evidence for a systems-focused PSII.

Statements are not recommended. Interviews and other information gathering approaches are preferred.

Findings

Notes on writing your findings

The purpose of this section is to summarise your analysis of the information you have gathered and to state the findings you have drawn from that analysis.

You may choose to include diagrams and/or tables to communicate your analytical reasoning and findings.

Do not re-tell the story in the description of the patient safety incident. This section is about the 'how' the incident happened, not the 'what' and 'when'.

Start with an introductory paragraph that describes the purpose of the section and structure you are going to use.

For your findings to have impact you will need to communicate them in a clear and logical way. Before you start, think about how best to structure the section, then make a plan.

You may find sub-headings useful. The structure you choose will depend on your investigation, but you could organise the information as follows:

- by the themes you have identified during the investigation – in which case put your strongest theme first
- following the framework or the analytical method you used
- in chronological order corresponding to the care pathway described in the reference event, eg community care, ambulance service, acute care (taking care not to repeat the story of the reference event)
- in order of the main decision points during the incident.

Use clear, direct language, eg 'The investigation found…'

If the section is long and contains multiple sub-sections, consider adding a summary of key points at the end of each sub-section.

Technical terms should be kept to an absolute minimum. If they are required, you should explain them in the text (glossaries should be avoided).

Include your defined areas for improvement and safety actions (where appropriate) in the relevant places in this section.

Areas for improvement that describe broader systems issues related to the wider organisation context are best addressed in a safety improvement plan. You should describe what the next stages are with regards to developing a safety improvement plan that will include meaningful actions for system improvement.

Summary of findings, areas for improvement and safety actions

Notes on writing the final summary

The purpose of this section is to bring together the main findings of the investigation.

Areas for improvement and associated safety actions (if applicable) should be listed using the table provided (also available in Appendix B of the safety action development guide).

If no actions are identified the safety action summary table is not required. Instead you should describe how the areas for improvement will be addressed (eg refer to other ongoing improvement work, development of a safety improvement plan)

Safety action summary table

Area for improvement: [eg r*eview of test results*]								
	Safety action description *(SMART)*	**Safety action owner** *(role, team directorate)*	**Target date for implementation**	**Date Implemented**	**Tool/measure**	**Measurement frequency** *(eg daily, monthly)*	**Responsibility for monitoring/ oversight** *(eg specific group/ individual, etc)*	**Planned review date** *(eg annually)*
1.								
2.								
…								

Area for Improvement: [eg *nurse-to-nurse handover*]								
	Safety action description *(SMART)*	**Safety action owner** *(role, team directorate)*	**Target date for implementation**	**Date Implemented**	**Tool/measure**	**Measurement frequency** *(eg daily, monthly)*	**Responsibility for monitoring/ oversight** *(eg specific group/ individual, etc)*	**Planned review date** *(eg annually)*
1.								
…								

Appendices

Notes on appendices

Include any necessary additional details such as explanatory text, tables, diagrams, etc (Delete this section if there are none).

References

Notes on references

Include references to national and local policy/procedure/guidance, and other data sources as required.

Item 8 – Patient Safety Incident Response Plan

Appendix C.4

Themed Review Template

Themed Review (TV) template

What is this for?

A themed review may be useful in understanding common links, themes, or issues within a cluster of investigations or incidents. It will seek to understand key barriers or facilitators to safety using reference cases (e.g. individual datix incidents or previous investigations).

What may benefit a themed review?

Grouped incidents, for example from the same portfolio like pressure ulcers, falls or deteriorating patient, may benefit from a themed review because they take the same safety concern and identify different reference cases and contexts. This helps the organisation make sense of the safety concern at different points of the system and with different aspects of variability e.g. staffing issues, high volume of acute patients. This is important, because safety incidents may occur when systems are 'pushed' or 'pressurised' and therefore our view of safety needs to be flexible to the variability around the context.

What should the output of a themed review be?

Themed reviews may identify fallibilities of the components of a safety system. For example, it may be that across all the reference cases a risk assessment was completed but the preventative measures were not actioned. Outputs of themed reviews can highlight these problems and identify safety recommendations. Themed reviews may provoke more questions than answers, and therefore may be best placed to link in to a quality improvement project for ongoing monitoring and PDSA-style improvement cycles. A themed review should be viewed as a diagnostic tool to help diagnose problems in the system, and therefore doing a themed review should **always** result in some improvement efforts after this diagnosis.

What are the stages of a thematic review?

Stage 1: Description of the reference cases
Stage 2: Description of the safety system
Stage 3: Relevant context to each reference case and key problems
Stage 4: Common themes across the reference cases – narrative analysis
Stage 5: Safety recommendations and future work

For more information or assistance with the template, please contact the author of this template Dr Samantha Machen (s.machen@nhs.net)

Stage 1: Description of the reference cases

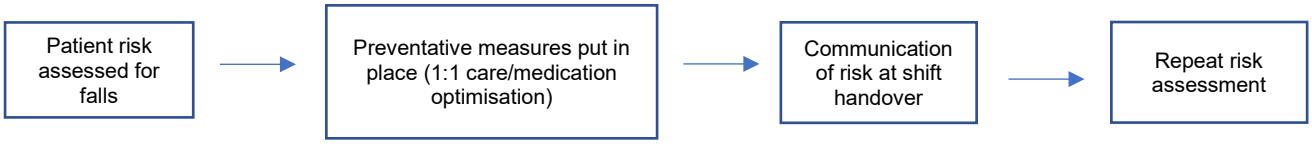
(In this stage, use the table below to list the reference cases using the headings. Remember, reference cases are the different incidents you are including in the themed review)

Date	Datix number	Harm	Description	Investigation level	Actions taken
Date of reference case	*Datix number for reference case*	*Harm level for reference case*	*Description of incident and findings of investigation (if applicable)*	*Level of investigation done (e.g. local investigation/RCA)*	*Actions taken as a result of individual incidents e.g. any recommendations/action plans from RCAs*

Stage 2: Description of safety system

(In this stage, describe the system of safety for the problem. That is, what safeguarding is in place to ensure patients' safety? This could be a list or a diagrammatic flow chart. Where there may be different systems in place (e.g. different processes for different locations or multiple safety risks), break them down in the box below.

E.g. A system of safety for falls below:



E.g. System of safety for deteriorating patient:

- Patient identified as being at risk of deterioration (clinical notes/observations)
- Clinical task of collecting observation data and calculating (NEWS2 score)
- Preventative/clinical measures put in place (e.g. increased observations/sepsis bundle)
- Senior review of deteriorating patient

System of safety for specific safety risk:

What is the difference between the incidents and the expected safety system? Use the template below to help identify across the different reference cases.

E.g. Safety barrier 1: Risk assessment for VTE

What is supposed to happen? *Risk assessment done within X hours*
What did happen? *Risk assessment delayed by Y hours*
Why did this happen? *Junior doctor not aware of need to do risk assessment before prescribing enoxaparin and is used to prescribing it for all patients. Limited time to do assessment before prescription given volume of patients in the ED department and pressure to reconcile medications*
What can we learn from this? Importance of risk assessments prior to prescription was not clear to this prescriber. Need to identify why this is. Tendency to prescribe enoxaparin as a departmental norm.

Safety barrier 1:

What was supposed to happen?	**What did happen?**
Why was there a difference?	**What can we learn from this?**

Safety barrier 2:

What was supposed to happen	**What did happen**
Why was there a difference?	**What can we learn from this?**

Safety barrier 3:

What was supposed to happen?	What did happen?
Why was there a difference?	**What can we learn from this?**

Safety barrier 4:

What was supposed to happen?	What did happen?
Why was there a difference?	**What can we learn from this?**

Safety barrier 5:

What was supposed to happen?	What did happen?
Why was there a difference?	**What can we learn from this?**

Stage 3: Relevant context to each reference case and key problems

This stage refers to contributory factors (as classified by the contributory and mitigating factors classification here: https://www.england.nhs.uk/wp-content/uploads/2020/08/PSII_Contributory_and_Mitigation_Factors_Classification.pdf)

For each incident, mark down the external context factors, organisational and strategic, workplace, equipment, and task factors that affected the safety incident. All components that fall under each group can be seen below.

External context factors	Components
National guidelines and policies	• Impact of national policy/guidance (DHSC/professional colleges, etc) • Locum/agency policy and usage • Contractor related
Economic and regulatory context	• Service provision • Bed occupancy levels (opening/closures) • Private finance initiative related • Equipment loan related • Financial constraints • Resource constraints
Societal factors	• Values • Beliefs

Organisational and strategic	Components
Structure	• Hierarchical structure (discussion, problem-sharing, etc) • Roles, responsibilities and accountability • Multidisciplinary working • Clinical/managerial approaches • Maintenance • Service-level agreements/contractual arrangements • Safety terms and conditions of contracts
Priorities/resource	• Safety focus • Finance focus • External assessment focus • Workforce resource management • Estates and technology resource management
Safety culture	• Safety/efficiency balance • Commitment to safety • Openness of culture and communication • Risk tolerance • Approach to escalation of concerns • Leadership response to whistleblowing
Policy, standards and goals	• Organisational processes (formal) • Organisational processes (informal) • Processes between/spanning organisations

Operational management factors	Components
Safety focus	• Rule compliance • Dealing with risks from past incidents • Awareness of current practice • Adherence to current practice • Empowerment of staff to act
Work planning and delivery	• Risk management plans • Scheduling • Incentive schemes • Contingency planning
Staffing levels and skill mix	• Skill mix • Staff to patient ratio • Workload/weighting/dependency • Temporary staff • Staff turnover
Workload, shift patterns, hours of work	• Working hours • Work breaks • Workload (under/over/balanced) • Extraneous tasks • Social relaxation, rest and recuperation
Training design	• Training needs analysis • Training design • Training/education content • Targeted training • Style of delivery • Time of day provided
Training availability/accessibility	• Training availability/accessibility • Core skills training • On the job training • Emergency scenario training (skills drills) • Team training • Refresher training
Staff supervision	• Orientation • Personal supervision • Monitoring of supervision (assessment) • Mentorship
Staff competence	• Knowledge • Skill • Experience • Familiarity with task • Competence testing and assessment

