MEETING OF THE BOARD OF DIRECTORS IN PUBLIC

Gateshead Health NHS Foundation Trust

Date: Wednesday 27th September 2023
Time: 9:30 am
Venue: Rooms 9&10, Education Centre/Teams

AGENDA

	TIME	ITEM	STATUS	PAPER
1.	9:30 am	**Welcome and Chair's Business**		
2.	9:33 am	**Declarations of Interest** To declare any pecuniary or non-pecuniary interests and receive the Declarations of Interest from Joanne Halliwell *Check – Attendees to declare any potential conflict of items listed on the agenda to the Company Secretary on receipt of agenda, prior to the meeting*	Declaration	Enclosure 2
3.	9:34 am	**Apologies for Absence** *Quoracy check: (s3.3.31 SOs: No business shall be transacted at a meeting unless a minimum of **4** members of the Board (including at least **one** Non-Executive and **one** Executive Member of the Board are present)*	Agree	Verbal
4.	9:35 am	**Minutes of the meeting held on 26 July 2023** To be agreed as an accurate record	Agree	Enclosure 4
5.	9:40 am	**Matters Arising / Action Log**	Update	Enclosure 5
6.	9:45 am	**Patient & Staff Story** • Research and Development Team	Assurance	Enclosure 6
		ITEMS FOR DECISION		
7.	10:05 am	**Winter Plan Submission** To approve the submission presented by the Interim Chief Operating Officer	Approval	Enclosure 7
8.	10:15 am	**Patient Safety Incident Response Plan** To approve the submission presented by the Chief Nurse/Deputy Chief Executive	Approval	Enclosure 8
		ITEMS FOR ASSURANCE		
9.	10:25 am	**Assurance from Board Committees** i. Finance and Performance Committee – 29 August 2023 and 26 September 2023 ii. Quality Governance Committee – 29 August 2023 iii. Digital Committee – 2 August 2023 iv. POD Committee – 12 September 2023 v. Audit Committee – 5 September 2023	Assurance	Enclosure 9
10.	10:45 am	**Chief Executive's Update Report** i. **Strengthening the Clinical Voice** To receive a briefing report from the Chief Executive	Assurance	Enclosure 10
11.	11:00 am	**Disclosure and Barring Service (DBS) Update Report** To receive the report, presented by the Chief Nurse / Deputy Chief Executive	Assurance	Enclosure 11
12.	11:10 am	**Health Care Assistant Pay Rates** To receive a briefing, presented by the Chief Nurse / Deputy Chief Executive	Assurance	Enclosure 12
13.	11:20 am	**Governance Reports** ii. **Organisational Risk Register** To receive the reports presented by the Chief Nurse	Assurance	Enclosure 13

14.	11:30 am	**Finance Report** To receive the report, presented by the Group Director of Finance and Digital	Assurance	Enclosure 14
15.	11:40 am	**Integrated Oversight Report/Leading Indicators** To receive the report, presented by the Group Director of Finance & Digital, Chief Nurse and Medical Director	Assurance	Enclosure 15
16.	11:55 am	**Nurse Staffing Monthly Exception Report** To receive the report, presented by the Chief Nurse	Assurance	Enclosure 16
17.	12:05 pm	**Maternity Update** i. **Maternity Integrated Oversight Report** To receive the report, presented by the Head of Midwifery	Assurance	Enclosure 17
18.	12.15 pm	**Staff Survey Results Action Plan Update** To receive the update, presented by the Interim Deputy Director of People & Organisational Development	Assurance	Enclosure 18
19.	12:25 pm	**Freedom to Speak Up Guardian Report** To receive the report presented by the Medical Director and Freedom to Speak Up Guardian	Assurance	Enclosure 19
20.	12:35 pm	**WRES and WDES Report** To receive the report presented by Interim Deputy Director of People and Organisational Development	Assurance	Enclosure 20
		ITEMS FOR INFORMATION		
21.	12:45 pm	**Register of Official Seal** To note the use of the official seal between 1 September 2022 and 31 August 2023 presented by the Company Secretary	Information	Enclosure 21
22.	12:50 pm	**Cycle of Business** To receive the cycle of business outlining forthcoming items for consideration by the Board, presented by the Company Secretary	Information	Enclosure 22
23.	12:55 pm	**Questions from Governors in Attendance** To receive any questions from governors in attendance		Verbal
24.	1:05 pm	**Date and Time of the next Meeting** The next scheduled meeting of the Board of Directors to be held in public will be Wednesday 29th November 2023		Verbal
25.	1:05 pm	**Chair Declares the Meeting Closed**		Verbal
26.	1:05 pm	**Exclusion of the Press and Public** To resolve to exclude the press and public from the remainder of the meeting, due to the confidential nature of the business to be discussed		Verbal

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 2

Report Title:	**Declaration of Board Members Interests, Gifts and Hospitality**			
Name of Meeting:	Board of Directors			
Date of Meeting:	Wednesday 27th September 2023			
Author:	Diane Waites, Corporate Services Assistant			
Executive Sponsor:	Alison Marshall, Chair of the Board of Directors Trudie Davies, Chief Executive			
Report presented by:	Jennifer Boyle, Company Secretary			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☒	**Discussion:** ☐	**Assurance:** ☐	**Information:** ☐
	In accordance with section 20 of Schedule 1 of the Health & Social Care (Community Health and Standards) Act 2003 NHS Foundation Trusts are required to maintain a register of Directors' and Governors' interests. This requirement is also enshrined in section 10 of the Trust's Constitution. The register for Gateshead Health NHS Foundation Trust is held at Trust Headquarters and is available to the public through the Company Secretary.			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☒ *No gaps in assurance*	**Partially assured** ☐ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	-			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	• The Register of Board Members interests has been updated to include Joanne Halliwell, Interim Chief Operating Officer as a new Board Member • Interests have been declared in accordance with the Trust's Managing Conflicts of Interest Policy. • This is aligned to the model policy issued by NHS England. • All Board Members must make an annual declaration and are required to make subsequent in-year declarations to record any changes in interests.			

<table>
<tr><td>Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper</td><td colspan="5">The Board is asked to:
Approve and record in the Board minutes the declared interest for Joanne Halliwell
Note that the next annual review of the declaration of Board members' interests will take place in March 2024.</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:</td><td>Aim 1
☒</td><td colspan="4">We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>Aim 2
☒</td><td colspan="4">We will be a great organisation with a highly engaged workforce</td></tr>
<tr><td>Aim 3
☒</td><td colspan="4">We will enhance our productivity and efficiency to make the best use of resources</td></tr>
<tr><td>Aim 4
☒</td><td colspan="4">We will be an effective partner and be ambitious in our commitment to improving health outcomes</td></tr>
<tr><td>Aim 5
☒</td><td colspan="4">We will develop and expand our services within and beyond Gateshead</td></tr>
<tr><td>Trust corporate objectives that the report relates to:</td><td colspan="5">Declarations of interests enable the early identification of any potential conflicts which may in turn impact upon the ability to achieve the strategic aims and objectives.</td></tr>
<tr><td>Links to CQC KLOE</td><td>Caring
☐</td><td>Responsive
☐</td><td>Well-led
☒</td><td>Effective
☐</td><td>Safe
☐</td></tr>
<tr><td colspan="6">Risks / implications from this report (positive or negative):</td></tr>
<tr><td>Links to risks (identify significant risks and DATIX reference)</td><td colspan="5">-</td></tr>
<tr><td>Has a Quality and Equality Impact Assessment (QEIA) been completed?</td><td colspan="2">Yes
☐</td><td colspan="2">No
☐</td><td>Not applicable
☒</td></tr>
</table>

Forename	Surname	Position	Interest	From	To	Comments
Andrew	Beeby	Medical Director	None			
Adam	Crampsie	Non-Executive Director	Chief Executive - Everyturn Mental Health	20/11/2021	present	Provider to Trust
			Chair - North East & North Cumbria VCSE Board	10/06/2023	present	
			Board Member - North East & North Cumbria MHLDA Board	10/06/2023	present	
Trudie	Davies	Chief Executive	None	01/03/2023	31/03/2023	Started in post on 1 March 2023
Gill	Findley	Chief Nurse	None			
Neil	Halford	Medical Director of Operations	None			
Joanne	Halliwell	Interim Chief Operating Officer	None	01/09/2023	present	Started in post on 1 September 2023
Steven	Harrison	Interim Managing Director QE Facilities	None			
Martin	Hedley	Non-Executive Director	Non-Executive Director - Royal Surrey NHS Foundation Trust	01/03/2016	present	
			Chair & Non-Executive Director - RSCH Pharmacy Limited	01/11/2019	present	
			Governor - Gateshead College	01/03/2019	present	
			Managing Director/Recruiting/Coaching - Vision Achievement Limited	01/02/2013	present	
Kris	Mackenzie	Group Director of Finance and Digital	None			
Alison	Marshall	Chair	Non-Executive Director of Northern Powergrid plc (North East and Yorkshire)	2014		
			Ambassador for North Northumberland Hospice Care	2015		
			Spouse - NED of North East Ambulance Service NHSFT	2017		
			Spouse - NED of North East Ambulance Service Unified Solutions Ltd	2019		
			Spouse - Chair of Newcastle Gateshead Initiative	2016		
			Spouse - Chair of North East England Chamber of Commerce	2020		
			Spouse - Director of Newcastle United Foundation Projects Ltd			
			Spouse - NED of Believe Housing Ltd	2019		
			Spouse - Chair of Trustees for Newcastle United Foundation			
			Spouse - Ambassador of North Northumberland Hospice Care	2015		
			Spouse - Chair of Regional Development Committee, Prince's Trust			
Andrew	Moffat	Non-Executive Director	Non-Executive Director of Advanced Northumberland	24/04/2023		
Hilary	Parker	Non-Executive Director	Non-Executive Director of Kingston Properties Ltd (wholly owned subsidiary of Bernicia Housing)	2019		Registered housing association
			Trustee - Newcastle University Development Trust	2016		Charitable Trust
			Non-Executive Director of QE Facilities Ltd (wholly owned subsidiary of GHNHSFT	2020		
			Consultant - Sintons LLP Law Firm	2016	present	
Mike	Robson	Vice Chair/Non-Executive Director	None	01/04/2022	31/03/2023	
Anna	Stabler	Non-Executive Director	Position in Family Court in Co Durham Justice area	01/02/2023		Note - this will exclude any public law cases in relation to the Trust
Maggie	Pavlou	Non-Executive Director	Owner / Director - People Gauge (software business)	2011		
			Trustee - The People's Kitchen (charitable organisation)	2020		
			The Chronicle Sunshine Fund (charitable organisation)	2020		
			Trustee - York Theatre Royal (arts)	2022		
			Non-Executive Director of QE Facilities Ltd (wholly owned subsidiary of GHNHSFT	2022		
			Spouse - Harlow Printing (printing firm)	2022		
Amanda	Venner	Interim Director of People and Organisational Development	None			

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NHS Foundation Trust

Trust Board

Minutes of a meeting of the Board of Directors
held at 9.30 am on Wednesday 26th July 2023, in
Rooms 9&10, Education Centre, Queen Elizabeth Hospital and via MS Teams

Present:	
Mrs A Marshall	Chair
Mrs T Davies	Chief Executive
Dr G Findley	Chief Nurse
Mr N Halford	Medical Director of Operations
Mr S Harrison	Interim Managing Director for QE Facilities
Mr M Hedley	Non-Executive Director
Mrs K Mackenzie	Group Director of Finance and Digital
Mr A Moffat	Non-Executive Director
Mrs H Parker	Non-Executive Director
Mrs M Pavlou	Non-Executive Director
Mr M Robson	Vice Chair / Non-Executive Director
Mrs A Stabler	Non-Executive Director
Mrs A Venner	Interim Director of People & Organisational Development
In Attendance:	
Mrs J Boyle	Company Secretary
Mrs N Bruce	Director of Strategy, Planning & Partnerships (23/159)
Mrs J Conroy	Interim Head of Midwifery (23/163)
Ms K Hooper	Lead Midwife for Risk, Safety & Quality (23/155)
Ms D Waites	Corporate Services Assistant
Governors and Members of the Public:	
Mrs H Adams	Staff Governor
Mr S Connolly	Public Governor – Central
Mrs L Curry	Staff Governor
Mr R Dennis	Public Governor – Western
Mr M Learmouth	Public Governor – Central
Ms M Ndam	Staff Governor
Mr G Riddell	Public Governor – Western
Apologies:	
Mr A Beeby	Medical Director
Mr A Crampsie	Non-Executive Director

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Agenda Item	Discussion and Action Points	Action By
23/150	**CHAIR'S BUSINESS:** The meeting being quorate, Mrs A Marshall, Chair, declared the meeting open at 9.30 am and confirmed that the meeting had been convened in accordance with the Trust's Constitution and Standing Orders. She welcomed those present including the Trust's Governors and welcomed Mr Martin Hedley to his first meeting as Non-Executive Director.	
23/151	**DECLARATIONS OF INTEREST:** Mrs A Marshall requested that Board members present report any revisions to their declared interests or any additional declaration of interest in any of the items on the agenda.	