Workplace factors	Components
Environmental factors	• Capacity • Fixture or fitting • Separation • Safety • Cleanliness/hygiene • Temperature • Lighting • Noise levels • Distractions (audio) • Distractions (visual) • Ligature/anchor points
Design of physical environment	• Work area design (eg size, shape, visibility, screens, space, storage) • Security provision • Lines of sight • Use of colour contrast/patterns (walls/doors/flooring, etc) • Space design (adjustable furniture, panic buttons, positioning, etc)
Administrative factors	• Administrative work systems • Administrative infrastructure (phones, bleep systems, etc) • Administrative support

Equipment and technology factors	Components
Displays	• Information/feedback available • Information clarity • Information consistency • Information legibility • Information Interference • Information displays (colour, contrast, anti-glare screens, etc)
Integrity and maintenance	• Working order • Reliability • Safety features (fail to safe, etc) • Maintenance programme • Emergency back-up services (power, water, piped gases, etc)
Positioning and availability	• Availability • Accessibility • Position/placement • Storage • Emergency backup equipment
Usability/design	• Controls • Intuitiveness • Use of colour • Use of symbols • User manual • Detectability of problems • Use of items which have similar names or packaging • Compatibility

Team and social factors	Components
Culture	• Approach to newcomers • Approach to adverse events • Approach to conflict • Approach to rules/regulations • Approach to seeking support • Approach to interprofessional challenge • Interpersonal relationships • Power relationships
Team structure and consistency	• Shared understanding • Familiarity • Mutual respect • Clarity of roles and responsibilities • Congruence of roles and responsibilities • Informal support networks
Leadership	• Clinical leadership • Managerial leadership • Leadership impact • Leadership decision-making • Timeliness of leadership action • Respect for leadership • Formal support networks for staff
Communication management	• Communication strategy and policy documents • Involvement of patient/family/carers in treatment and decisions • Communication of risks to patient/family/carers • Communication of risks to staff • Communication of risks to the board • Information from patient/family/carers • Communication flow to staff up, down and across • Communication with other agencies (partnership working) • Measuring effectiveness of communication
Verbal communication	• Tone of voice • Style of verbal communication delivery • Use of language • Specificity • Direction • Channel/route • Verbal communication aids/equipment
Written communication	• Readability • Accessibility/availability • Collated • Completeness • Contemporaneous • Accuracy • Currency • Circulation of written information • Patient identification • Information to patients
Non-verbal communication	• Body language/gestures/facial expression

Task factors	Components
Clinical condition	• Pre-existing co-morbidities • Complexity of condition • Seriousness of condition • Options available to treat condition
Plans, guidelines, policies, procedures and protocols	• Informative • Instructional • Representative • Routine use • Usability • Currency • Accuracy • Availability • Accessibility (ambiguous, complex, irrelevant, incorrect) • Monitoring • Review • Targeting/focus (ie audience)
Decision-making aids (information/results/ tools/machines, etc)	• Available • Accessible • Working • Accurate • For prioritisation of tasks • Access to specialist advice • Access to technical information, flow charts and diagrams
Procedural or task design and clarity	• Task complexity • Task memorability • Understandable • Agreed with staff (feasibility) • Time allocation • Task sequencing/stage sequencing • Workload (under/over/balanced) • Compatibility of tasks/task stages • Competing task demands • Feedback from the task • Transferability to/from other situations • Influence on task/outcome • Automation • Audit, quality control, quality assurance

Individual patient factors	Components
Physical factors	• Physical health/condition • Nutrition/hydration • Age related • Body mass related
Social factors	• Cultural/religious beliefs • Language/communication • Lifestyle choices • Life events • Living accommodation • Support networks • Social protective factors (relevant to mental health services) • Risk tolerance • Engagement/motivation/compliance/concordance • Interpersonal relationships (staff-patient; patient-family; staff-family)
Psychological factors	• Mental health • Mental capacity • Learning disability • Intent (relevant to mental health services)

Individual staff factors	Components
Physical health	• General health (nutrition, hydration, wellness, fitness) • Health related conditions (eg eyesight, dyslexia)
Psychological/mental health	• Mental health • Mental alertness • Motivation level (boredom, complacency, low job satisfaction)
Social domestic factors	• Domestic (family related) • Lifestyle (financial, housing, etc) • Language
Personality factors	• Confidence • Risk awareness/risk tolerance
Social factors	• Motivation and values • Beliefs and expectations • Attitudes • Habits
Cognitive factors	• Focus/attention • Perception • Reasoning and decision-making • Group influence • Workload (underload/overload/well-balanced)

Mark the factors that affected each reference case based on the description above:

Causal Factors	Domain	Components	Contributory, Causal and Mitigating Factors Analysis – for identified PROBLEMS/WEAKNESSES and STRENGTHS									
Incident numbers			1	2	3	4	5	6	7	8	9	10
CONTRIBUTORY and MITIGATING FACTORS Described as they relate to the **PROBLEMS/WEAKNESSES and STRENGTHS** identified (NB: There may be none, one or more CF/MF in each category)	**External Contextual Factors**	*National guidelines and policies*										
		Economic and regulatory context										
		Societal factors										
		Total										
	Organisational Strategic Factors	*Structure*										
		Priorities/resource										
		Safety culture										
		Policies, standards, and goals										
		Total										
	Operational Management Factors	*Safety focus*										
		Workplanning and delivering										
		Staffing levels and skill mix										
		Workload, shift pattern, hours of work										
		Training										
		Staff supervision										
		Staff competence										
		Total										
	Workplace Factors	*Environmement factors*										
		Design of physical environment										
		Administrative factors										
		Total										
	Equipment & Technology Factors	*Display*										
		Integrity and maintenance										
		Positioning and availability										

		Usability/design										
	Total											
	Team & Social Factors	*Culture*										
		Team structure and consistency										
		Leadership										
		Communication management										
		Verbal communication										
		Written communication										
		Non-verbal communication										
	Total											
	Task Factors	*Clinical condition*										
		Plans/policies/procedures in place for task										
		Decision making aids										
		Procedual or task design and clarity										
	Total											
	Individual Patient Factors	*Physical factors*										
		Social factors										
		Psychological factors										
	Total											
	Individual Staff Factors	*Physical health*										
		Psychological factors										
		Social/domestic factors										
		Personality factors										
		Social factors										
		Cognitive factors										
Incident numbers			**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Stage 4: Narrative analysis

Use the space below to compile narrative data surrounding the above sections. For example, if 2 or more incidents have a X by the group, then clarify the similarities/differences in the boxes below:

External Contextual Factors	*E.g., How did national guidelines affect the reference cases?*
Organisational Strategic Factors	*E.g., How did local guidelines/organisational resource affect the reference cases?*
Operational Management Factors	*E.g., How did local organisational level factorsl (e.g. staffing, skill mix, training, and staff supervision) affect the reference cases?*
Workplace Factors	*E.g., How did environment factors/design of workplace affect the reference cases?*
Equipment & Technology Factors	*E.g., How did equipment/technology affect the reference cases?*
Team & Social Factors	*E.g., How did local team dynamics/team culture/leadership/communication affect the reference cases?*
Task Factors	*E.g., How did task clarity/decision-making prompts affect the reference cases?*

Individual Patient Factors	*E.g. How did individual patient factors (e.g. acuity/clinical/psychological) affect the reference cases?*
Individual Staff Factors	*E.g. How did individual staff factors (e.g. social/psychological) affect the reference cases?*

Stage 5: Safety recommendations

In this section, linking to the sections above, list the safety recommendations based on this thematic review.

Different types of safety recommendations:

Category	Definition	Example
Fix	Resolve problems in reliably doing what we said we would do. These were usually issues that could be resolved with rapid operational changes.	Linear or more 'simple' things you can do to help the process. E.g., if you identify that there are conflicting local policies which meant a clinician was confused with the task, then the **fix** would be to resolve the confusion by rewriting the policy
Improvements	Find better ways of delivering standard care; improve what is currently being done.	Where improvement need to be made in an already defined process. This may be linked to a Quality Improvement (QI) project and should involve metrics to measure improvements.
Changes	Significant changes in clinical or operational practice.	Where a system, process, or pathway needs to change. N.b. this should be based on multiple cases of evidence, rather than being linked to one case. Where change is needed, an output may be a task and finish group, and this will involve multiple stakeholders.
Further insight	Where investigations have resulted in more questions relating to a safety issue, it may be appropriate for a safety recommendation to involve gaining more insight	If you do an investigation for a particular safety risk but are not sure of the scale of the problem or the mechanism of action then collecting further data may then help identify safety recommendations later.

Safety recommendation	**Category** (Fix/improvement/change/further insight)	**Date Due**	**Evidence**	**Owner**

Item 8 – Patient Safety Incident Response Plan

Appendix C.5

Falls Review Tool

Rapid Review
Date: / /
Completed by:

NHS
Gateshead Health
NHS Foundation Trust

Inpatient Falls
Investigation Report

The **Standard Operating Procedure** for the investigation of an inpatient fall which has resulted in moderate, severe harm, or death.

1. Incident details			
Name & DOB of person affected:		Unit Number:	
Business Unit & Ward:			
Date & time of fall		Injury sustained:	
Reported Harm level:		Datix Number:	
Harm level suggested by STG :			
Serious Incident:	Yes / No	StEIS Reference:	
Actual Harm following investigation:			

2. Investigation Team		
Name	**Job title**	**Date safety meeting**

3. Duty of Candour – *complete for all Incidents of moderate harm and above*	
Has the patient/relative been fully informed of the incident and DoC letter sent? If no please do ASAP	
Have the family been offered an opportunity to discuss the findings following completion of the investigation?	
By whom:	

(member of staff name and designation)	
Do patient/family require a copy of the final investigation report?	
Where is the patient now and how are they progressing/rehabbing?	

4. Summary of incident		
	SITUATION – ***brief description of incident***	
	BACKGROUND - ***Give brief history of the patient's clinical status, past medical history and falls history***	
	Patient Voice – Any feedback from the patient regarding the fall (if appropriate)?	
	Date/Time	**Action/Event**
	Date/time of admission to QEH	
	Date/time transfer to ward:	
	Date and Time of Fall:	

5. Assessment of Falls Risk – *identification of gaps in standards of care*		*Care Delivery Problem (**CDP**) and Service Delivery Problem (**SDP**), Potential Learning (**PL**)				
What should have happened – *for further guidance on standards refer to the Trust guideline for the prevention of falls*		**What actually happened**			**Explanation of the gaps in care identified**	***CDP/ SDP/PL**
Falls Risk Assessment		**Yes**	**No**	**NA**	**Did the gaps in care contribute to the fall?**	
1.	Was the correct Falls Care Bundle put in place and was the patient assessed within 12 hours of admission?	☐	☐	☐		
2.	Was the patient identified as being at risk of falls (on E-record and verbally on handover)	☐	☐	☐		
3.	Was the bedrails risk assessment completed?	☐	☐	☐		
4.	Was the bedrails risk assessment outcome accurate?	☐	☐	☐		
5.	If applicable, was Nurse Rounding/cohorting/1-1 care implemented?	☐	☐	☐		
6.	Were there any gaps in documentation (either Falls Care Bundle or Nurse Rounding)?	☐	☐	☐		
7.	Was the Falls Assessment/Care bundle completed as per policy (i.e. admission, weekly and post fall)?	☐	☐	☐		
8.	Was the Post Fall Evaluation completed fully (if not, provide details of gaps in documentation)?	☐	☐	☐		
9.	Was the Post Fall Medical review completed fully (if not, provide details of gaps in documentation)?	☐	☐	☐		
10.	Was the Post Fall Medical review undertaken in the appropriate timescale? (patient seen within 30 mins for suspected moderate/severe injuries (fractures, head injuries) and within 12 hours for no/minor injuries (cuts, bruises, abrasions)	☐	☐	☐		
11.	Was appropriate manual handling undertaken? For example, if a hip fracture suspected/sustained, was the Hover Jack used?	☐	☐	☐		

Patient Risk Factors		Yes	No	NA		
12.	Admitted with a fall or history of falls within the last 12 months, or fallen since Admission?	☐	☐	☐		
13.	Was lying and standing BP performed? (all patients aged over 65, all patients complaining of dizziness, and all patients who have fallen should have a L&S BP recorded within 12 hours of admission)	☐	☐	☐		
14.	Does the patient have postural hypotension?	☐	☐	☐		
15.	Medications (either high risk medications or polypharmacy – taking 4 or more medications)	☐	☐	☐		
Mobility		**Yes**	**No**	**NA**		
16.	Reduced mobility or altered gait (include change in mobility status if usually independent)	☐	☐	☐		
17.	Had a Physiotherapy assessment taken place and interventions implemented?	☐	☐	☐		
18.	Was the patient mobilising against advice?	☐	☐	☐		
Continence		**Yes**	**No**	**NA**		
19.	Was the appropriate continence plan of care in place? Incontinent of: Urine / Faeces / Both /	☐	☐	☐		
20.	Was Nurse rounding implemented and performed?	☐	☐	☐		
Nutrition		**Yes**	**No**	**NA**		
21.	Was the Nutritional risk assessment undertaken within 24 hours of admission and when condition changed?	☐	☐	☐		
22.	Was the nutritional risk assessment accurate?	☐	☐	☐		
23.	Did the nutritional risk assessment lead to an appropriate plan of care?	☐	☐	☐		

24.	Was the patient dehydrated?	☐	☐	☐		
25.	Was there evidence of measures taken to maximise hydration?	☐	☐	☐		
Environmental factors		**Yes**	**No**	**NA**		
26.	Did environmental factors contribute to the fall? (including whether walking aid in use or not, wet floor, trip hazard)	☐	☐	☐		
Cognition & Communication		**Yes**	**No**	**NA**		
27.	Did the patient have any confusion which may have inhibited patients' ability to follow falls prevention interventions; was the patient concordant with fall prevention care? (Use of buzzer etc.)	☐	☐	☐		
28.	Was the patient/Family given information regarding falls prevention?	☐	☐	☐		
29.	If barriers to communication were present, was appropriate support in place?	☐	☐	☐		
30.	Did the patient have any visual impairment which may have contributed to the fall? If so, what was in place to support the patient?	☐	☐	☐		
31.	Did the patient have a hearing impairment which may have contributed to the fall? If so, what was in place to support the patient?	☐	☐	☐		
32.	If not concordant, were other experts or family accessed to provide support? E.g. Clinician, Sister, Matron, NOK, carer, Specialist Nurse (Dementia Care).	☐	☐	☐		

AFLOAT Score (At time immediately before fall)	Yes	Score
Confused (delirium/dementia)	☐	+1
Unsteady when standing/mobilising	☐	+1
Previous falls	☐	+1
Urinary/faecal urgency	☐	+1
Postural hypotension	☐	+1
Inpatient fall this admission	☐	+2
Completely immobile/unconscious	☐	-3
Total Score		

Level of Observation (Enhanced Care - EC)		AFLOAT Points	AFLOAT Score (Suggested EC)	Enhanced care at time of fall (Actual EC)
Level 1	2 Hourly (Rounding)	≤0	☐	☐
Level 2	Hourly (Rounding)	1-2	☐	☐
Level 3	Line of sight (cohort)	3-5	☐	☐
Level 4	Arms Reach (1 to 1)	≥ 6	☐	☐

6. Staff support	
Support required/provided for staff involved in the incident:	

7. Investigation findings

Analysis of incident (please describe the patient journey/story and findings from review)

Good Practice Identified

8 Organisational findings

Further factors:		Explanation of the gaps in care identified	*CDP/ SDP/PL
Staffing			
1.	Over the period of this patient's stay have nursing staffing levels/skill mix been adequate? If no, has this impacted on this patient's care?		
2.	Had the patient been assessed using the AFLOAT (Avoiding Falls Level of Observation) tool? This is used for patients that require more than a general level of observation with the aim to reduce risk and protect the patient.		
Learning from previous incidents			
3.	What is the incidence of falls for this ward in the last 12 months?		

4.	Has there been a significant variation in incidence of falls (increase/decrease) or level of harm?		
5.	Has the ward effectively implemented action plans from previous investigations? / Evidence of doing so?		

9 Learning identified

Care and Service Delivery Problems	KEY contributory factors	Recommendations

10. Falls Serious Investigation Panel		
Level of Investigation decision		
Rationale for level of investigation		
Terms of Reference for investigation		
11. External notification requirements		
Safeguarding referral required? Record rationale for safeguarding alert		
Other notification required? Eg RIDDOR		
Date SI reported to CCG		StEIS No:

12. Improvement Action Plan SMART Objectives, Specific, Measurable, Achievable, Relevant and Time Bound

	Specific Recommendation	Specific actions required to implement the recommendation	Lead(s)	**Completion Date** Name and job title required for the Lead for each action	What are we hoping to achieve?	How will we know we've achieved it?
1.		•				
2.		•				

13. Report approval and sign-off

Sign-off	Date
Falls SI Panel (within 25 working days) – *quality assurance review*	
Head of Risk and Patient Safety– final approval (within 30 working days)	

14. Dissemination of Rapid Review Report

Arrangements for sharing of learning

Within the specific ward/department where the incident occurred or where improvement actions are required, Ward/Department Managers are expected to share this report with all of the staff. Ward/Department Managers and Matrons must ensure their staff receive effective support to ensure they understand the findings of the investigation and the required improvement actions.

Trust distribution list

- Deputy Director of Nursing
- Matrons/Chief Matrons
- Directorate Managers/Service Line Manager/Assistant Service Line Manager

Item 9i – F&P Committee – NHS Impact Self-Assessment

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 13

Report Title:	**NHS Impact – Self Assessment**			
Name of Meeting:	Finance and Performance Committee			
Date of Meeting:	26th September 2023			
Author:	Kirsty Roberton, Deputy Director Corporate Services and Transformation			
Executive Sponsor:	Trudie Davies, CEO			
Report presented by:	Kirsty Roberton, Deputy Director Corporate Services and Transformation			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☒	**Discussion:** ☐	**Assurance:** ☐	**Information:** ☐
	NHS IMPACT (Improving Patient Care Together) has been launched to support NHS organisations and systems to have the skills and techniques to deliver continuous improvement. It will inform the ways of working across services at every level including NHS England. Integrated care board (ICB) and provider leaders have asked for a jargon free NHS IMPACT self-assessment. This should help systems, providers and partners understand where they are on their journey to embed each of the five components of NHS IMPACT. It should allow organisations to identify their strengths and opportunities for development when applying an organisational/system wide approach to improvement, and it will allow for a complete national picture to develop NHS IMPACT support and activities accordingly. In the first instance, this self-assessment focuses on NHS acute and mental health trusts. Once approved by Finance and Performance the submission will be completed by the 31st October deadline.			
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*	EMT – 21st August 2023 SMT – 14th September 2023 for comments and approval			

<table>
<tr><td>Key issues:
Briefly outline what the top 3-5 key points are from the paper in bullet point format

Consider key implications e.g.
• Finance
• Patient outcomes / experience
• Quality and safety
• People and organisational development
• Governance and legal
• Equality, diversity and inclusion</td><td colspan="2">A draft self assessment is attached and for discussion by SMT alongside a development plan which will be incorporated into the final Service Improvement Strategy.

The development plan will be implemented in collaboration with other corporate services as there is clear dependencies and alignment to existing work underway eg planning, culture, leadership etc

The self assessment asks a number of questions against the 5 key areas as follows:

1. Building a shared purpose and vision
2. Building improvement capability
3. Developing Leadership Behaviours for improvement
4. Invest in culture and people
5. Embedding a Quality Management system

The initial assessment carried out indicates in most areas the organisation are developing with some areas spreading. One specific improvement area that requires focus is engagement with people with Lived experience and co-production.

The improvement strategy has been in development and will aim to incorporate the NHS Impact to support the organisation to embed a continuous improvement culture.