Agenda Item	Discussion and Action Points	Action By
	Mrs J Boyle, Company Secretary, presented the Register of Board Members interests which has been updated to include new Board Members. She explained that all Board Members must make an annual declaration and are required to make subsequent in-year declarations to record any changes in interests. She confirmed that interests have been declared in accordance with the Trust's Managing Conflicts of Interest Policy and is aligned to the model policy issued by NHS England. Following consideration, it was: **RESOLVED:** to approve the declared interests and note that the next annual review of the declaration of Board members' interests will take place in March 2024.	
23/152	**APOLOGIES FOR ABSENCE:** Apologies for absence were received from Mr A Beeby and Mr A Crampsie.	
23/153	**MINUTES OF THE PREVIOUS MEETING:** The minutes of the meeting of the Board of Directors held on Wednesday 24th May 2023 were approved as a correct record.	
23/154	**MATTERS ARISING FROM THE MINUTES:** The Board reviewed the action tracker as below: • 22/139 re. Risk Management Strategy – presented and approved at the last Board meeting (May 2023). The strategy had been reviewed by the Audit Committee however feedback was awaited from the QE Facilities Board. Delegated authority was therefore agreed to ensure any changes were completed. It was agreed to close this action as complete. • 23/12 re. Integrated Oversight Report in relation to Duty of Candour compliance – new process in place and review taking place via Quality Governance Committee. It was agreed to close this action as complete. • 23/64 re. Board Committee Assurance Reports in relation to proposed rescheduling of meetings – to be reviewed as part of Good Governance Institute review and therefore to remain open until this work is complete. • 23/67 re. Annual NHS Staff Survey Results – on Board cycle of business therefore action agreed to be closed on this basis. • 23/111 re. Trust Strategic Aims and Objectives in relation to ensuring appropriate leads and assurance committees are identified. Requested updates have been made and Quarter 1	

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Agenda Item	Discussion and Action Points	Action By
	update on today's agenda. It was agreed to close this action as complete. • 23/112 re. ensuring Governors are included in the Equality, Diversity and Inclusion (EDI) Strategy work. An EDI session has been delivered as part of a Governor Workshop on 19th July 2023. It was agreed to close this action as complete. • 23/114 re. Thematic Review in relation to leading indicators being shared with the Board. Paper on Board Part 2 Agenda of today's meeting. Further action in relation to the Board receiving a six-monthly update and this has been added to the Board Cycle of Business. It was agreed to close these actions as complete. • 23/117 re. Integrated Oversight Report in relation to ensuring that Non-Executive Directors receiving a summary of reported serious incidents. It was confirmed that this process is now in place therefore it was agreed to close this action as complete. • 23/118 re. Safe Staffing Review Report in relation to ensuring that embedded documents were distributed to the Board. It was confirmed that this has been actioned. There was a further action in relation to "red flag" process being included in the monthly reports going forward and it was confirmed that this is now in place. It was therefore agreed to close these actions as complete. • 23/119 re Maternity Integrated Oversight Report in relation to reviewing the use of graphs within the report. It was confirmed that this has been incorporated into the new style report. It was agreed to close this action as complete. Mrs Marshall highlighted the new section of the tracker which shows actions closed at the last meeting. This allows the Board to ensure actions have been closed in line with expectations and the agreements made at the previous Board meeting.	
23/155	**PATIENT STORY – MATERNITY** The Board welcomed Karen Hooper, Lead Midwife for Risk, Safety & Quality, who provided a presentation on a patient story. She explained that sadly this related to a pregnancy loss and follows the family's experience from submitting a complaint to the learning and actions undertaken to improve guidelines and support provided to other families. Mrs Hooper highlighted that the maternity estates issue remains on the Trust risk register and it is hoped that once completed, will provide bespoke arrangements for bereaved parents. Mrs Marshall and Mrs Davies thanked the family for sharing their story with the Board and also thanked the maternity team for improving services from the learning provided from this experience. Mrs T Davies, Chief Executive, queried how this was shared with the team as felt that this process may benefit the rest of the organisation. Mrs Hooper	

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Agenda Item	Discussion and Action Points	Action By
	explained that regular meetings take place within the team including daily huddles, weekly safety meetings and monthly Safe Care meetings take place. A newsletter is also being developed and this will be supported by the new risk management admin role. Mrs Hooper left the meeting.	
23/156	**NURSING APPRENTICESHIPS 4 YEAR PROGRAMME PROPOSAL:** Dr G Findley, Chief Nurse and Deputy Chief Executive, and Mrs A Venner, Interim Director of People and Organisational Development, presented the recommendations detailed in the report to support the recruitment of two cohorts of 10 students on the programme for 2023/24 and 2024/25. Dr Findley reminded the Board that in July 2022, the Senior Management Team approved ongoing support for the successful Trainee Nurse Associate and Registered Nurse Degree Apprenticeship programmes and explained that the current programme is aimed at existing staff however the new approach will be aimed at school leavers as an alternative to universities. This will be an opportunity to open up a new pathway into nursing at Gateshead by training students straight from college in a grow our own approach and will support the need to fill the gap within current registered nursing vacancies and reduce agency and bank staff rates. Dr Findley highlighted that it is reported that the current intake into universities is down and there is a low drop out rate for this programme. Currently there is one intake a year at the start of the academic year however the Trust is working with universities to explore a second intake half way through the year. There are currently 10 posts per cohort however it is hoped that more places could become available following further work to ensure placements are in place and wards are able to accommodate the posts. Mrs T Davies, Chief Executive, felt that this programme supported the Trust's strategic objectives around sustainability and innovation and ensured that patient outcomes were supported via an engaged workforce. Mrs K Mackenzie, Group Director of Finance and Digital, felt that this also supported future plans around cost avoidance particularly around bank and agency spend as well as highlighting the benefits around increasing substantive roles. Mr M Hedley, Non-Executive Director, felt that this was an excellent programme and a good example of the Trust's role as an anchor institution. He queried the levels of local interest in the programme and Dr Findley highlighted that currently there have been 70 applications received and the closing date has been extended to ensure further school leavers were included however the posts are advertised via NHS jobs therefore identifying local applicants would need to be explored. The Trust is working with local schools and colleges to support the	

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Agenda Item	Discussion and Action Points	Action By
	programme which should maximise the potential that local applications will be received. Mr M Robson, Vice Chair, raised some concern in relation to the potential shifts in centralised funding, i.e. that the Trust may incur costs traditionally covered and funded via the education sector. Mrs Venner explained that the costs of the university programme are covered by the apprenticeship levy, with the Trust covering its own backfill costs. She noted that further potential funding sources are expected to arise from the links to increased apprenticeships within the NHS Long Term Workforce plan and redirection of internal funding currently invested in the recruitment of international nurses. There is however currently a residual funding shortfall of £1,129,061 phased over 2024/25 to 2028/29 financial years however there are plans in place to review and evaluate the programme. The Board agreed that this should be undertaken via the People and Organisational Development Committee who should continue to ensure that the ambition of the programme is challenged (i.e. to ensure that it is ambitious enough), with feedback to be received at a later date. Following further discussion, it was: **RESOLVED:** to approve the recommendation to support the recruitment of two cohorts of 10 students on the programme for 2023/24 and 2024/25.	GF/AV
23/157	**ASSURANCE FROM BOARD COMMITTEES** **Finance and Performance Committee (F&P):** Mr M Robson, Chair of the F&P Committee, provided a brief verbal overview to accompany the narrative report following the June 2023 meeting and provided a verbal update of the meeting yesterday (25 July 2023). Mrs A Stabler, Non-Executive Director, raised a query from the June 2023 report in relation to transformation and queried whether an update on the gap identified in respect of a transformational strategy would be provided. She also raised some concerns in relation to the results of the recent Care Quality Commission Accident and Emergency survey and felt that this should be supported from the operating model work. Mr Robson explained that these gaps will be linked with the leading indicators framework and current cost reduction plans and Mrs T Davies, Chief Executive, reported that updates will be provided on the transformation programmes following discussions at the Committee meeting yesterday (25 July 2023). Mr Robson provided a verbal update on yesterday's meeting and highlighted that there was one item for escalation in relation to the progress of the Community Diagnostic Centre programme and the significant risk around escalating costs and slippage. It was therefore felt that further work was required to identify mitigations and an	

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Agenda Item	Discussion and Action Points	Action By
	Extraordinary Board meeting may be required in August 2023 to discuss further, once this has been considered by the QE Facilities' Board of Directors. Other key areas of discussion included: • Leading Indicators development – as previously discussed, further understanding is required around the links to sustainability and transformation as well as clarity around definitions and drivers. It was suggested that a Board Development Session may be required to discuss further. • Integrated Oversight Report – concerns raised in relation to growing waiting lists and the Committee has requested performance modelling and impact work to be completed. • New operating model – consideration required around how this is addressed going forward. This will be aligned with the new leading indicators framework and delivery of strategic objectives. A new oversight model is to be set up to bring transformation workstreams together and link to productivity. The Committee noted that a benefits realisation review had identified that the original planned outcomes in the business case had been challenging to demonstrate. It was agreed that a lessons learned exercise would be completed to support the improvement of the future grip and control over key projects. The new operating model itself would become business as usual with linkage of its components to the transformation programme. • Finance report – update to be provided in August 2023 around the impact of industrial action on elective targets and recovery approach. • Capital plan – received report (Agenda Item 11) and supported the adoption of the recommended plan. • Financial risks – it was suggested that some of the risk scores will require review and will be included on the Organisational Risk Register (Agenda Item 10iii). Following a query from Mrs Stabler in relation to concerns raised around meeting targets particularly around trolley waits. Mrs Davies highlighted that significant improvements have been made (noting a reduction from 560 12 hour breaches in December 2022 to 0 in June 2023), however acknowledged that further work was required in relation to grip and control around the delivery of the operating model and this will be aligned to the new framework supporting the leading indicators work and delivery of strategic objectives. **Quality Governance Committee (QGC):** Mrs A Stabler, Chair of QGC, provided a brief verbal overview to accompany the narrative report following the June 2023 meeting. She reported that there were no items for escalation however highlighted that discussions had taken place:	JB JB

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Agenda Item	Discussion and Action Points	Action By
	• Palliative Care Annual Report – funding had been secured and there is an opportunity to develop a transformation programme to improve pathways. • Maternity Oversight Report – update to be provided via a later report (Agenda Item 14) however Mrs Stabler reported that a listening and engagement event took place with Special Care Baby Unit (SCBU) staff and a staffing review is being undertaken. • Complaints Update – acknowledgement of the excellent work completed around the target however some overdue complaints remain. Dr G Findley, Chief Nurse and Deputy Chief Executive, explained that only 6 remain and provided assurance that these will be closed in the near future. The Committee will continue to review and provide feedback to the Board via the Quality Governance Committee. **Digital Committee** Mr A Moffat, Chair of the Digital Committee, provided a brief verbal overview to accompany the narrative report following the June 2023 meeting and reported that there were three items for escalation in relation to the lack of progress around key performance indicators (KPIs), limited assurance rating following the internal audit report on asset management, and the progress around the electronic patient record (EPR) development. He highlighted the following key points: • KPIs – a lot of development work has been undertaken however further work was required in relation to cyber and information governance. It had been noted that some items had remained red-rated since the previous year despite assurance that an escalation process had been in place to support resolution of these issues. Mrs K Mackenzie, Group Director of Finance and Digital, shared the concerns raised and informed that a full review of the KPIs was being undertaken. • Internal audit report providing limited assurance on asset management – a lack of identified policies and guidance resulted in an increased risk of loss of equipment and data breaches. Work is being undertaken around the audit recommendations, particularly around increased controls. • EPR development – concerns have been raised in relation to the completion of milestones and further clinical engagement required. Mrs Mackenzie shared the concerns and reported that a detailed presentation and road map will be presented at the next Committee. A discussion took place around whether a Board Development Session with clinical input would be useful to link the EPR options through to the strategic intent. On reflection it was felt that an additional Digital Committee may be more appropriate with report back to Board in September. Mrs Mackenzie will discuss this with Mr Moffat outside of the meeting. **People and Organisational Development (POD) Committee** Mrs M Pavlou, Chair of POD Committee, provided a brief verbal overview to accompany the narrative report following the July 2023	KMac