The improvement strategy will be presented to SMT and Finance and Performance Committee in October 2023

The trust framework (the house) has already been aligned to the NHS impact at a strategic level.</td></tr>
<tr><td>Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper</td><td colspan="2">F&P committee to approval assessment and development plan and agree final submission to be completed by the 31st October deadline.</td></tr>
<tr><td rowspan="4">Trust Strategic Aims that the report relates to:</td><td>Aim 1 ☒</td><td>We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>Aim 2 ☒</td><td>We will be a great organisation with a highly engaged workforce</td></tr>
<tr><td>Aim 3 ☒</td><td>We will enhance our productivity and efficiency to make the best use of resources</td></tr>
<tr><td>Aim 4 ☒</td><td>We will be an effective partner and be ambitious in our commitment to improving health outcomes</td></tr>
</table>

	Aim 5 ☐	We will develop and expand our services within and beyond Gateshead
Trust corporate objectives that the report relates to:	SA1.2 Develop and implement a continuous Quality improvement plan that enables the delivery of improved performance against key indicators by March 2024 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 SA2.3 Being a great place to work in order to improve staff survey outcomes and impact upon patient outcomes within 2-years. 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	

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

NHS Impact – Self Assessment

To be completed by 31st October. This self-assessment will be taken to September 2023 Board and shared with the ICB.

NHS IMPACT (Improving Patient Care Together) has been launched to support NHS organisations and systems to have the skills and techniques to deliver continuous improvement. It will inform the ways of working across services at every level including NHS England.

Integrated care board (ICB) and provider leaders have asked for a jargon free NHS IMPACT self-assessment. This should help systems, providers and partners understand where they are on their journey to embed each of the five components of NHS IMPACT.

It should allow organisations to identify their strengths and opportunities for development when applying an organisational/system wide approach to improvement, and it will allow for a complete national picture to develop NHS IMPACT support and activities accordingly.

In the first instance, this self-assessment focuses on NHS acute and mental health trusts.

The self-assessment is as follows:

Section 1 - Building a Shared Purpose and Vision

What this looks like in practice:

- Create a vision and shared purpose in an inclusive and transparent way ensuring meaningful input from all, including those with lived experience. The executive leadership of the organisation must drive this work, but it cannot be designed and created by one team.
- Involve communities and people with lived experience as partners in the design of the vision and shared purpose.
- Find ways to make the vision and shared purpose practical, so that they are lived everyday by its people and are underpinned by core values.
- Ensure all improvement work is focused on the shared purpose and vision and question any work which does not align to these. Start by focusing on the current NHS priorities and your own organisation's context, including the pressures it is facing.
- Create a powerful, purpose-driven context and narrative for improvement work so that people are more likely to engage, based on commitment to the purpose rather than compliance with a process.
- Understand the world in which frontline staff are working, their challenges, their successes, and the improvement they'd like to see to guide this vision and shared purpose, for example through methods of co-design and collaboration like crowd sourcing platforms or engagement events.
- Take account of the current Care Quality Commission 'Well-Led' scores and where there are areas for improvement.
- The shared purpose and vision should allow staff to understand the importance of their work and to see it from the patient or service user's perspective. Celebrate and share good practice where possible.

Q1 Board and Executives setting the vision and shared purpose

○ **Starting**: We are starting to develop a shared vision aligned to our improvement methodology, although only known by a few and not lived by our Executive team. Our organisational goals are not yet aligned with the vision and purpose in a single, strategic plan.

○ **Developing**: Our Board, Executive leaders and Senior Management team can describe a shared vision and purpose that is the start of the process to align these with our organisational goals.

○ **Progressing**: Our Board, Executive leaders and Senior Management team are active and visible in promoting the shared vision and translating it into a narrative that makes it meaningful and practical for staff. Measures have been agreed and defined with a small number of key metrics (e.g. Operations, Quality, Financial and People / workforce).

◉ **Spreading**: Our vision and shared purpose inform our journey and plans, and operational and clinical leaders and teams across our organisation know how they are contributing to, and own, our organisational goals. All employees have been communicated to and understand our shared vision in a way that means something to them.

○ **Improving & Sustaining**: Our vision and shared purpose is well embedded and often referred to by the Board and other leaders, who are able to bring it to life and make the link between their team's priorities and improvement plans and the agreed organisational goals. Most of our staff can describe our vision and shared purpose in their own words and what they can do in their role to contribute.

Q2 Improvement work aligned to organisational priorities

○ **Starting**: Our organisational purpose, vision, values and strategic priorities are in development, but not yet widely communicated to staff. Organisational goals are yet to be defined in a way that enables them to be cascaded to all of our teams.

○ **Developing**: Our organisational purpose, vision, values and strategic priorities are understood by some within our organisation, but generally seen as organisational goals rather than something which is directly meaningful to them.

○ **Progressing**: Our organisational purpose, vision, values and strategic priorities have been translated into agreed organisational goals, and measurement systems have been established. The priorities are well understood by most leaders and managers, which is helping to create organisational alignment.

◉ **Spreading**: Our organisational purpose, vision, values and strategic priorities are visible and understood by leaders, managers and most staff. Our organisational goals have been agreed and measurement systems have been established and are being used across most areas.

○ **Improving & Sustaining**: Our organisational purpose, vision, values and strategic priorities are role modelled and actively reinforced and communicated by leaders and managers, widely understood by most staff across our organisation and translates into improvement activity at team level.

Q3 Co-design and collaborate - celebrate and share successes

○ **Starting**: We are at the early stages of working out what quality or continuous improvement means in our context and how we will apply it systematically. So far engagement has been largely focused on senior leadership.

○ **Developing**: The Board has set a small number of bold aims with measurable goals for improvement, and a communications and engagement plan ensures that staff have at least heard about these goals.

◉ **Progressing**: Our improvement goals are developed and refined through a collaborative engagement process, which at least involves leaders and most managers and a two-way feedback process.

○ **Spreading**: We have an agreed plan for delivery at organisational level which is cascaded through line managers down to team level, based on an established engagement and co-development process and a common approach to improvement. Celebration and learning events are used to recognise and share improvements.

○ **Improving & Sustaining**: Our leaders and managers model collaborative working as part of the organisation's continuous improvement approach. We have an agreed plan for delivery at organisational level that we can systematically track to team level. Celebrate and learning events are an established practice to recognise and share improvements widely.

Q4 Lived experience driving this work

◉ **Starting**: There is an aspiration or stated commitment to engage people using services, unpaid carers, staff and the community in further design of our shared purpose and vision, but it is not yet fully worked through or systematic.

○ **Developing**: People using services, unpaid carers, staff and the community are involved in the design and communication of our shared purpose and vision, and may have a role in setting improvement priorities.

○ **Progressing**: Patients, carers, staff and the public are actively engaged in co-designing organisational purpose, vision, values and setting strategic priorities for improvement.

○ **Spreading**: Patients, carers, staff and the public are actively engaged in setting improvement priorities, including at service, pathway or team level, and in evaluating the impact of improvements from a user perspective.

○ **Improving & Sustaining**: Patients, carers, staff and the public have a voice which influences the strategic improvement agenda and decision making at Board level, including setting the strategic direction of the organisation and wider system.

Section 2 Investing in People and Culture

What this looks like in practice.

- Set the expectation (e.g. through new joiners' welcome and induction process) that all staff should have a common understanding of improvement, that it is a priority for the organisation and that they will be supported to make improvements in their own area of work.
- Engage with people who work in healthcare roles and organisations and those with lived experience to design and implement the improvements based on what matters to them.
- Facilitate opportunities for people to visit other systems and organisations to understand different ways of operating and different organisational cultures.
- Invest in and support people to understand and own their work, enabling them to make improvements in their own area of work.
- Undertake planned and deliberate cultural readiness work prior to any improvement programme or activity, to establish and maintain a shared set of values that everyone can align to.
- Use a coaching-based approach to leadership in areas where improvement is required, encourage idea generation and run PDSA (Plan, Do, Study, Act) cycles regularly. Encourage the use of measurement to evaluate improvements and to learn.
- Have a locally agreed method to measure and assess organisational improvement culture, including drawing on NHS staff survey information, to support organisational development and learning.

Q1 Pay attention to the culture of improvement

○ **Starting**: There is an aspiration or stated commitment at Board level to establish an improvement culture, but it is yet to be worked through even at Board and Executive level.

◉ **Developing**: Our Board is committed to establishing an improvement culture and has plans to put this into practice, including Board development. The organisation has ways of measuring culture change (e.g. using a cultural survey or the NHS staff survey) and readiness for improvement

○ **Progressing**: Our improvement approach considers culture as an integral aspect, including for corporate functions, recognising the value they bring to enabling organisational improvement. The majority of improvement activity starts with ways to actively engage staff and teams from clinical, operational, and corporate services in support of improvement goals and effective delivery of care. Our organisation has ways of measuring culture change and readiness for improvement at departmental or team level.

○ **Spreading**: Leaders and managers at all levels understand their part in establishing a culture consistent with improvement. We consider measures and markers of culture change alongside other ways of evaluating improvement, down to team level. We have established a culture where our staff feel confident and empowered to take part in improvement activity in their own area and talk openly and honestly to leaders and managers when they are 'walking the floor' (e.g. during 'go & see' visits).

○ **Improving & Sustaining**: We have a reputation for having established a culture consistent with improvement, and we can evidence that with data (e.g. NHS staff survey). Teams and departments work collaboratively across organisational boundaries to deliver improvement which benefits people using services and unpaid carers. We recognise leaders, managers and staff who are role models for the kind of behaviour and culture we want to create.

Q2 What matters to staff, people using services and unpaid carers

○ **Starting**: Our ways of understanding what matters most to staff, people using services and unpaid carers tend to be reliant on formal mechanisms (e.g. surveys) and the link to improvement is not strong or systematic.

◉ **Developing**: We understand well as an organisation what matters most to staff, people using services and unpaid carers (e.g. through two-way engagement) and this helps to shape our overall improvement priorities and our approach. Picking up on what matters most to our staff helps to bring us together around a common agenda and creates energy for improvement.

○ **Progressing**: Most of our services and functions have a good understanding of what matters most to staff, people using services and unpaid carers (e.g. through two-way engagement) and this informs their local improvement priorities and activity. Our staff have a voice at Board level to provide feedback on how it feels to work here (e.g. through staff stories, informal interactions, staff networks). Leaders and managers help to translate the needs of patient and carers into improvement priorities or goals.