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Agenda Item	Discussion and Action Points	Action By
	meeting. She reported that there were no items for escalation however highlighted the following key points: • Disclosure and Barring Service (DBS) Update – the Board acknowledged the huge amount of work which has been undertaken with only 4 historic DBS checks outstanding The POD team were commended for their hard work and it was noted that the wider policy and processes for future implementation were being considered by the Executive Management Team. • Freedom to Speak Up (FTSU) – full time Guardian has been appointed and due to commence in post shortly, with 9 newly trained FTSU Champions now in place. • Organisational Risk Register – high risk scores being reviewed and supply issues remain the main focus of work. • Mrs Pavlou also highlighted that the Trust is the first organisation to sign the Unison Anti-Racism Charter in the North. **Audit Committee:** Mr A Moffat, Audit Committee Chair, provided a brief verbal overview to accompany the narrative report following the June 2023 meeting. He reported that there were no items for escalation however highlighted the following key points: • Audited Annual Accounts and Report – the annual accounts and report were presented to the Committee for approval and comments prior to ratification by the Board at its extraordinary meeting on 28th June 2023. Mr Moffat reported that the Trust's external auditors, Mazars, had felt that this had been a smooth audit process due to improved and strengthened position of the Trust. Mrs Marshall thanked the Committee Chairs for their reports and after consideration, it was: **RESOLVED**: to receive the reports for assurance	
23/158	**CHIEF EXECUTIVE'S UPDATE REPORT** Mrs T Davies, Chief Executive, gave an update to the Board on current issues which have aligned to the Trust's Strategic Aims. She drew attention to the following updates: • Strategic Aim 1 – the Trust achieved a CQC 'good' rating for maternity services following an unannounced focussed CQC inspection in February 2023. • Strategic Aim 2 – there have been some operational challenges as a result of planned industrial action with some cancellations of elective activity, noting the continued impact on staff resilience and wellbeing and the impact on our patients. Mrs K Mackenzie, Group Director of Finance and Digital, reported that there has been a total of 46 cancelled sessions affecting 357 patients	

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	therefore this will have resulted in reduced activity across the organisation. The figures do not account for the sessions which had deliberately not been scheduled for these dates and therefore the impact on patients is more significant than the figures indicate. • Strategic Aim 3 – winter planning will be taking place earlier this year with regional plans due to be signed off in late August ahead of the national deadline of early September. Therefore delegated authority from the Board was provided to submit the plan in line with national deadlines with the report to come to the Board in September 2023 (as outlined in the cycle of business). Mrs Davies explained that the plan can be amended if required following Board feedback. • Strategic Aim 4 - Gateshead Health and Wellbeing Board has approved a plan for Gateshead Place, which focuses on the ICB strategic priorities as well as health inequalities and the Trust will be an active partner in taking this forward which will enhance relationships within the community. Mr Andy Beeby, Medical Director, will be leading on this work. • Strategic Aim 5 – the Trust hosted an Open Day on 8th July 2023 which was a great opportunity to share information on health screening programmes, community services, recruitment opportunities, engagement and involvement and our charity. • Framework for Delivery – Mrs Davies explained that this represents a coordinated collection of strategic processes and decisions that enables the most effective balance of organisational change and business as usual. Kirsty Roberton, Deputy Director of Corporate Services and Transformation, is developing measurable outcomes which will be supported with the Trust's Certified Leaders. **Mental Health Services Overview:** Mrs Davies drew attention to the report which outlines the ICB priorities for mental health and learning disability care across the North East and Cumbria. Mrs Davies explained that a key focus for the Trust will be working with partners to further develop community teams with a range of professional and voluntary sector partner involvement. These will assist to address the wider determinants of health. Other priorities will address the need to reduce waiting times for assessment and treatment for children with autism and ensuring that our Older Persons Mental Health services deliver safe, effective, patient focussed care Following a query from Mrs Marshall in relation to whether there were any contractual obligations and how this was being streamlined, Mrs Davies reported that this work is being led by Mr Levi Buckley, Executive Area Director North for the ICB, and will request further clarification. **RESOLVED:** to receive the report for assurance.	TD

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Agenda Item	Discussion and Action Points	Action By
23/159	**GOVERNANCE REPORTS** **Strategic Aims and Objectives update** Mrs N Bruce, Director of Strategy, Planning and Partnerships, provided assurance to the Board over progress made towards the delivery of the strategic objectives for 2023/24. She reported that the strategic objectives were agreed at the last Board meeting in May 2023 and delivery plans have been developed by the Executive Director owners of each of the objectives and reviewed at the relevant Board committee meetings. The report provides an update for Quarter 1 and Mrs Bruce highlighted that there are 34 sub-objectives in total and overall good progress has been made. Two sub-objectives have been completed, there are 10 sub-objectives with some risk to delivery and one sub-objectives that has not yet started. There has been a request to update the expected outcome measures for SA2.3 and SA4.2 and the suggested changes have been highlighted in red. Mr M Robson, Vice Chair, drew attention to discussions which had taken place at the Finance and Performance Committee in relation to the finance objective SA3.1 and the need to reframe the new operating model objective and Mrs Bruce confirmed that work is being undertaken with the Business Unit Operational Directors to refocus outcome measures. After consideration it was: **RESOLVED**: to receive the report for assurance and accept the recommendation changes. Mrs Bruce left the meeting. **Board Assurance Framework (BAF) update:** Mrs J Boyle, Company Secretary, provided the Board with the current Board Assurance Framework 2023/24 for review and assurance, following scrutiny by each of the mapped Board committees. She explained that graphs to track the current risks scores will be incorporated into the BAF once each extract has been reviewed twice by its respective Committee. There are no summary risks that have reached their target score at this point in the year which is in line with current expectations of the Q1 position. Mr M Robson, Vice Chair, reminded the Board of the discussions which took place at the Finance and Performance Committee in relation to the increased financial risks and these will be incorporated into the BAF accordingly. Following discussion, it was: **RESOLVED**: to receive the report for assurance, noting that the BAF is under continuous review and update at the relevant Board committees.	

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Agenda Item	Discussion and Action Points	Action By
	Organisational Risk Register (ORR): Dr G Findley, Chief Nurse and Deputy Chief Executive, presented the updated ORR to the Board which shows the risk profile of the ORR, including a full register, and provides details of reviewed compliance and risk movements. This report covers the period 16th May 2023 to 16th July 2023. Dr Findley reported that there are currently 21 risks on the ORR and following Executive Risk Management Group (ERMG) meetings in June and July 2023, there have been 4 additions to the ORR, although 1 risk has been increased, and 3 reduced. This includes an increase in the overarching financial risk score (Risk 3127) and subsequent two sub risks relating to activity and efficiency. Dr Findley highlighted that following the ERMG meeting in June 2023, it was agreed that a standing agenda item will be added to the meeting to collectively agree the Trust's top 3 organisational risks. These have been identified as workforce and people risks around staffing gaps in all levels within the organisation; financial risks as described above and reputation and performance risks in relation to waiting times and access to various patient services. Following a query from Mrs H Parker, Non-Executive Director, in relation to reputational risks, Dr Findley explained that it is expected that these risks will be decreased as mitigating actions are undertaken. Mr Robson highlighted the discussions which have taken place in relation to the financial risks particularly around the risk relating to the new operating model (Risk 2868) and Dr Findley agreed that this will be reviewed by ERMG. After consideration, it was: **RESOLVED:** to receive the report for assurance.	GF
23/160	**FINANCE REPORT:** Mrs K Mackenzie, Group Director of Finance and Digital, provided the Board with the monthly finance report including an overview of financial sustainability and the proposed capital plan. **Month 3 Report:** Mrs Mackenzie highlighted that the Month 3 financial position demonstrates that the Trust is delivering as expected per submitted plans. Inherent risk includes the capacity to achieve required cost efficiencies and the sustained impact of industrial action on both income and direct costs however she reported that this is in line with peers across the system. **Financial sustainability presentation:** Mrs Mackenzie explained that this presentation was shared with the Integrated Care Board (ICB) to provide assurance that the Trust is	

UNCONFIRMED

Agenda Item	Discussion and Action Points	Action By
	focussed on longer term financial sustainability and outlines the financial strategy and internal governance being utilised to achieve this. Following a query from Mrs A Stabler, Non-Executive Director, on the likelihood of the achievement of cost reduction plans, Mrs Mackenzie explained that Equality and Quality Impact Assessments (EQIAs) are still being completed on schemes however sustainability plans will require the achievement of further recurrent plans. Mr M Robson, Vice Chair, felt that it was important to fully understand the financial risks and Mrs Mackenzie highlighted the regional challenge in the development and delivery of recurrent plans. Mrs T Davies, Chief Executive, acknowledged the challenges in the delivery of plans however highlighted the importance of sustainability for the wider Gateshead population. Mrs Mackenzie felt that it would be beneficial to discuss plans in more detail at a Board Development Session. **Capital Plan 2023/23** Mrs Mackenzie reported that capital funding of £27.947m is now available to support the capital programme for 2023/24 however £29.792m has been approved by the Finance and Performance Committee which exceeds the funding envelope by £1.845m. She highlighted that is consistent with previous years approach and delegated authority is required to be approved by the Board to allow the Executive Management Team to spend capital in line with the capital plan. Following a query on capital investment and revenue savings, Mrs Mackenzie explained that there is a need to reduce revenue expenditure however due to fluctuating costs and restricted funding, a longer-term strategy is required. Mr Moffat noted the inclusion of the CDC in the capital plan and the potential slippage risk identified in the Finance and Performance Committee. Following consideration, it was: **RESOLVED:** i) to receive Month 3 financial position and note that financial performance is as per plan in both year to date and forecast terms ii) to receive the sustainability presentation and note the strengthened governance in respect of the internal delivery model iii) to ratify the proposed capital programme, noting it currently represents an over-commitment against funding.	JB/KMac
23/161	**INTEGRATED OVERSIGHT REPORT:** Mrs K Mackenzie, Group Director of Finance and Digital, Dr G Findley, Deputy Chief Executive & Chief Nurse, and Mrs A Venner, Interim	

UNCONFIRMED

Agenda Item	Discussion and Action Points	Action By
	Director of People and Organisational Development, introduced the Integrated Oversight Report (IOR) for May and June 2023. Mrs Mackenzie explained that the report continues to be reviewed and revised and has been discussed and received in-depth scrutiny by the various Board Committees. Dr Findley provided an update in relation to the Safe and Effective domains and highlighted that there have been seven serious incidents reported in June. Four of the incidents relate to falls therefore focussed work will take place in line with the National Patient Safety Strategy and Dr Findley will lead on this. Following a query from Mrs Marshall in relation to the Patient Safety Incident Response Framework (PSIRF), Dr Findley reported that work is underway and the Patient Safety Incident Response Plan (PSIRP) that supports this needs to be submitted prior to the next Board. It was therefore agreed that the plan will be approved by the Quality Governance Committee prior to ratification by the Board in September 2023. Mrs Mackenzie provided an update in relation to the Responsive domain and reported that high levels of attendance continue to be an area of focus as well as increased waiting times. Following a query from Mrs A Stabler, Non-Executive Director, in relation to waiting list validation work, Mrs T Davies, Chief Executive, explained that a validation programme is being developed however there is currently no centralised waiting list function. Mrs Mackenzie explained that weekly performance clinics are taking place to ensure mitigation plans are in place. Mrs Venner provided an update in relation to Well Led domain and reported that sickness absence, core training and appraisal rates are all within set targets. The number of staff in contracted posts has increased slightly and the overall vacancy rate appears positive. Agency spend has increased particularly around nursing and medical staff however bank spend has reduced. The Board acknowledged the improvements in these targets and thanked the teams for this achievement. After consideration, it was: **RESOLVED:** to receive the report for assurance, noting the improvements in key areas as well as the impact of industrial action in elective recovery and waiting times.	GF
23/162	**NURSE STAFFING EXCEPTION REPORT:** Dr G Findley, Deputy Chief Executive & Chief Nurse, presented the report for June 2023 which provides an exception report for nursing and midwifery staffing, including healthcare support workers, and provides information relating to ward staffing levels (funded against actual) and details of the actions taken to address any shortfalls.	