○ **Spreading**: Most of our teams have a good understanding of what matters most to staff, people using services and unpaid carers (e.g. through two-way engagement) and this informs their local improvement priorities and activity. Most staff feel invested and excited about the opportunities they have to participate in improvement activity which matters to them. People using services have a role in the development, prioritisation and monitoring of delivery of improvement goals

○ **Improving & Sustaining**: Most of our staff can describe what matters most to them, people using services and unpaid carers and how this translates into their local improvement priorities and activity. There is a strong and direct connection between their improvement activity and making things better for people using services, which is energising. People with lived experience often work in close partnership with our teams on improvement activity, helping to focus on what will make the greatest difference.

Q3 Enabling staff through a coaching style of leadership

○ **Starting**: There is some recognition of how a coaching style of leadership helps to encourage improvement, but it is not widely applied.

◉ **Developing**: There is an organisational endorsement of a coaching-style of leadership, but it is not applied systematically (e.g. through leadership training). There are some good examples of how a coaching-based approach can bring about improvement, and this is increasingly recognised and encouraged. Staff are often supported to make changes when doing improvement activities.

○ **Progressing**: A coaching style of leadership is well established with training available for leaders and managers who request it. Leaders and managers are widely engaged in improvement and regularly sponsor improvement activities (e.g. to help unblock issues). Senior leaders participate in improvement, celebration and learning events on a regular basis. Staff generally feel supported and empowered.

○ **Spreading**: Leaders and line managers are trained systematically in coaching and enabling teams to solve problems for themselves. Our Executive leaders act as coaches and teachers of the improvement method for all levels, including role modelling a coaching style. Managers and clinicians participate in improvement, celebration and learning events on a regular basis. Staff talk about feeling more trusted and empowered.

○ **Improving & Sustaining**: A coaching style of leadership is embedded as the default approach throughout the organisation, and it is applied to our greatest challenges. Staff and teams thrive in this environment and take greater ownership of improvement. Our leaders and managers are recognised as effective improvement coaches and are often sought after to lead and support improvements beyond our own organisation.

Q4 Enabling staff to make improvements

○ **Starting**: Improvement activity is limited and may be centralised (e.g. led by a discrete 'improvement team' with relevant skills operating independently). Staff do not generally feel able to make improvements in their own area of work.

◉ **Developing**: Some staff and teams feel able to make improvements (e.g. if they have been trained or are supported by a central team). There may be learning locally but it is generally not shared across teams and departments.

○ **Progressing**: The majority of staff are actively involved in improvement activity and feel able to suggest ideas for improvement and to make changes in their own area.

○ **Spreading**: The majority of teams feel empowered and trusted to carry out improvement activity in their own areas, applying a consistent approach. Our staff understand the factors driving progress (whether positive or negative), and can solve problems effectively

○ **Improving & Sustaining**: Staff and teams are systematically engaged in improvement activity as part of their day to day work and are proactive in sharing the learning, and in looking for ways to collaborate with people with lived experience and other teams and organisations in improvement programmes.

Section 3 Developing Leadership Behaviours

What this looks like in practice:

- Have a clear leadership and management development strategy in place outlining capability requirements and access to training.
- Understand current leadership styles and approaches through board development sessions identifying strengths and gaps for each individual and as a team.

- Create leadership stability and continuity of approach.
- Support leaders and managers across the system to live and breathe the values and behaviours of the organisation and hold leaders and managers to account for behaviours, not just improvement outcomes.
- Clearly agree and outline the support which is in place for people to improve their own services.
- Provide induction, training and development for everyone who has a formal leadership or management role so they have skills and experience of delivering improvements and can role model leading for improvement.
- Encourage board development to better understand how current leadership and management behaviours are demonstrating organisational values, identifying strengths and gaps.
- Engage with peer support networks to understand different approaches to the issues and leadership and management behaviours.
- Empower teams delivering on the ground to carry out and test improvement projects.

Q1 Leadership and management development strategy

○ **Starting**: Our Board, senior leaders and line managers are not yet trained in a consistent and defined improvement approach which they are expected to apply and role model.

○ **Developing**: Our leadership team have started to develop their improvement knowledge and are gaining an understanding in how it can impact their role.

◉ **Progressing**: Our leadership works with managers and teams across the organisation to develop improvement skills and enable and co-ordinate improvement.

○ **Spreading**: Our leadership and management teams actively enable staff to own improvement as part of their everyday work and all teams and staff have had training in improvement.

○ **Improving & Sustaining**: Our Board focus on constancy of purpose through multi-year journey and executive hiring and development, including succession planning. Our Board are visibly linked to future planning at a system level.

Q2 Leadership and management values and behaviours

○ **Starting**: Our leadership values and behaviours and our expectations of managers are not explicitly defined, or do not include reference to an improvement-based approach.

○ **Developing**: Leadership values and behaviours are agreed across our organisation.

◉ **Progressing**: Leadership values and behaviours are agreed, and role modelled by leaders and managers across the organisation.

○ **Spreading**: Leadership values and behaviours are agreed, role modelled and supportively challenged when not lived up to.

○ **Improving & Sustaining**: A clear framework and expectations for leadership and management values and behaviours which are consistent with an improvement-based approach are applied throughout the organisation.

Q3 Leadership and management acting in partnership

○ **Starting**: Our leadership works to competing and misaligned goals lacking in clarity.
○ **Developing**: Most of our leaders work in partnership with their fellow leaders and managers.
◉ **Progressing**: Our leadership team have shared goals with commissioners and work effectively with systems partners.
○ **Spreading**: Our leadership team has shared longer term goals with network partners or commissioners as well as collaborative involvement over wider health economy.
○ **Improving & Sustaining**: Our Board and system focus on constancy of purpose through multi-year journey with improvement at its core.

Q4 Board development to empower collective improvement leadership

○ **Starting**: Our Board discusses improvement at Board meetings, but it is not a regular occurrence.
○ **Developing**: Our Board has received some improvement training and visit to parts of the organisation at least monthly. Improvement is discussed at every Board meeting.
◉ **Progressing**: Our leadership works with managers and teams across the organisation to enable and co-ordinate improvement.
○ **Spreading**: Our leadership and management teams actively enable staff to own improvement as part of their everyday work.
○ **Improving & Sustaining**: Our leaders and managers - Chief Executive Officer through to front line demonstrate their commitment to change by acting as champions of the improvement and management method, by removing barriers and by maintaining a visible presence in areas where direct care / operational work is done.

Q5 Go and see visits

○ **Starting**: Some senior leaders spend time on the ‘shop floor’ from time to time to engage directly with staff and teams but it is not routine or widely practiced.
○ **Developing**: Our leaders understand the importance of 'walking the floor' to 'go & see'; but we have variation in leader participation; some leaders and managers use our improvement tools .
○ **Progressing**: Our Executives regularly 'walk the floor'/'go & see'; they incorporate the tools and methods into their meetings, strategic planning and daily management.

◉ **Spreading**: All levels of leadership and management 'walk the floor'/'go & see' as a matter of routine and the insights they gain informs decision making and problem solving to support improvement.

○ **Improving & Sustaining**: Leaders undertake 'walk the floor'/'go & see' visits for external bodies to visit their site and to observe different ways of working.

Section 4 Building Improvement Capability and Capacity

What this looks like in practice:

- Identify or create an improvement methodology to use across your entire organisation, ensuring a local and systemic way of practising improvement.
- Give all people access to induction, improvement training and support, so that everyone can run improvement projects and continuously improve their daily work.
- Determine how success will be measured at an early stage, use appropriate tools and frameworks, and include feedback from people working at the point of care and people with lived experience.
- Demonstrate the impact of co-producing improvements with people who use services as an integral part of daily work.
- Set an expectation that there is an organisational focus on data and all staff are empowered to make and track changes in their workplace.
- Create and embed a training strategy to increase improvement capability.
- Leaders and managers attend team's daily huddle Boards and work to unblock issues which teams are facing.

Q1 Improvement capacity and capability building strategy

○ **Starting**: We do not have a structured training or capability building approach for improvement skills. Training is ad hoc and focused on small central teams. We have some use of external resources (e.g. Academic Health Science Networks and Institute for Healthcare Improvement Open School).

○ **Developing**: Our improvement methodology has been agreed and the Board has undergone its own development to build literacy around improvement. Staff have access to induction on joining, improvement training and a small group of staff support capability building.

◉ **Progressing**: Training is a balance of both technical skills, behavioural attributes and data analysis. Coaching support is available during and post training and time is given for staff to undertake training and development in the adopted improvement methodology. Some learning is shared across the organisation. A system exists to identify, engage and connect all those people that have existing improvement capability.

○ **Spreading**: Sustainability is addressed via ‘in-house’ training and development approaches including train the trainer models. Improvement capability building for ‘lived experience’ service user partners is underway; they are seen as contributors to improvement teams. The programme is working towards being self-sustaining through developing its own improvement coaches.

○ **Improving & Sustaining**: There is a systematic approach to improvement, and induction and training are provided to every member of staff as part of learning pathways and career progression, including induction and line manager training with >80% coverage. Capability building is self-sustaining, meeting the improvement needs of the organisation. The organisation consistently shares capability, building learning with other sites, regionally and nationally.

Q2 Clear improvement methodology training and support

○ **Starting**: No single improvement methodology has been adopted and only limited sharing of improvement gains/learning is cascaded beyond the immediate area where improvement is underway.

○ **Developing**: There are pockets of capability built by motivated staff with an interest in improvement. We have a training needs analysis which is underway to understand staff development & training needs for NHS IMPACT components, alongside a dosing formula and skills escalator to support capability building ambitions.

◉ **Progressing**: Clarity exists on which improvement methodology and approach is being consistently applied. A longer term commitment exists to a training and development system for building capability at scale. Service users and carers are recognised as key stakeholders.

○ **Spreading**: Training and development are undertaken by all leaders, managers and staff. Learning from all improvement activity is effectively shared across the organisation. Staff, people with lived experience and wider teams are using their skills and knowledge to deliver improvement and cascade improvement techniques to their peers.

○ **Improving & Sustaining**: Learning from improvement activity is driving continuous improvement. There is a common improvement language across the organisation. Knowledge and learning from improvement is highly visible, harvested, collated and shared widely as part of a scaling up and spread strategy.

Q3 Improvements measured with data and feedback

○ **Starting**: Our organisational approach to reviewing and tracking progress against goals has yet to be defined, at present improvement doesn’t feature in whole organisational measures.