UNCONFIRMED

Agenda Item	Discussion and Action Points	Action By
	Dr Findley reported that there have been some staffing challenges this month in relation to vacancies and short-term sickness absence alongside increased patient activity. A staffing escalation protocol is in operation across all areas and reported via the incident reporting system. Nursing Red Flag reporting has also been introduced and Dr Findley explained that a red flag can be raised by the nurse in charge via HealthRoster if an area feels they cannot deliver the expected standards of care due to staffing issues. Dr Findley also reported that a staffing review is taking place within the Special Care Baby Unit following an external review of staffing requirements and discussions are taking place via the Executive Management Team and Senior Management Team meetings. Following discussion, it was: **RESOLVED:** to receive the report for assurance.	
23/163	**MATERNITY UPDATE:** **Maternity Integrated Oversight Report:** Mrs J Conroy, Interim Head of Midwifery, presented a summary of the maternity indicators for the Trust for May 2023. Mrs Conroy highlighted that the report is still being developed in line with Local Maternity Services (LMS) and Integrated Care Board (ICB) recommendations and statistical process control charts have been introduced. She drew attention to some of the key performance indicators from the dashboard and reported that most are under target at present. Discussion took place around the post-partum haemorrhage (PPH) target rates and Mrs Conroy explained that discussions were taking place at regional meetings as to whether this was an appropriate target to measure against. The Board acknowledged the good Care Quality Commission (CQC) rating and thanked the teams for this achievement. After consideration, it was: **RESOLVED:** to receive the report for assurance. Mrs Conroy left the meeting.	
23/164	**QUALITY ACCOUNT 2022/23:** Dr G Findley, Chief Nurse and Deputy Chief Executive, presented the Trust's Quality Account for 2022/23 and explained that this had been approved by the Quality Governance Committee in June on behalf of the Board prior to submission to NHS England on 30th June 2023.	

UNCONFIRMED

Agenda Item	Discussion and Action Points	Action By
	After consideration, it was: **RESOLVED:** to receive the report for assurance and information.	
23/165	**CYCLE OF BUSINESS:** Mrs J Boyle presented the cycle of business which outlines forthcoming items for consideration by the Board. This provides advanced notice and greater visibility in relation to forward planning. The Board are therefore encouraged to review the cycle of business ahead of the next meeting in September 2023 and it was: **RESOLVED:** to receive the cycle of business for 2023/24.	
23/166	**QUESTIONS FROM GOVERNORS IN ATTENDANCE:** A question was received in advance from Steve Connolly in relation to Agenda Item 7, Nursing Apprenticeships 4 Year Programme Proposal, around whether the annual intake will be on a specific date annually or on a rolling basis to enable an apprentice to commence should another leave mid-course. Dr Findley explained that currently there is one intake a year at the start of the academic year in September, however teams are working with universities to seek to introduce a second intake halfway through the year (January).	
23/167	**DATE AND TIME OF THE NEXT MEETING:** The next meeting of the Board of Directors will be held at 9:30am on Wednesday 27th September 2023.	
23/168	**CLOSURE OF THE MEETING:** Mrs Marshall declared the meeting closed.	
23/169	**EXCLUSION OF THE PRESS AND PUBLIC:** **RESOLVED:** to exclude the press and public from the remainder of the meeting due to the confidential nature of the business to be discussed	

UNCONFIRMED

PUBLIC BOARD ACTION TRACKER

Gateshead Health NHS Foundation Trust

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

Agenda Item Number	Date of Meeting	Agenda Item Name	Action	Deadline	Lead	Progress	RAG-rating
23/59	29/03/2023	Constitutional Amendment	To be presented at the AMM	20/09/2023	JB	**Sept 23** – constitutional amendments approved at the AMM on 20 September 2023. **Action recommended for closure.**	
23/64	29/03/2023	Board Committee Assurance Report	Discussion around proposed rescheduling of committee meetings required – to be discussed at Exec Team	24/05/2023	Exec	May 23 – outcome to be provided July 23 – to be reviewed as part of GGI review. Action to be retained as open until this review concludes. **Sept 23** – review is due to conclude in early October. Board discussion planned for October Board Development day.	
23/120	24/05/2023	Learning from Deaths	To include suggested links to litigations and Getting It Right First Time in next iteration of the report	29/11/2023	AB	Action not yet due.	
23/156	26/07/2023	Nursing Apprenticeships 4 year programme	Progress to be reviewed and evaluated via POD committee. Feedback to Board at later date. To ensure that this is cross-referred to POD Committee and included in the cycle of business.	29/11/2023	GF / AV	Will be added to POD committee cycle of business **Sept 23 –** completed. **Action recommended for closure**	
23/157	26/07/2023	Board Assurance Report – F&P	Item for escalation re. slippage and escalating costs of CDC programme. Extraordinary Board may be required for further	27/09/2023	JB	**Sept 23** – extraordinary Board was not required. Item features on Part 2. **Action recommended for closure.**	

Agenda Item Number	Date of Meeting	Agenda Item Name	Action	Deadline	Lead	Progress	RAG-rating
			discussion following review at QEF Board				
			Leading indicators development – further discussion may be required at Board Development session	27/09/2023	JB	**Sept 23** – proposal to include on next Board development day on 18 October. **Action recommended for closure.**	
		Board Assurance Report - Digital	To discuss with the Digital Committee Chair the most appropriate approach for agreeing the next steps for the Electronic Patient Record development (e.g. Board development session or additional Digital Committee) and report back to Board.	27/09/2023	Kmac		
23/158	23/07/2023	CEO update	Mental Health Services overview – to request further clarification re. contractual obligations	27/09/2023	TD		
23/159	23/07/2023	Organisational Risk Register	To review new operating model risk (2868) via Exec Risk Management Group	27/09/2023	GF	**Sept 23** - risks on risk register reviewed. Action recommended for closure.	
23/160	23/07/2023	Finance Report	To consider Board Development Session to discuss delivery of financial sustainability plans	27/09/2023	KMac/ JB	**Sept 23** – this was featured as part of the August Board Development session. **Action recommended for closure.**	
23/161	23/07/2023	Integrated Oversight Report	Patient Safety Incident Response Plan (PSIRP) to be approved at QGC prior to ratification by Board in September.	27/09/2023	GF	Sept 23 - PSIRP was presented at August Quality Governance Committee. **Action recommended for closure**	

Closed Actions from last meeting

Agenda Item Number	Date of Meeting	Agenda Item Name	Action	Deadline	Lead	Progress	RAG-rating
22/139	27/09/2022	Risk Management Strategy	To come back to Board for approval at future meeting	31/12/2022	GF	To be reviewed with enabling strategies in February. It was felt that the risk management policy should sit above this and will be discussed at Audit Committee. March 23 – a draft risk management strategy has been developed and is currently being consulted on. This included being shared with Audit Committee. This will be presented to Board following the consultation process – expected at May Board May 23 – on agenda. July 23 - Feedback awaited from QEF Board. Delegated authority agreed to ensure changes completed. Action agreed as closed.	
23/12	25/01/2023	Integrated Oversight Report	Duty of candour compliance – proposed new recording method being considered with focussed work taking place. To discuss outside of meeting	29/03/2023	GF/AS	March 23 – this is in progress and will be changing with the implementation of the new incident reporting system to replace our current provider. May 23 – new process in place and review taking place via QGC. July 23 – as the new process was in place and being led by QGC it was agreed to close this action.	
23/67	29/03/2023	Annual NHS Staff Survey Results	Progress on action plan to come back to Board for review	27/09/2023	LCJ/AV	Action not yet due but included on cycle of business for September. July 23 – agreed to close given this has been included on the cycle of business and will be picked up through agenda setting.	

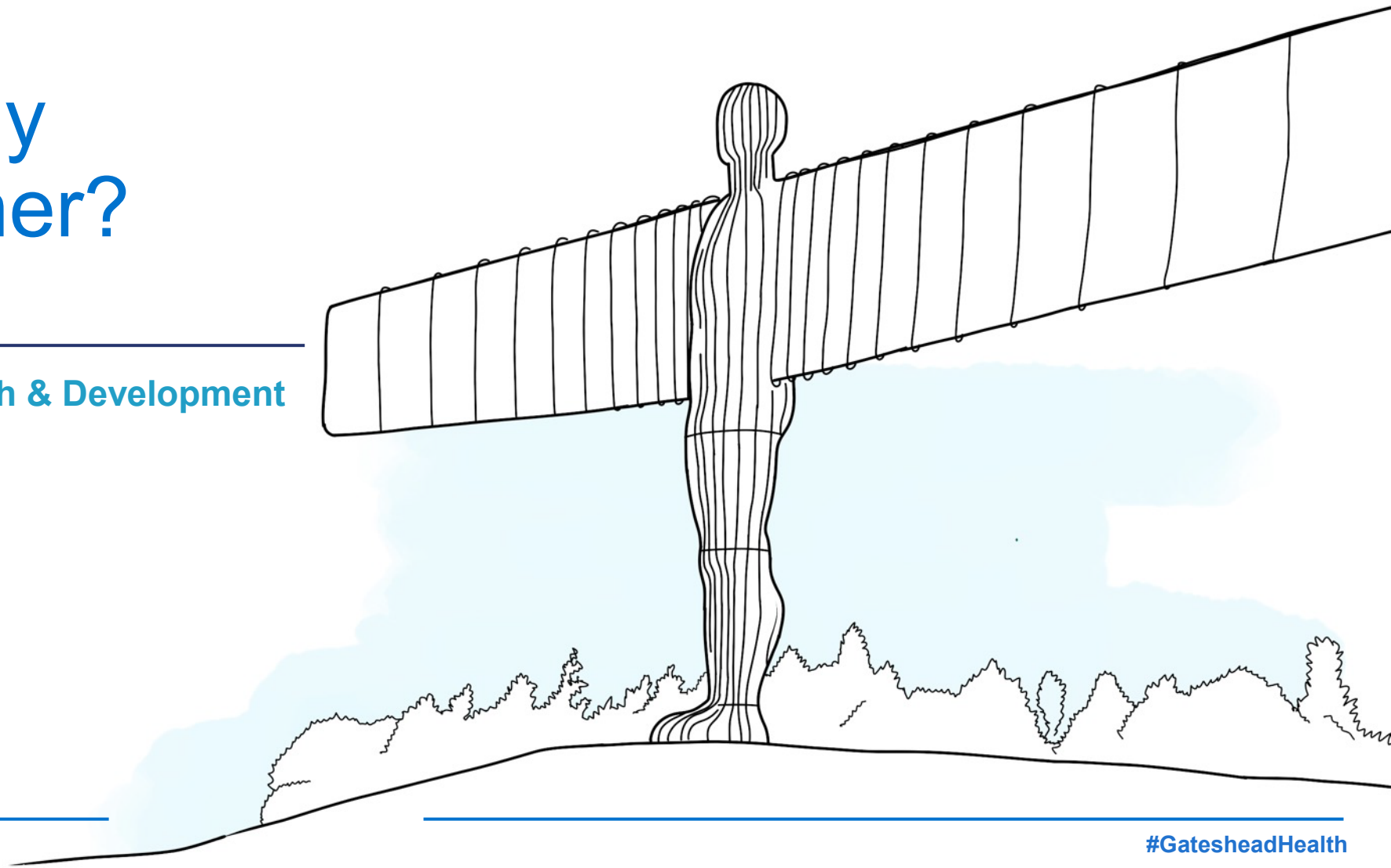
23/111	24/05/2023	Trust Strategic Aims and Objectives	To make minor adjustments to the strategic aims and objectives document to ensure appropriate leads and assurance committees are identified	31/07/2023	TD/JB	July 23 - Requested updates have been made and included on Q1 update at July Board. Action therefore agreed to be closed.	
23/112	24/05/2023	Enabling Strategies	EDI strategy – to include Governors within this work and update document	26/07/2023	LCJ / AV	July 23 – EDI session as part of Governor workshop on 19 July 23. Action therefore agreed to be closed.	
23/114	24/05/2023	Thematic Review	Consultation process taking place and following this key indicators to be shared with Board	26/07/2023	TD/JB	July 23 - Leading indicators feature on the July Board Part 2 agenda. Action therefore agreed to be closed.	
			6 month update to be provided to Board – to add to cycle of business	26/07/2023	JB	July 23 - Added to the cycle of business. Action therefore agreed to be closed.	
23/117	24/05/2023	Integrated Oversight Report	To ensure Non-Executive Directors receive summary of reported SIs	31/05/2023	GF	July 23 - process now in place and confirmed by the Non-Executive Directors at Board. Action therefore agreed to be closed.	
23/118	24/05/2023	Safe Staffing Review Report	To ensure embedded documents are distributed to the Board separately	31/05/2023	GF	July 23 – sent separately via email. Action therefore agreed to be closed.	
			Recommendation to receive “red flags” within monthly assurance report going forward	26/07/2023	GF	July 23 - included in the next report. Action therefore agreed to be closed.	
23/119	24/05/2023	Maternity IOR	To review the use of graphs within the report	26/07/2023	GF/JC	July 23 - New style maternity IOR being presented this month. Action therefore agreed to be closed.	

Gateshead Health
NHS Foundation Trust

Research - Why should we bother?

Alison Harvey - Head of Research & Development

Wednesday 27th September 2023



Who, What, Where, When, Why?

Gateshead Health NHS Foundation Trust

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
James Harvey

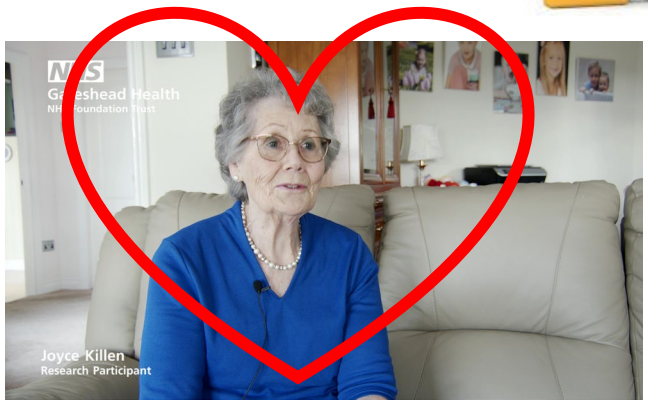
Research Assistants

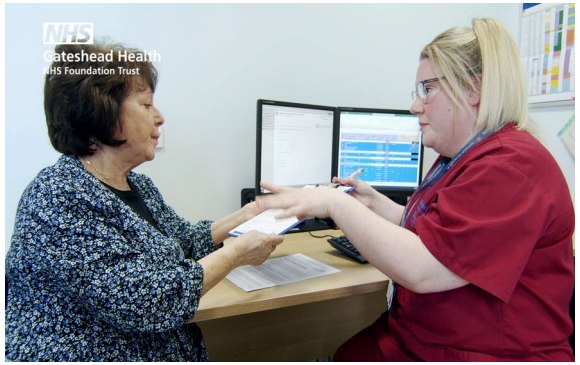
Jess Rice
Jacob Douglass

26

QEH, BGH, Gateshead, Newcastle, GP Surgeries, Community

213





The Good

New figures show that a total of **46,831** people took part in research supported by the NIHR Clinical Research Network (CRN) North East and North Cumbria in 2022/23; almost enough to fill St James' Park! They were recruited into 885 studies across a wide range of disease areas and settings including public health and social care.

NHS Gateshead Health NHS Foundation Trust

NIHR | Clinical Research Network North East and North Cumbria

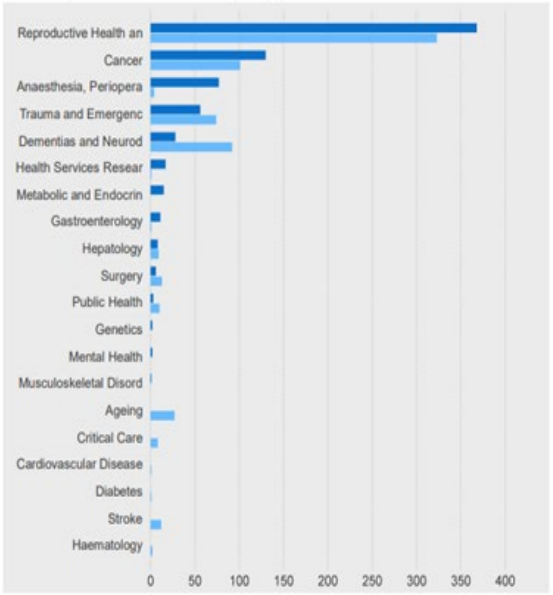
Data correct at 18/09/2023

Gateshead Health NHS Foundation Trust

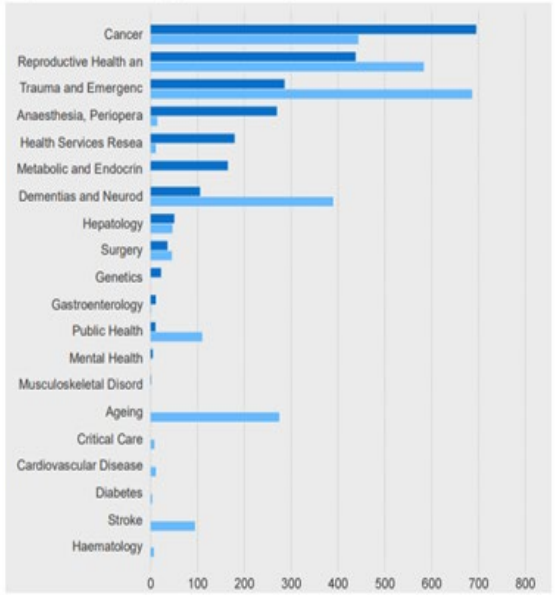
2	RECRUITING SITES (CURRENT FY)	724	PARTICIPANTS (CURRENT FY)	33	RECRUITING STUDIES (CURRENT FY)	14	RECRUITING SPECIALTIES (CURRENT FY)

Key: 2023-24 2022-23 2021-22

RECRUITMENT BY MANAGING SPECIALTY

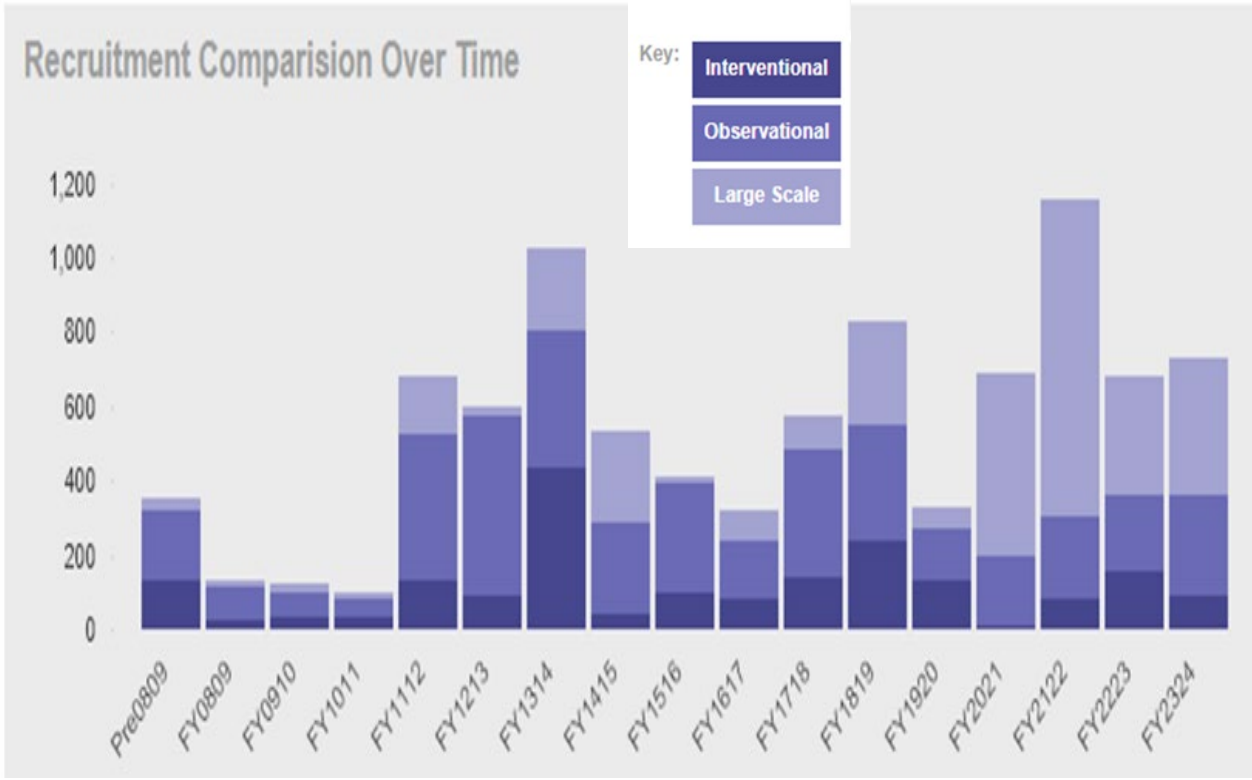


COMPLEXITY ADJUSTED RECRUITMENT



This report was generated from the LCRN NENC Open Data Platform (ODP) Application
For queries relating to ODP please contact the Business Intelligence Team
nencbusinessintelligence@nihr.ac.uk

Recruitment Comparision Over Time



The Bad

Who are you exactly?

I don't have time for this!

You are a pest!

Not my responsibility!

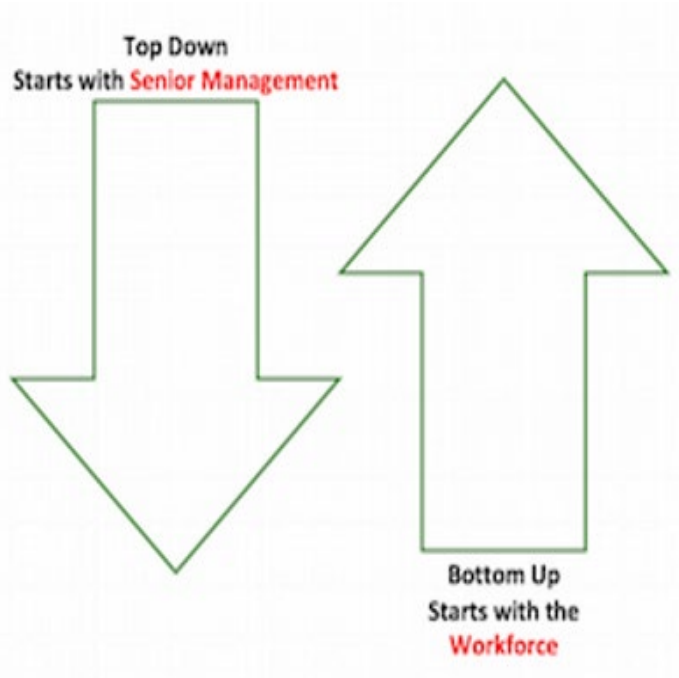
Evidence based what?

I thought you didn't do research?

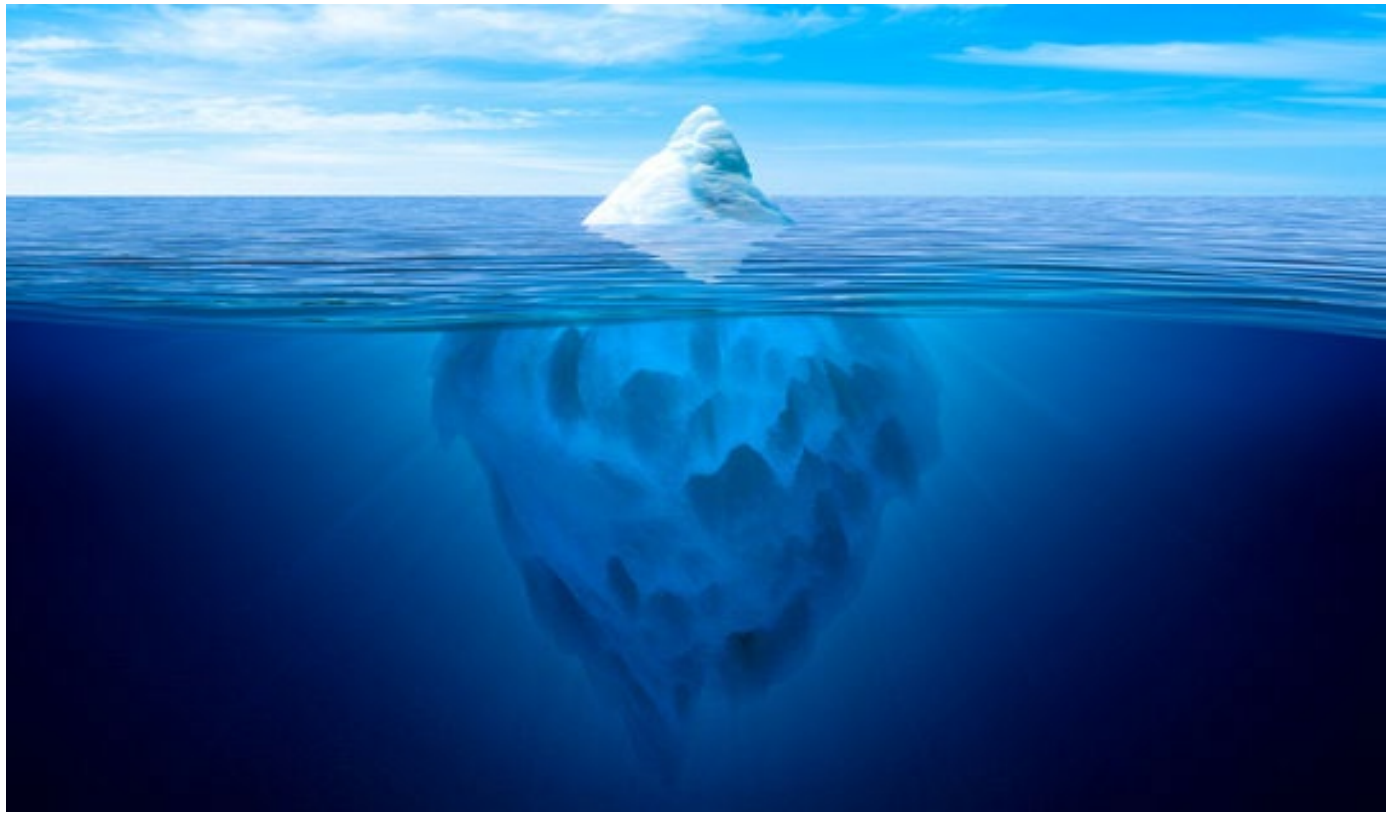
There is no benefit to research!