○ **Developing**: We are seeing minimal improvement in our organisational measures. We have developed some elements of our organisational approach to reviewing and tracking progress, however this is ad-hoc and stakeholders do not feel it supports them to deliver.

◉ **Progressing**: We are tracking improvement over time for some of our organisational measures. We have a holistic approach to achieving our goals, evidenced by data, centred on problem solving, and management that stakeholders feel is supportive.

○ **Spreading**: Improvement is sustained for most organisational measures. Our goals are reviewed regularly at organisational level and our plans are adapted to ensure they meet the clearly defined goals if required.

○ **Improving & Sustaining**: Sustained improvement over time for all system measures. We understand what is driving performance, (whether positive or negative), and problem solve effectively. Our goals around longer term sustainability are reviewed regularly at organisational level.

Q4 Co-production

○ **Starting:** We have small discrete teams with relevant skills operating independently from one another labelled as clinical governance, service development, clinical audit or transformation, that are working in silos reporting to various directors with no lived experience partners co-producing improvement.

◉ **Developing**: People with lived experience are infrequently co-producing improvement. Learning is captured when doing improvements, but this is rarely shared across departments.

○ **Progressing**: People with lived experience and wider stakeholders are strongly involved in co-designing and co-producing the capability building approach. Staff, people with lived experience and other stakeholders have access to improvement capability development.

○ **Spreading**: Stakeholders including people with lived experience are both supported and challenged to ensure success. We understand the factors driving progress (whether positive or negative), and problem solve effectively together.

○ **Improving & Sustaining**: Stakeholders are both supported and challenged to ensure success. People with lived experience and wider stakeholders are embedded within teams and are an integral part of the capability building process.

Q5 Staff attend daily huddles

○ **Starting**: Any huddles are only traditional shift change clinical handovers.

○ **Developing**: There is a plan in place for team huddles to focus on continuous improvements in all clinical frontline areas with clinical and operational staff in attendance.

◉ **Progressing**: All clinical frontline areas have continuous improvement team huddles established. There is a plan in place to establish continuous improvement team huddles in all operational/support/corporate areas.

○ **Spreading**: All operational/support/corporate areas have continuous improvement team huddles established.

○ **Improving & Sustaining**: There is a cascade of huddles for all teams from Executive to frontline teams (clinical, operational, corporate) which hold regular continuous improvement huddles using a standardised format and process.

Section 5 Embedding Improvement into Management Systems and Processes

What this looks like in practice.

- Develop an explicit management system that aligns with the strategy, vision and purpose of the organisation at Board level and throughout all services and functions.
- Put systems in place to identify and monitor early warning signs and quality risks with clear processes of how to respond to these.
- Set up the management system as a way of standard operating that enables ongoing continuous improvement of access, quality, experience, and outcomes.
- Building a management system which enables the organisation to respond to system and national priorities more easily and with greater agility as the organisation has a consistent and coherent set of management systems and processes.
- A committed Board and senior management team who own and use this approach to manage the everyday running of their organisation, including simple and visual ways of understanding performance with tracking progress.

Q1 Aligned goals

○ **Starting**: Where improvement plans exist they are very locally determined and driven. Our business planning is an activity conducted at Board and senior leadership level but executives and functions goals are often not well aligned with each other.

◉ **Developing**: Our department goals may involve up or downstream departments; we do not share improvement planning across departments. Our business planning is an activity conducted at board and senior leadership level to produce goals that are cascaded top-down to the rest of the organisation.

○ **Progressing**: Our organisational goals are established to support our overall vision; our departmental goals align systematically with those of our organisation. Our business planning process is based on two-way engagement leading to greater local ownership of the goals.

○ **Spreading**: Our organisational and departmental goals are systematically aligned to our overall vision; and we are working to align goals across our system. Our organisational goals are developed using a consistent management system, based on two-way engagement leading to strong ownership of the goals and greater transparency between areas.

○ **Improving & Sustaining**: Our organisational and departmental goals are systematically aligned to our overall vision and that of our system. Individual objectives are clearly linked to the strategic plan through the team, departmental and organisational goals and improvement plans.

Q2 Planning and understanding status

○ **Starting**: Our business planning and performance management processes do not make it easy for us to understand status or progress against our goals. We do not have visibility of what we are working on across the organisation.

○ **Developing**: Our business planning and performance management processes give the Board and senior managers reasonable visibility of status and progress against our goals. There are some routines for selecting and prioritising improvement work. Although we have some resource available there is no defined process for prioritising and allocating resource.

◉ **Progressing**: Our business planning and performance management processes give the Board and most line managers good visibility of status and progress against our goals. There is good visibility of what we are working on across the organisation. We have an agreed approach for selecting and prioritising improvement work. Staff and assets from enabling services (e.g. Human Resources, Finance, Comms, Informatics) are also aligned to our improvement priorities.

○ **Spreading**: Our business planning and performance management processes give good visibility of status and progress against our goals across all departments and teams. We have an agreed and transparent approach for selecting and prioritising improvement work which generally works well. Our supporting resources are assigned to supporting delivery of improvement goals across the organisation in a way that is perceived to be fair and effective. Staff and assets from enabling services (e.g. Human Resources, Finance, Comms, Informatics) are also aligned to improvement priorities and are shared across the system in an agile way.

○ **Improving & Sustaining:** Our business planning and performance management processes give good visibility of status and progress against our goals across all departments and teams, and is considered the 'one version of the truth' across the organisation. We have an agreed and transparent approach for selecting and prioritising improvement work which works well and can flex to meet changing needs. There is complete and timely visibility of what teams are working on across our organisation. There is a co-ordinated approach to review, prioritise and co-ordinate allocation of resources to support pathway-level improvement.

Q3 Responding to local, system and national priorities

○ **Starting**: We do not yet have a coordinated or consistent management approach to how we respond to changing needs, address problems or deliver against our plans. Instead it is perceived as reactive or firefighting.

○ **Developing**: Across the organisation, we believe having a management method (e.g. Lean) is important to our success. Some of our leaders are using management methods daily, which is recognised to be helping.

◉ **Progressing**: Most leaders and managers in the organisation use our management methods to manage and run their departments, including responding to problems that may arise or to take account of changing priorities.

○ **Spreading**: Our management method is well embedded in how we work in all parts of the organisation to team level. As an organisation we are using run charts and statistical process control (SPC) charts not just RAG or tables. Our technology, staff and facility decisions are aligned with our management system goals.

○ **Improving & Sustaining**: All teams use the management method to understand, run and improve each aspect of our organisation; we use data effectively (e.g. SPC) to understand and improve performance. Whether our work is succeeding or is challenged, we strive for continuous improvement.

Q4 Integrating improvement into everything we do

○ **Starting**: Improvement is seen as separate to the day to day delivery of services. Our performance management system is seen as separate from any improvement activity or methods we apply, and may be sending conflicting signals within the organisation.

◉ **Developing**: Improvement is starting to be more integrated with day-to-day delivery and targeted towards particular performance priorities or risks. Improvement activity is contributing to performance in some front-line clinical areas.

○ **Progressing**: Improvement is generally well integrated with day-to-day delivery across the organisation and is increasingly the basis of how we deliver against our performance goals. Improvement activity is contributing to performance in many front-line clinical areas and supporting clinical functions.

○ **Spreading**: As part of our management system, all parts of the organisation are using improvement methods, and learning occurs between areas (e.g. to understand and reduce waste). We have multiple examples of sustained improvement over months and years, not just month-to-month variation.

○ **Improving & Sustaining**: The way we understand, manage and improve performance across the organisation – including how we use and report data – is consistent with our approach to improvement and based on an improvement cycle. We have many examples of sustained improvement, including reference cases recognised beyond our organisation.

END

High level NHS Impact - Development Plan – V0.1 Draft 12th September 2023

	Impact Area	Theme	Aim	Timescale
1	Building a Shared Purpose and Vision	Board and Executives setting the vision and shared purpose	Our vision and shared purpose is well embedded and often referred to by the Board and other leaders, who are able to bring it to life and make the link between	March 2024

			their team's priorities and improvement plans and the agreed organisational goals. Most of our staff can describe our vision and shared purpose in their own words and what they can do in their role to contribute.	
		Improvement work aligned to organisational priorities	Our organisational purpose, vision, values and strategic priorities are role modelled and actively reinforced and communicated by leaders and managers, widely understood by most staff across our organisation and translates into improvement activity at team level.	April 2025
		Co-design and collaborate - celebrate and share successes	We have an agreed plan for delivery at organisational level which is cascaded through line managers down to team level, based on an established engagement and co-development process and a common approach to improvement. Celebration and learning events are used to recognise and share improvements.	June 2024
		Lived experience driving our improvement work	People using services, unpaid carers, staff and the community are involved in the design and communication of our shared purpose and vision, and may have a role in setting improvement priorities.	June 2024