I am too busy with clinical work!

NHS
Gateshead Health
NHS Foundation Trust



The Ugly



Gateshead Health
NHS Foundation Trust

The Future!

NHS
Gateshead Health
NHS Foundation Trust

Commercial = money = Sustainable workforce

Non-commercial = recruitment = NIHR Funding

Gateshead Health
NHS Foundation Trust

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 07

Report Title:	**Draft Winter Plan 2022/23 – Strategic Overview Assurance Report**			
Name of Meeting:	Trust Board			
Date of Meeting:	27 September 2023			
Author:	David Patterson Head of Emergency Preparedness, Resilience and Response			
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 seeks the endorsement of the Trust Board for the draft Winter Plan 2023-24 – Strategic Overview prior to submission to NHS England			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☐ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	Executive Management Team, Strategic EPRR Committee and Gateshead Health Winter Operational Group			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	Winter 2023-24 is expected to be challenging and complex due to • expected continuing covid surges / variants alongside other respiratory viruses e.g. Influenza, Respiratory Syncytial Virus (RSV) and Norovirus • the on-going costs and challenges of attaining and optimising greater winter capacity • a parallel need to recover elective activity • ongoing Industrial Action risk management and response. These factors will impact the Trust's ability to deliver a high-quality service over the winter months. Robust planning, mitigation and forecasting has taken place in order to reduce these impacts and to ensure our patients continue to have a positive patient experience and receive safe, compassionate and effective care. It is important our winter planning facilitates			

<table>
<tr><td></td><td colspan="2">resilience in all services (both Trust and place) to ensure that winter pressures are managed appropriately.

The requirements for meeting the challenges of winter are dynamic and iterative and a supporting Operational Trust Winter Plan has been produced to provide specific guidance, information and instructions for teams to operationally respond during the winter period.

The focus of the Operational Winter Plan for 2023-24 is on:

a) Maintaining patient support in the community where safe to do so.
b) Maximising alternatives to our Emergency Department attendances and/or admissions
c) Optimal use of in-patient beds by reducing length of stay; ensuring timely discharges and maximising the investment in winter service provision.
d) Maintaining performance and ensuring patient safety through the hospital with a specific focus on ambulance handover delays and delays in the Emergency Department.

As a Trust we will have increased our place-based collaboration in winter response. In addition, we have strong networks through our EPRR teams, the Integrated Care System, the Regional Chief Operating Officer Group and the Urgent & Emergency Care Network which we will use to dynamically inform our plans going forwards.

The draft Winter Plan 2022-23 – Strategic Overview is attached as Appendix 1 to this report.</td></tr>
<tr><td>Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper</td><td colspan="2">The Trust Board are asked to review the draft Winter Plan Strategic Overview and to confirm that it provides assurance to support the work of the Trust during the Winter period 2023-24 noting the risks identified.</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:</td><td>Aim 1
☒</td><td>We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>Aim 2
☒</td><td>We will be a great organisation with a highly engaged workforce</td></tr>
<tr><td>Aim 3
☒</td><td>We will enhance our productivity and efficiency to make the best use of resources</td></tr>
<tr><td>Aim 4
☒</td><td>We will be an effective partner and be ambitious in our commitment to improving health outcomes</td></tr>
<tr><td>Aim 5
☒</td><td>We will develop and expand our services within and beyond Gateshead</td></tr>
<tr><td>Trust corporate objectives that the report relates to:</td><td colspan="2">Strategic aim one: We will continuously improve the quality and safety of our services for our patients</td></tr>
</table>

<table>
<tr><td></td><td colspan="5">Strategic aim three: We will enhance our productivity and efficiency to make the best use of our resources

Strategic aim four: We will be an effective partner and be ambitious in our commitment to improving health outcomes</td></tr>
<tr><td>Links to CQC KLOE</td><td>Caring
☒</td><td>Responsive
☒</td><td>Well-led
☒</td><td>Effective
☒</td><td>Safe
☒</td></tr>
<tr><td colspan="6">Risks / implications from this report (positive or negative):</td></tr>
<tr><td>Links to risks (identify significant risks and DATIX reference)</td><td colspan="5">There are several risks that are factors to the successful delivery of the winter plan that may impact the trust concurrently. This includes:

<u>Organisational / locally managed trust risks</u>

• Ref 3095 – risk of quality of care due to industrial action
• Ref 3063 –unfunded increase in bed base and delay in transfers of care to Local Authority
• Ref 2764 – workforce planning
• Ref 2982 – delay in transfer due to lack of social care provision
• Ref 3029 – surge in covid-19 activity that could impact on operational delivery
• Ref 3035 – delay in ambulance handovers

<u>National / system risks</u>

• Industrial action across various public sectors
• Negative impacts on population health of seasonal illness and cold weather
• Disruption to Adult Social Care resulting in extended lengths of stay and inability to move patients to their next point of care delivery in a timely manner
• Ambulance service pressure resulting in higher than forecast demand
• Outbreaks of infectious disease restricting bed base flexibility and availability
• Agency caps with staffing frameworks resulting in poor staffing ratios
• Increases in the cost of living resulting in high numbers of social care presentations or factors in discharge planning

The detail of the likelihood and consequence of any impacts will be a dynamic process and will be continually monitored throughout the winter period.</td></tr>
<tr><td>Has a Quality and Equality Impact Assessment (QEIA) been completed?</td><td colspan="2">Yes
☐</td><td colspan="2">No
☐</td><td>Not applicable
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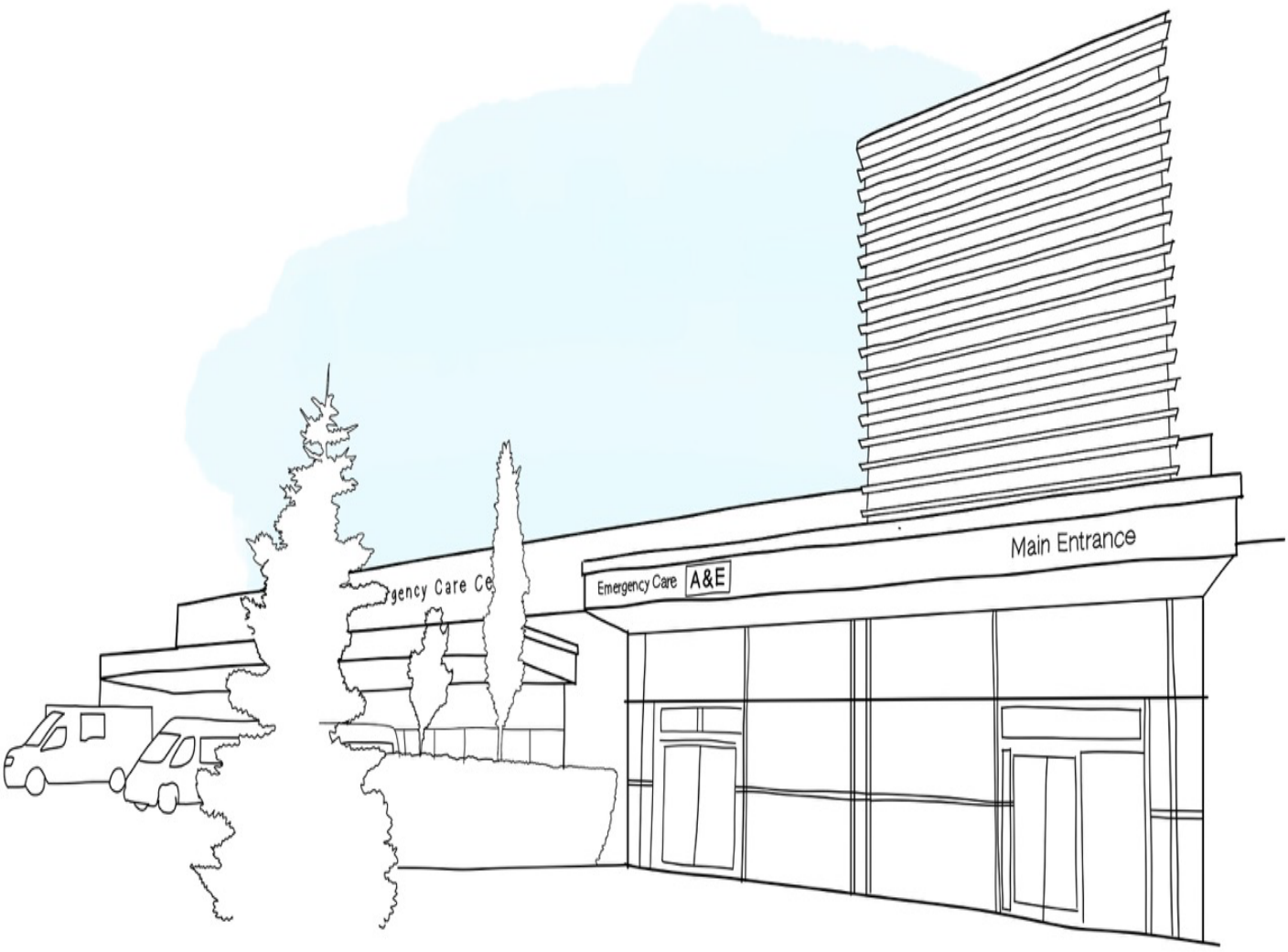
</table>

Gateshead Health
NHS Foundation Trust

Winter Plan 2023-24

A strategic overview

September 2023



Contents

1. Introduction & Overview

Historically, winter impacts on the Gateshead population served by the Trust, our local communities and the NHS are well known:

- Increased fractures due to slips, trips and falls due to winter weather conditions
- Increase in respiratory viruses including influenza and Covid-19
- Increase in Norovirus and similar gastrointestinal conditions
- Increased emergency admissions because of the deterioration of chronic health problems
- Increased staff absences due to sickness
- Potential transport difficulties due to adverse weather impacts

For the purposes of this document - Winter 2023-24 covers the period from **24 November 2023 until 2 April 2024.**

This period is expected to be particularly challenging. This will impact on the Trust's ability to deliver a high-quality service and in some instances may increase our organisational and clinical risk profile. Robust planning, mitigation and forecasting are therefore required in order to reduce impacts and to ensure our patients continue to have a positive patient experience and receive safe, compassionate and effective care.

The Trust has continued to evolve the robustness of our plans and has taken a number of steps to improve overall resilience going into the winter period. This has included:

- A review of the patient flow model and implementation of revised schedules and information flows
- A review of all related policies and procedures, incident response and the on-call framework to deliver the NHS England (NHSE) Emergency Preparedness, Resilience and Response (EPRR) core standards and strengthening our response
- An ongoing digital transformation programme including real-time performance dashboards to support operational decision making
- Incorporation of the lessons learned from business continuity and Industrial Action responses into future plans
- An ongoing review of the Trust Operational Pressures Escalation Level (OPEL) escalation procedures and multi-agency response arrangements in alignment with a new national Framework and System Coordination Centre documentation

The plan was presented to the Gateshead Health NHS Foundation Trust Board on 27 September 2023.