2	**Investing in People and Culture**	Pay attention to the culture of improvement	Our improvement approach considers culture as an integral aspect, including for corporate functions, recognising the value they bring to enabling organisational improvement. The majority of improvement activity starts with ways to actively engage staff and teams from clinical, operational, and corporate services in support of improvement goals and effective delivery of care. Our organisation has ways of measuring culture change and readiness for improvement at departmental or team level.	March 2025
		What matters to staff, people using services and unpaid carers	Most of our services and functions have a good understanding of what matters most to staff, people using services and unpaid carers (e.g. through two-way engagement) and this informs their local improvement priorities and activity. Our staff have a voice at Board level to provide feedback on how it feels to work here (e.g. through staff stories, informal interactions, staff networks). Leaders and managers help to translate the needs of patient and carers into improvement priorities or goals.	Sept 2024
		Enabling staff through a coaching style of leadership	A coaching style of leadership is well established with training available for leaders and managers who request it. Leaders and managers are widely engaged in improvement and regularly sponsor improvement activities (e.g. to	Sept 2024

			help unblock issues). Senior leaders participate in improvement, celebration and learning events on a regular basis. Staff generally feel supported and empowered	
		Enabling staff to make improvements	The majority of staff are actively involved in improvement activity and feel able to suggest ideas for improvement and to make changes in their own area.	Sept 2024
3	**Developing Leadership Behaviours**	Leadership and management development strategy	Our leadership and management teams actively enable staff to own improvement as part of their everyday work and all teams and staff have had training in improvement.	March 2025
		Leadership and management values and behaviours	A clear framework and expectations for leadership and management values and behaviours which are consistent with an improvement-based approach are applied throughout the organisation.	Sept 2024
		Leadership and management acting in partnership	Our leadership team has shared longer term goals with network partners or commissioners as well as collaborative involvement over wider health economy.	Sept 2024
		Board development to empower collective improvement leadership	Our leadership and management teams actively enable staff to own improvement as part of their everyday work.	Sept 2024
4	**Building Improvement Capability and Capacity**	Improvement capacity and capability building strategy	Sustainability is addressed via ‘in-house’ training and development approaches including train the trainer models. Improvement capability building for ‘lived experience’ service user	April 2024

			partners is underway; they are seen as contributors to improvement teams. The programme is working towards being self-sustaining through developing its own improvement coaches.	
		Clear improvement methodology training and support	Training and development are undertaken by all leaders, managers and staff. Learning from all improvement activity is effectively shared across the organisation. Staff, people with lived experience and wider teams are using their skills and knowledge to deliver improvement and cascade improvement techniques to their peers.	March 2025
		Improvements measured with data and feedback	Improvement is sustained for most organisational measures. Our goals are reviewed regularly at organisational level and our plans are adapted to ensure they meet the clearly defined goals if required.	Sept 2024
		Co-production .	People with lived experience and wider stakeholders are strongly involved in co-designing and co-producing the capability building approach. Staff, people with lived experience and other stakeholders have access to improvement capability development.	April 2024
		Staff attend daily huddles	All operational/support/corporate areas have continuous improvement team huddles established	Sept 2024
5	**Embedding Improvement into Management**	Aligned goals	Our organisational and departmental goals are systematically aligned to our overall vision; and we are working to	Sept 2024

	Systems and Processes		align goals across our system. Our organisational goals are developed using a consistent management system, based on two-way engagement leading to strong ownership of the goals and greater transparency between areas.	
		Planning and understanding status	Our business planning and performance management processes give good visibility of status and progress against our goals across all departments and teams. We have an agreed and transparent approach for selecting and prioritising improvement work which generally works well. Our supporting resources are assigned to supporting delivery of improvement goals across the organisation in a way that is perceived to be fair and effective. Staff and assets from enabling services (e.g. Human Resources, Finance, Comms, Informatics) are also aligned to improvement priorities and are shared across the system in an agile way.	April 2024
		Responding to local, system and national priorities	Our management method is well embedded in how we work in all parts of the organisation to team level. As an organisation we are using run charts and statistical process control (SPC) charts not just RAG or tables. Our technology, staff and facility decisions are aligned with our management system goals.	ongoing

		Integrating improvement into everything we do	Improvement is generally well integrated with day-to-day delivery across the organisation and is increasingly the basis of how we deliver against our performance goals. Improvement activity is contributing to performance in many front-line clinical areas and supporting clinical functions.	Dec 2024

Item 9i – F&P Committee – Elective Recovery Return

Gateshead Health
NHS Foundation Trust

Report Cover Sheet Agenda Item: 14

Report Title:	**Trust Response to the Elective Care 23/24 Priorities**			
Name of Meeting:	Finance and Performance Committee			
Date of Meeting:	26 September 2023			
Author:	Joanne Halliwell Chief Operating Officer			
Executive Sponsor:	Joanne Halliwell Chief Operating Officer			
Report presented by:	Joanne Halliwell Chief Operating Officer			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
	This report outlines the requirements for elective care recovery during 23/24 which were set out in a national letter (PRN00496) published on 23 May 2023. On 4 August 2023 a formal request (PRN00673) was made for Trust Boards to provide a self-certification for assurance as to organisational progress against 4 key areas of the elective care recovery plan identified to drive outpatient recovery at pace. These are A) Validation B) First Appointments C) Outpatient Follow-Ups D) Support Required The Board delegated responsibility for the review of the self-assessment return and its approval to the Tier 1 Finance and Performance Committee given the timing of the return and the subject matter being integral to the Committee's terms of reference. This return is included in this report. The deadline for submission to NHS England is 30 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*	In part – Finance and Performance Committee, Trust Board, Executive Team and Senior Leadership Team			
Key issues:	The high-level assurance questions asked in the four areas have identified some good practice within our organisation. Partial assurance can only be evidenced in relation to our validation			

<table>
<tr><td>Briefly outline what the top 3-5 key points are from the paper in bullet point format

Consider key implications e.g.
• Finance
• Patient outcomes / experience
• Quality and safety
• People and organisational development
• Governance and legal
• Equality, diversity and inclusion</td><td colspan="6">activity and this requires organisational focus linked to the Outpatients Transformation Programme.

Areas of non-compliance
Given the volume of patients in the over 12 week category (6526 as of August 23) the Trust cannot evidence an ability to contact and validate this cohort by the 31 October deadline identified nationally – an internal standard of 31 December 2023 has been identified as viable.

In relation to the patients who will breach 65 weeks at the end of March 2024 – there is no ability in paediatric (149 patients) and pain services (113 patients) to ensure that these patients have a first outpatient appointment before 31 October 2023.

The tracking and performance against both of these indicators is through the corporate Performance Clinics weekly.</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 Finance and Performance Committee are asked to review the self-assessment document and support the submission of this information to NHS England.

To note and agree to the recommendation regarding the development of a single elective recovery report which will be formally reported through Finance and Performance Committee</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:</td><td>Aim 1
☒</td><td colspan="5">We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>Aim 2
☐</td><td colspan="5">We will be a great organisation with a highly engaged workforce</td></tr>
<tr><td>Aim 3
☒</td><td colspan="5">We will enhance our productivity and efficiency to make the best use of resources</td></tr>
<tr><td>Aim 4
☐</td><td colspan="5">We will be an effective partner and be ambitious in our commitment to improving health outcomes</td></tr>
<tr><td>Aim 5
☐</td><td colspan="5">We will develop and expand our services within and beyond Gateshead</td></tr>
<tr><td>Trust corporate objectives that the report relates to:</td><td colspan="6">SA3.1 Improve the productivity and efficiency of our operating services through the delivery of the new operating model and associated transformation plans.
SA3.2 Achieving Financial sustainability.</td></tr>
<tr><td>Links to CQC KLOE</td><td>Caring
☐</td><td>Responsive
☒</td><td>Well-led
☒</td><td>Effective
☒</td><td colspan="2">Safe
☒</td></tr>
<tr><td colspan="7">Risks / implications from this report (positive or negative):</td></tr>
<tr><td>Links to risks (identify significant risks and DATIX reference)</td><td colspan="6">Risk 3102 Activity is not delivered in line with planned trajectories, resulting in the Trust having reduced access to core funding
Risk 2945 Risk of ineffective and inefficient management of services due to availability and access to appropriate and timely business intelligence to deliver and improve service</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>

Trust Response to the Elective Care 23/24 Priorities

1. Executive Summary

1.1 The joint letter published 23 May 2023 from Sir James Mackey, Sir David Sloman, Dame Cally Palmer and Professor Tim Briggs regarding Elective Care Priorities in 2023/24 has asked Boards within provider organisations and systems to use a specific checklist to ensure elective recovery plans and actions have been undertaken, giving assurance to the elective ambitions set out nationally and evidencing local progress towards the year end standards.

1.2 The supplementary request for Trusts to self-assess their position in regard to four key elements of elective recovery was received in the organisation on 4 August 2023. As part of this request Trust boards were asked to undertake a self-certification process to provide assurance in four key areas. The Gateshead Health proposed self-certification return is included in Appendix 1.

1.3 It is requested that the Finance and Performance Committee (with delegated authority from the Trust Board) reviews the content of the return and approves for submission.

1.4 Recommendations as to the representation of elective recovery information to the Finance and Performance Committee are included as part of this paper.

2. Introduction

2.1 Nationally, elective and cancer recovery remains a significant challenge. The national standards regarding reductions in overall waiting list size and improvements in long wait performance have been evidenced but at a slower pace than the original forecasts identified.

2.2 A letter was published by Sir James Mackey, Sir David Sloman, Dame Cally Palmer and Professor Tim Briggs thanking all providers for their continued focus and effort on elective and cancer recovery recognising the challenges being experienced due to the requirement to plan for and risk mitigate during periods of Industrial Action. The letter continues to request focus on delivering the next ambitions as set out in the Operational Planning Guidance for 2022-23. The three key performance deliverables and metrics are;

a) Virtually eliminate elective waits of over 65 weeks for Referral to Treatment (RTT) by March 2024

b) Reducing the cancer 62-day backlog

c) Meeting the 28-day faster diagnosis standard – March 2024

2.3 The letter set out the key priorities for the year ahead as summarised below

Excellence in Basics – improving and maintaining data quality, validation, clinical prioritisation and maximising booking rates

Performance and Long Waits – Continued recovery of 78 and 65 weeks and recovery of the 62-day cancer backlog in conjunction with delivery 28 day faster diagnostic standards (FDS) which will involve a new tiering mechanism for challenged Trusts

Outpatients – Productivity actions to delivery 25% reduction in follow-up activity compared to 2019/20 and repurpose more capacity to new outpatient appointments using frameworks and programmes such as GIRFT and Action on Outpatients

Cancer pathway redesign - focussing on funded improvement schemes via the Cancer Alliance including Lower Gastrointestinal (LGI) skin and prostate best practice timed pathway redesign

Activity – Improved utilisation of the Community Diagnostic Centres (CDC) and acute diagnostic capacity to reduce cancer backlogs and improve FDS ass well as general step up on activity to mitigate loss impacted by ongoing industrial action

Choice – Early and clear collaborative plans working with Independent Sector Providers (ISP) to provide long waiting patients with choice for where and when they would want their treatment

2.4 The letter also set expectations for Systems to outline and evidence actions to minimise inequality across services, continue to address recovery of Children and Young People (CYP) services and reduce elective activity gaps between CYP and adults and equitably recover specialised complex services in balance with high volume activity.

2.5 Following receipt of this letter the Gateshead Health elective recovery programme has been incorporating elements of this into the overarching recovery plans. However, there is scope to revisit these priorities as part of the inclusion of several elements within the newly formed Delivery Oversight Group workstreams.

2.6 On 4 August a further letter was received which acknowledged and quantified the significant improvements which has been made regarding the longest waiting patients and the patients on 62-day cancer pathways nationally. However, further focus was requested regarding outpatient transformation which hadn't (nationally) evidenced as significant a beneficial impact from the focussed actions undertaken.

2.7 The letter requested that Trusts undertake three further actions as identified below

- Revisit your plan on outpatient follow-up reduction to identify more opportunity for transformation

- Set an ambition that no patient in the 65 week 'cohort' (patients who, if not treated by 31 March 2024, will have breached 65 weeks) will be waiting for a first outpatient appointment after 31 October 2023

- Maintain an accurate and validated waiting list by ensuring he at least 90% of patients who have been waiting over 12 weeks are contacted and validated (in line with |December 2022 validation guidance) by 31 October 2023, and ensuring that RTT rules area applied in line with the RTT national rules suite and local access policies are appropriately applied.

2.8 As part of this reaffirmation of priorities, the letter requested that Trusts provide assurance against a set of core key activities that would drive outpatient recovery at pace. This would support the identification of providers who require additional support alongside those with notable areas of good practice that could be scaled up to accelerate recovery.

It is this document that the Finance and Performance Committee are being asked to review and approve.

3. Assurance and Areas for Further Focus

3.1 The return is detailed in Appendix 1.

3.2 **Validation**

Full assurance cannot be provided on validation due to the following factors

- There is no pre covid validation benchmark which can be determined to evidence a baseline against which the current validation activity can be compared

- Through the weekly performance clinics – there is evidence that validation activity is being undertaken but it is not possible to identify this activity through a centralised reporting structure generated electronically to provide a Trust view and therefore full assurance

- There are three types of validation activity, technical validation which can be undertaken in an automated fashion or by a technical expert – this will identify where there are illogical outcomes which cannot be correct – a follow up before a first outpatient appointment for example. This can be corrected at system level. Administrative validation whereby nonclinical teams can undertake validation activity along a spectrum of interventions – this may include ensuring the clinical outcomes post appointment or treatment have been correctly represented on the system. This may also include and involve discussions with patients regarding their intentions to continue with treatment pathways. The final element is clinical validation whereby a healthcare practitioner would review the patients records or have a clinical discussion about whether the original treatment plan may still be a suitable and safe option. At present there is no formal structured programme of validation or evidence of completion against the three different types.

- A specific requirement of the board assurance checklist is in the need to evidence that at least 90% of patients who have been waiting over 12 weeks are contacted and validated by 31 October 2023. As of August 2023 this represented 6526 patients. It is not possible to provide a summary report to identify who from this cohort has been validated, however it is known that a very small number will have been contacted as part of the validation activity. Given the requirement to identify, resource and deliver this activity it has been identified that this cannot be completed before December 2023.

3.2 **First Appointments**

Through the weekly performance clinics, a focus on providing first outpatient appointments for all patients who will be waiting 65 weeks at the end of March 23 has

been a priority. All services are currently providing a detailed patient level tracking update each week. There are two services who have large patient number in this cohort who cannot presently identify a robust delivery plan. These are paediatrics (149 patients) and pain services (113 patients). Both services have unique challenges which are requiring additional support to resolve, however, these remain a risk to the national standard achievement.

3.3 **Outpatient Follow Ups**

Assurance in terms of outpatient follow ups can be more robustly provided as this has been a focus of the Outpatient Transformation Programme for some time. Although further work is required to reduce the follow up requirement to hit the 25% metric, there are robust plans in place to deliver this.

3.4 **Support Required**

As part of the review process being undertaken by the Interim Chief Operating Officer, additional support through regional or national teams is being evaluated. It is likely that specific waiting list management and validation expertise will be needed, however, the exact nature of this is to be determined.

4. Reporting and Information

4.1 Following the self-assessment exercise and subsequent reflections of the current information suites it has been identified that we are currently unable to provide a single oversight report which would clearly map all the elective recovery metrics in one place. It is therefore recommended that a single elective recovery oversight report is produced for Finance and Performance Committee which would include information regarding

Validation activity, common themes and evidence of lessons learned to improve data quality
Activity delivered against baseline and recovery trajectories
Total waiting list size and variations in month linked to ROTT (removal for reasons other than treatment), activity and validation impacts
Trust waiting list shape to reflect high quality booking practices
Confirmation of non RTT activity to ensure equity of provision
PIFU rates and instances of PIFU activity and discharges
DNA rates
65 and 52 week projections
Cancer standards to reflect the newly issued changes
Use of the Independent Sector / in sourcing and outsourcing activity
Future use of the DMAS mutual aid platform and PIDMAS – patient initiated digital choice including the number of patients who have had their care transferred as a consequence of these platforms

5. Solutions / recommendations

The Finance and Performance Committee are asked to review the self-assessment document and support the submission of this information to NHS England, noting the areas of partial assurance and subsequent actions to be taken in this regard.

To note and agree to the recommendation regarding the development of a single elective recovery report which will be formally reported through Finance and Performance Committee to provide a clear set of elective recovery metrics which will provide clear measures of progress or challenge.

APPENDIX 1

Board Assurance Checklist – September 2023

1	Validation	Trust response	Assurance gained
The board:			
a. has received a report showing current validation rates against pre-covid levels and agreed actions to improve this position, utilising available data quality (DQ) reports to target validation, with progress reported to board at monthly intervals. This should include use of the nationally available LUNA system (or similar) to address data quality errors and identify cohorts of patients that need further administrative and clinical validation.		Validation is in place with a planned programme of expansion. The last Trust Data Quality Maturity Index Score for the Trust (May 23) was 93.7 against a national average of 80.8	Partial
b. has plans in place to ensure that at least 90% of patients who have been waiting over 12 weeks are contacted and validated (in line with validation guidance) by 31 October 2023, and has sufficient technical and digital resources, skills and capacity to deliver against the above or gaps identified. We are developing a range of digital support offers for providers to improve validation.		Technical validation on patient cohorts has been undertaken across the Specialties and this is monitored through a weekly Access and Performance meeting. Clinical validation including patient contact is incomplete.	Due to the volume of patients and the resources required it is not possible to complete this by the 31 October 2023. An internal deadline has been set of December 2023
c. ensures that the RTT rules and guidance and local access policies are applied and actions are properly recorded, with an increasing focus on this as a means to improve data quality. For example, Rule 5 sets out when clocks should be appropriately stopped for 'non-treatment'. Further guidance on operational implementation of the RTT rules and training can be found on the Elective Care IST Future NHS page. A clear plan should be in place for communication with patients.		Support, training materials and standard operating procedures is in place. Validation themes are shared through the weekly Access and Performance Meeting	Yes
d. has received a report on the clinical risk of patients sitting in the non RTT cohorts and has built the necessary clinical capacity into operational plans.		Non-RTT pathway patients are monitored and reported in the same way as RTT pathway patients. Planned cases are mapped against RTT	Yes

	pathways when relevant.	

2	First appointments	Trust response	Assurance gained
The board:			
a. has signed off the trust's plan with an ambition that no patient in the 65 week 'cohort' (patients who, if not treated by 31 March 2024, will have breached 65 weeks) will be waiting for a first outpatient appointment after 31 October 2023.		Formal plan in place however due to the volume of patients in paediatric and pain services this timeline will extend beyond 31 October for these specialties.	Yes. Noting the specialty position in the services identified
b. has signed off the trust's plan to ensure that Independent Sector capacity is being used where necessary to support recovery plans. To include a medium-term view using both insourcing and outsourcing, the Digital Mutual Aid System, virtual outpatient solutions and whole pathway transfers. National support and information on utilisation of the Independent Sector is available via the IS Co-ordination inbox england.iscoordination@nhs.net		Agreement to continue to utilise the IS and continuation of in and outsourcing pathways currently in place. New requests for additional IS capacity or new in/outsourcing proposals are monitored through the Access and Performance Meeting	Yes

3	Outpatient Follow ups	Trust response	Assurance gained
The board:			
a. has received a report on current performance against submitted planning return trajectory for outpatient follow-up reduction (follow-ups without procedure) and received an options analysis on going further and agreed an improvement plan.		Reported monthly through the Integrated Oversight Report	Yes
b. has reviewed plans to increase use of PIFU to achieve a minimum of 5%, with a particular focus on the trusts' high-volume specialties and those with the longest waits. PIFU should be implemented in breast, prostate, colorectal and endometrial cancers (and additional cancer types where locally agreed), all of which should be supported by your local Cancer Alliance. Pathways for PIFU should be applied consistently between clinicians in the same specialty.		Use of PFIU is a central component of the Outpatients Transformation Programme	Yes
c. has a plan to reduce the rate of missed appointments (DNAs) by March 2024, through:		Monitoring of DNA rates and mechanisms	Yes

engaging with patients to understand and address the root causes, making it easier for patients to change their appointments by replying to their appointment reminders, and appropriately applying trust access policies to clinically review patients who miss multiple consecutive appointments.	to address are part of the specialty specific elective recovery plans	
d. has a plan to increase use of specialist advice. Many systems are exceeding the planning guidance target and achieving a level of 21 per 100 referrals. Through job planning and clinical templates, the Board understands the impact of workforce capacity to provide advice and has considered how to meet any gaps to meet min levels of specialist advice. The Trust has utilised the OPRT and GIRFT checklist, national benchmarking 6 data (via the Model Health System and data packs) to identify further areas for opportunity.	Advice and guidance pathways are in place however there is an opportunity to expand on these. This forms part of the Outpatient Transformation Programme	Yes
e. has identified transformation priorities for models such as group outpatient follow up appointments, one-stop shops, and pathway redesign focussed on maximising clinical value and minimising unnecessary touchpoints for patients, utilising the wider workforce to maximise clinical capacity.	These are all considered as part of the Outpatient Transformation Programme	Yes

4	**Support required**	**Trust response**	**Assurance gained**
The board has discussed and agreed any additional support that maybe required, including from NHS England, and raised with regional colleagues as appropriate.		New Chief Operating Officer is currently evaluating where additional support may be required	Yes

Sign off Trust lead (name, job title and email address):	Joanne Halliwell Chief Operating Officer Joanne.halliwell4@nhs.net
Signed off by Chair	Alison Marshall
Signed off by Chief Executive	Trudie Davies