2. Aim and Objectives

The aim of this plan is to provide a strategic overview and assurance for winter planning arrangements at Gateshead Health NHS Foundation Trust.

The following objectives have been identified to deliver our overall aim:

- To identify and embed organisational learning from previous winter periods, Industrial Action and Business Continuity incidents
- To enable a robust governance process with our system partner organisations across the Gateshead Place Based System and the Northeast and North Cumbria Integrated Care Board (NENC ICB)

- To establish clear roles and responsibilities to support clarity of organisational decision making and escalation
- To establish a framework for winter surge and demand management
- To utilise national guidance and best practice
- To identify and manage risks and to enhance patient safety and experience
- To provide appropriate staffing and resources during the winter period
- To provide a costed budget to deliver our Winter Plan 2023-24

3. Review of Winter 2022-23

Winter 2022-23 was one of the most challenging ever faced by the NHS.

The key features were:

- Management of Covid-19 variants and associated respiratory infections
- Ongoing staffing pressures linked to Covid-19 and other seasonal absences
- Management of industrial action within the nursing, ambulance and medical workforce sectors
- Staffing challenges locally and nationally in health and social care
- Demand pressures resulting in the need to
    - expand the bed base above the planned levels
    - opening winter planned beds for a longer period of time than in the original plan resulting in an adverse staffing and financial impact
- Poor patient experience
- Operating across an extended period of time at an increased level of clinical and organisational risk
- Levels of performance fell below national targets (including a significant number of nationally declarable breaches of 12 hour waiting times)
- Impact on the personal resilience and mental health of staff
- Requests to other Trusts for mutual aid

Winter pressures were experienced across the Northeast and in particular in some neighbouring Trusts. Consequently, there was an unknown (and therefore unplanned) impact on increased activity in Gateshead which led to patients in ambulances being diverted to us and impacting on our ability to respond.

Organisational debrief findings.

An organisational debrief took place in May 2023 with a number of key recommendations identified that included:

- The revision of the winter recruitment strategy and earlier timescales
- An earlier commencement of winter planning
- A review of operating models on the dedicated winter ward
- Strengthening the co-operation with medical teams in identifying patients fit for winter wards and the management of medical patients outlying in the surgical bed base
- A review of escalation with very clear stages based on trigger points and decision-making structures.
- An increase the uptake of both flu and covid vaccinations across the workforce
- A review of the primary care support over the winter period.

All this feedback has informed and been incorporated within our 2023-24 Winter Plan.

A full overview of the debrief findings is available on request.

4. Approach to Winter 2023-24

The planning requirements for meeting the challenges of winter are a dynamic and on-going process and a supporting Operational Trust Winter Plan has been produced to provide specific guidance, information and instructions for teams to operationally respond during the winter period. This plan has been written in conjunction with the Gateshead place approach to winter and is complementary to this.

The focus of the Operational Winter Plan for 2023-24 is on:

- Maintaining patient support in the community where already safer to do so
- Maximising alternatives to our Emergency Department attendances and/or admissions
- Optimal use of in-patient beds by reducing length of stay; ensuring timely discharges and maximising the investment in winter service provision
- Supporting our staff to be healthy and well throughout the Winter period
- Mitigating the risk of ongoing Industrial Action
- Maintaining performance and ensuring patient safety through the hospital.

The key aims of the operational winter plan are therefore to:

- Ensure the Trust has the ability to respond effectively and quickly to increased seasonal and surges of demand along with the recovery of our elective position
- Maintain the highest standards of patient safety, quality of care and patient experience
- Make the most efficient use of resources available
- Ensure staff feel supported
- Ensure key performance standards are met
- Provide organisational continuity throughout periods of Industrial Action
- Provide effective management of any infection prevention and control issues

The Gateshead Health populated plan includes:

- A dedicated winter ward increasing the bed capacity by 24 beds
- A frailty front of house project and virtual frailty ward across medicine and in the community
- A weekend discharge support team
- A triage and streaming project to ease pressure on the Emergency Department at peak times
- A robust model for managing outbreaks and IPC issues
- An adverse weather response plan

Please see the Operational Winter Plan 2023-24 for further detail.

The following sections provides some highlights of our corporate approach to Winter:

Flu vaccination planning

This year the Trust are looking to repeat the very successful campaigns that delivered Flu vaccinations to 80% of Trust staff prior to the Covid-19 Pandemic that includes the following highlights:

- The Flu campaign commences 26 September 2023 (this is due to Vaccine delivery dates)
- The Vaccine Committee (including a wide range of representatives from across the Trust) is currently meeting on a monthly basis to consider the plans for both Flu Vaccine and Covid-19 booster (if recommended) for Health Care Workers this Autumn.
- Plans to give the flu vaccine and Covid-19 booster dose both at the same time
- Staff can continue to inform the Trust they've received the Flu or booster vaccine elsewhere

- Bank staff employed to offer vaccines to staff in their normal workplace (including Twilight shifts and weekends)
- Peer vaccinators to be used in the Community
- A communications plan will be implemented by the Communications Team, (commencing 4 weeks preceding the campaign/delivery)
- Level of uptake will be shared with all staff via QE Weekly/Screensavers/Flu page to encourage competition between wards and departments.
- Business Units/Service Lines will be informed of their current level of uptake and senior teams asked to engage/encourage/communicate key messages
- Planning is reliant on a consistent supply of relevant vaccines to meet planned demand

Infection, Prevention and Control

During the winter months there is an increase in seasonally related infectious diseases which can lead to higher incidence rates of infections such as respiratory viruses (Covid-19, Influenza and RSV) and Norovirus. These viruses thrive in the hospital environment, particularly in the context of high bed occupancy rates and excess patient and staff movement throughout the organisation. They result in an increase in morbidity and mortality rates in patients as well as increasing length of stay.

It is important therefore, that the organisation identify and isolate infectious patients in a timely manner.

Written information/guidance is available for staff: NHS England » National infection prevention and control manual (NIPCM) for England Other supporting IPC policies can also be found within the policy suite on the intranet.

All staff working in clinical areas should be vaccinated against Influenza in a timely manner and this is a key focus of our communications and vaccination campaign.

Transmission of infections is particularly likely to occur when patients are nursed in close proximity (i.e. corridors in ED or 5-6 bed bays) therefore, every effort should be made to avoid such circumstances wherever possible. Patient movement between beds and wards should also be limited as far as possible to prevent unnecessary spread of infection between wards. This guidance is explicit within our operational planning guidance.

As per national guidance, any patient with an infectious respiratory disease MUST be promptly isolated in single room en suite accommodation or cohorted by organism type. Again, organisational policies and procedures are in place to support operational decision making to minimise risk.

Test (Viral screen)

As in previous years, a bespoke local testing strategy will be developed. Anyone with a respiratory or Influenza like illness should undergo a respiratory viral screen (Covid/Influenza) as soon as possible to direct treatment and patient placement within the organisation. Such patients should ideally be isolated (if possible) until the result is back. The microbiology team will produce separate guidance. Asymptomatic testing is no longer recommended according to national guidance.

Workforce Planning

The following actions build on NHSE guidance issued in relation to COVID-19 workforce models and the fundamental principles for the nursing and midwifery workforce as set out in the National Quality Board (NQB) Safe Sustainable and Productive Staffing guidance.

Planning

- The Chief Matrons will review all staffing plans on a weekly basis (or more frequently as required by the operating context and changing circumstances) to ensure safe staffing levels are maintained. This will be supported by the Deputy Chief Nurse / Head of Nursing – Workforce who will be responsive in order to support matrons to dynamically manage any risk.

- Establishment change (electively going below safe staffing levels) will be subject to a Equality/Quality Impact Assessment (EQIA) with final sign-off by the Chief Nurse (Executive Director of Nursing) and countersigned by the Medical Director as joint quality lead. (NHSi2021).

- Chief Matrons will be collectively responsible for workforce planning, providing practice safeguards, to ensure there is a Trust-wide effort to ensure staff with the right skills and experience are redeployed throughout the winter period

- Collaborative working with matrons and People and Organisational Development (POD) ~~(~~Health Roster clinical lead~~)~~ will identify temporary workforce requirements for activity peaks and consider steps such as 'block booking' for 'hard to fill' areas. There should be consideration of redeployment and use of alternative nursing workforce within the financial envelopes identified.

- Identification of additional winter resources will be supported by clinical leaders and service managers and subject to MDT review and risk assessment.

- Redeployment of any nursing staff should be voluntary where possible and individual risk assessments will be undertaken with staff prior to any immediate, short or long term redeployment.

Decision Making and Escalation

With reference to: NQB Safe Sustainable and Productive staffing guidance and Developing Workforce Safeguards guidance.

- When implementing escalation plans, decisions regarding skill mix and nurse ratios will be taken in conjunction with an assessment of patient acuity and dependency, professional judgement, and the environment of care. Oversight of elective skill mix (if we are making a conscious decision to go outside safer staffing rations, this needs oversight from cooperate nursing) and must have Chief Nurse or Deputy Chief Nurse authorisation before implementing.

- In preparation for periods of increased demand, matrons will ensure that staffing plans are reviewed and signed off by the Chief nurse.

- Matrons will be responsible for staffing levels on a shift by shift basis and concerns escalated in a timely manner via clearly established routes. Unresolved issues will be escalated in line with local governance processes. A system wide discussion in and out of hours should be taken to reach solutions wherever appropriate using the existing infrastructure.

- Staff should be supported to discuss and raise concerns regarding staffing and their ability to safely care for patients. Where concerns are raised, the matrons will support staff and mitigate where possible.

Governance

The governance and delivery of the nursing winter staffing plan including all professional groups will be led with support from the Deputy Chief Nurse and Operational Directors. The plan will be mobilised,

implemented and monitored by the Chief Matron/Matrons in the acute setting and by the Clinical Lead / Director of Operations for community services.

The following are already in place as part of winter planning:

- Nurse recruitment - including internationally trained nurses, and a review of domestic processes for Health Care Support Workers (HCSW)
- A continuation of the Trainee Nurse Associates programme and deployment of newly registered Nursing Associates
- Real time staff monitoring through electronic systems, capturing acuity, staffing resource and deployment
- A review of flexible working initiatives
- Frontline support for clinical practice from Specialist nurses, Practice Education and Practice Development (where deemed appropriate through risk assessment).

This is particularly relevant as specific clinical skills training will be scoped to support where necessary deployment of specialist/non-ward-based nursing staff in the event of industrial action.

Assurance and Oversight

Daily operational pressure and staffing shortfalls are managed by the matrons in line with the staffing policy at the operational site patient flow meetings. Out of hours the site resilience team support staff redeployment.

There is a weekly meeting between the Chief Matrons, the Head of Nursing and the Chief Nurse and Deputy to identify areas of concern. Reporting of concerns by staff is actively encouraged to aid understanding the current staffing levels and its impact on patient care. A daily and weekly forecast position allow risk assessment and mitigation via operational discussions. Activation of staffing deployment plans are clearly documented in the incident logs (including where assurance is gained and safe care is sustained).

The monthly staffing report informs the Trust Board and Quality Governance Committee where wards fall below 75% compliance with fill rates. Actions and risks are also identified. The Trust Board considers the impact of any significant and sustained staffing challenges on their ability to deliver on strategic objectives and these risks are clearly documented in the Board Assurance Framework (BAF).

Medical Cover

To ensure the delivery of safe, high-quality care, additional medical staff, both senior and junior are recruited to support the winter/escalation ward. These posts have already been recruited too in line with the winter plan.

5. Governance

Gateshead Health has co-operated and collaborated in its winter planning with system partners via the Regional Chief Operating Officer Group (COO Group) and Urgent and Emergency Care (UEC) Network the Integrated Care System (ICS), Local A&E Delivery Boards (LAEDB), Gateshead Care System Board, Integrated Care Partnership (ICP) and the Integrated Care Board (ICB).

To manage winter pressures the Trust works with health and care partners in Gateshead through the Gateshead System Board and Gateshead System Winter Operational Group. Internally the Gateshead Health Winter Operational Group oversees the tactical and operational responsibility for the monitoring, management and delivery of winter plans for Gateshead Health.

The following provides an overview of the boards and groups:

Gateshead System Board

The Winter Board has strategic oversight of planning, assurance and the delivery of winter plans for the Gateshead System equalising risk wherever possible across the system. The Board oversees any financial allocations received ahead of winter and makes decisions about how this will be best utilised across the system. Post financial investment this group will be provided with oversight as to the benefits analysis and may choose to change the investment profile dynamically to best effect.

Responsibilities
The Board brings together system programme leads and organisational winter leads to have strategic oversight of winter schemes and winter planning.

The purpose of the Winter Board is to have strategic oversight and monitoring of the combined impact of all our programmes and winter schemes across the Gateshead place.

The Board is responsible for all aspects of winter planning, including;

- Demand and Capacity planning
- Oversight of winter schemes
- Oversight of Urgent & Emergency Care Assurance Framework

The Board oversees the submission of system assurance in line with the ICB Board Assurance Framework and any associated action plans required to manage any gaps over winter.

The Board is responsible for oversight and allocation of capacity monies through a distributed governance function and if schemes are not able to deliver according to plans, the funding is redistributed.

Values and principles:
The Board works within the collective values and principles as outlined within all partnership and organisational principles.

Governance and reporting:
The Winter Board is accountable to and provides assurance to the ICB and Place partnership committees. Members attend as decision makers within their organisations and with the Place partnerships.

Gateshead System Winter Operational Group

The Winter Operational Group has tactical and operational responsibility for the monitoring, management and delivery of winter plans for the Gateshead System equalising risk wherever possible across the system. The group oversees all key influencing factors, such as Covid-19, flu, RSV and activity levels and act as a team across Gateshead place to ensure actions and resources are optimised and safety is maintained.

Responsibilities
The group brings together system partners to monitor and respond to key indicators over the winter period.

The purpose of the group is to take tactical and operational responsibility for monitoring the combined impact of all our programmes and winter schemes and seeking to resolve issues where they arise.

The group is responsible for all aspects of winter delivery, including;

- Measurement and monitoring
- Acting together to ensure quality is maintained and risk is understood
- Escalation according to agreed frameworks

The group is responsible for shared delivery of additional actions if schemes are not able to deliver according to plans.

The group is responsible for ensuring all partners are informed and aware of issues and emerging risks

Values and principles:
The group works within the collective values and principles as outlined within all partnership and organisational principles.

Governance and reporting:
The Winter group is accountable to the ICB and Place partnership committees and individual organisational structures.

Members attend as decision makers within their organisations and with the Place partnerships.

Gateshead Health Winter Operational Group

Internally, the Gateshead Health Winter Operational Group has tactical and operational responsibility for the monitoring, management and delivery of winter plans for Gateshead Health. The group oversees all key influencing factors, such as Covid-19, Flu, RSV and activity levels and act as a team to ensure actions and resources are optimised and safety is maintained

Responsibilities
The group brings together operational leaders from across the Trust to monitor and respond to key indicators over the winter period taking collective ownership for the delivery of the agreed Winter Plan.

The purpose of the Winter group is to take tactical and operational responsibility for monitoring and acting upon the combined impact of all our winter schemes and seeking to resolve issues. It will work in alignment to the System Winter Operational and Strategic Groups, identifying and escalating issues which require system support for resolution

The group is responsible for all aspects of winter delivery, including;

- Measurement and monitoring
- Acting together to ensure quality is maintained and risk is understood.
- Escalation according to agreed frameworks

The group is responsible for action and have responsibility for shared delivery of additional actions if schemes are not able to deliver according to plans.

The group is responsible for ensuring all partners are informed and aware of issues and risks

Values and principles:
The group works within the iCORE values of the Trust using these principles to drive collegiate and collective delivery of the plan

Governance and reporting:
The Winter group is accountable to the Trust Executives and Trust Board via the Senior Management Team

Members attend as decision makers for their Division / Team or specialist area of expertise.

6. National Guidance & Good Practice

Our approach to winter planning 2023-24 has been developed in conjunction with the following national guidance and good practice:

NHS England Winter Plan 2023-24

In light of the feedback in regards to earlier winter planning - in July 2023, NHSE published it's 2023/24 winter plan for the NHS in England that comprised of the following core elements:

- High-impact priority interventions drawn from the UEC recovery plan that all systems will be asked to deliver and provide assurance against
- Clear roles and responsibilities for each part of the system so that both shared and individual organisational accountability is clear
- Returns from systems on system-level resilience and surge planning to avoid systems becoming overwhelmed at times of peak demand.

https://www.england.nhs.uk/publication/delivering-operational-resilience-across-the-nhs-this-winter/

High-Impact Interventions

Action	
1	**Same Day Emergency Care**: reducing variation in SDEC provision by providing guidance about operating a variety of SDEC services for at least 12 hours per day, 7 days per week.
2	**Frailty**: reducing variation in acute frailty service provision. Improving recognition of cases that could benefit from specific frailty services and ensuring referrals to avoid admission.
3	**Inpatient flow and length of stay (acute)**: reducing variation in inpatient care (including mental health) and length of stay for key iUEC pathways/conditions/cohorts by implementing in-hospital efficiencies and bringing forward discharge processes for pathway 0 patients.
4	**Community bed productivity and flow**: reducing variation in inpatient care and length of stay, including mental health, by implementing in-hospital efficiencies and bringing forward discharge processes.
5	**Care transfer hubs**: implementing a standard operating procedure and minimum standards for care transfer hubs to reduce variation and maximise access to community rehabilitation and prevent re-admission to a hospital bed.
6	**Intermediate care demand and capacity**: supporting the operationalisation of ongoing demand and capacity planning, including through improved use of data to improve access to and quality of intermediate care including community rehab.
7	**Virtual wards**: standardising and improving care across all virtual ward services to improve the level of care to prevent admission to hospital and help with discharge.
8	**Urgent Community Response**: increasing volume and consistency of referrals to improve patient care and ease pressure on ambulance services and avoid admission.

9	**Single point of access**: driving standardisation of urgent integrated care co-ordination which will facilitate whole system management of patients into the right care setting, with the right clinician or team, at the right time. This should include mental health crisis pathways and alternatives to admission, eg home treatment
10	**Acute Respiratory Infection Hubs**: support consistent roll out of services, prioritising acute respiratory infection, to provide same day urgent assessment with the benefit of releasing capacity in ED and general practice to support system pressures.

Adult Social Care Winter Letter 2023-24

In July 2023, the Adult Social Care Winter Letter was published that sets out the key steps needed so that adult social care systems are resilient and able to provide people and their carers with the support they need this winter.

This letter also sets out expectations for how NHS organisations will work with adult social care in both the planning and delivery of support. This is part of a joined-up approach to planning across the health and care system this winter alongside the letter sent to NHS organisations. The collaborative nature of the NHS and Adult Social Care letter being co-produced and issued on the same day, reiterates the collarborative approach to winter planning and management expected at local place level.

https://www.gov.uk/government/publications/adult-social-care-winter-letter-2023-to-2024/adult-social-care-winter-letter-2023-to-2024

Adverse Weather Health Plan

The UK Health and Security Agency (UKHSA) Adverse Weather and Health Plan was published in September 2023 aims to protect individuals and communities from the health effects of adverse weather and to build community resilience.

The Plan outlines key areas where the public sector, independent sector, voluntary sector, health and social care organisations and local communities can work together to maintain and improve integrated arrangements for planning and response to deliver the best outcomes possible during adverse weather.

https://www.gov.uk/government/publications/adverse-weather-and-health-plan

The internal Gateshead Adverse Weather Plan has been reviewed and amended in light of the new guidance.

7. Roles and Responsibilities

To enable the winter plan to work effectively staff must be clear about their roles and responsibilities in delivery of the plan. Outlined below are the identified roles and responsibilities of the Trust Board and Executive Management Team who are instrumental in supporting delivery of this strategic winter plan:

Trust Board

The role of the Trust Board is to ensure that the winter plan is produced and is fit for purpose to meet expected patient demand.

Chief Executive

The role of the Chief Executive is to ensure that there are robust winter planning arrangements in place, that there is delegated responsibility to an Executive Director for the delivery and monitoring of the plan and to ensure adequate resources are made available to implement it.

Chief Operating Officer

The Chief Operating Officer (COO) has delegated responsibility from the Chief Executive for the development, implementation and monitoring of effectiveness of the plan, alongside being the Accountable Emergency Officer (AEO). In addition, the Chief Operating Officer has the responsibility of bringing to the attention of the Chief Executive and other Executive Directors aspects of the plan that require input from support service directorates.

The Chief Operating Officer has shared responsibility, along with the Medical Director and the Chief Nurse, through the Executive triumvirate to ensure that the quality of care and patient safety is maintained during times of increased patient activity and acuity throughout the winter period.

The Chief Operating Officer is also responsible for the development of appropriate communication mechanisms in collaboration with ICS partners and the local COO network specifically relating to winter management and escalation and will liaise with the Trust Communication lead as appropriate

Medical Director and Medical Director for Operations

The Medical Director has shared responsibility with the Chief Nurse and Chief Operating Officer of ensuring the quality of care and patient safety and clinical outcomes is maintained during times of increased patient activity and acuity during the winter period.

The Medical Director will ensure that when quality and safety risks occur, they are quantified and escalated appropriately, and that mitigating actions are identified, implemented and monitored. The medical director is responsible for ensuring clinical outcomes are maintained.

The Medical Director will continue to provide visible, professional, leadership to medical colleagues, most specifically at times of increased pressure. The Medical Director will play a major role in liaising with the ICB, Social Services and GPs and will provide leadership and support during any staff vaccination programmes.

Chief Nurse

The Chief Nurse has shared responsibility with the Medical Director and Chief Operating Officer to ensure the quality of care and patient safety is maintained at times of increased patient activity and acuity during the winter period. The Chief Nurse must ensure that quality and safety risks are quantified and escalated appropriately and ensure that mitigating actions are identified, implemented and monitored. The chief nurse will be responsible for the monitoring of safe staffing in line with the safer nursing tool kit recommendations and escalate to CEO and AEO when issues arise.

The Chief Nurse will continue to provide visible professional leadership to Nursing, Midwifery and AHP colleagues, most specifically at times of increased pressure, and provide leadership and support as Director for Infection Prevention and Control during planned staff vaccination programmes.

Group Director of Finance and Digital

The Group Director of Finance and Digital will ensure that there are adequate finance/resources are made available for the discharge of Gateshead Health's winter planning responsibilities and consider the need for a contingency budget if required in the context of the organisational overarching financial position.

Executive Director of People & OD

The Executive Director of People & OD will ensure there are adequate workforce arrangements specifically made available for the discharge of Gateshead Health's winter planning responsibilities.

Managing Director QEF

The Managing Director for QEF will ensure that arrangements are in place to monitor the temperature of clinical areas and take action to ensure safe temperatures are maintained; timely repairs are made and contingency plans put in place to address winter issues; access to the hospital is clear and safe in the event of snow and ice and the site is adequately gritted and that QEF support the actions to manage winter pressures and surges in activity and ensure adequate provision of transport, portering and domestic resources to support the delivery of operational services whilst also embedding a robust health and safety culture.

8. Risk management

The winter of 2023-24 will require Gateshead Health to operate against a backdrop of existing pressures and associated risks.

There are several **risks** that are factors to the successful delivery of the winter plan that may impact the trust concurrently. This includes:

Organisational / locally managed trust risks

- Ref 3095 – risk of quality of care due to industrial action
- Ref 3063 –unfunded increase in bed base and delay in transfers of care to Local Authority
- Ref 2764 – workforce planning
- Ref 2982 – delay in transfer due to lack of social care provision
- Ref 3029 – surge in covid-19 activity that could impact on operational delivery
- Ref 3035 – delay in ambulance handovers

National / system risks

- Industrial action across various public sectors
- Negative impacts on population health of seasonal illness and cold weather
- Disruption to Adult Social Care
- Ambulance service pressure
- Outbreaks of infectious disease
- Agency caps with staffing frameworks
- Increases in the cost of living.

The detail of the likelihood and consequence of any impacts will be a dynamic process and will be captured on the organisation / EPRR risk register and will be continually monitored throughout the winter period.

9. Communications

Gateshead Health are part of the regional communications network, which leads the #HeretoHelp campaign. This encourages people to take responsibility to protect themselves, each other and their communities and focusing on messages around our recovery, flu vaccinations, surge plans and staying well over winter.

The campaign includes shared content which can be used across multiple channels, region-wide media and advertising buy which enables us to amplify messages but also localise options where the Trust need to.

The Gateshead Health Strategic Overview and Operational Winter Plan will be cascaded through the staff newsletter. Information will be added to the intranet and any urgent 'all staff' internal communications will be determined by the executive team or strategic on call and disseminated via appropriate channels.

Bespoke communications will continue to be shared and circulated in line with organisational events and / or continuing Industrial Action.

10. Financial Plan

Gateshead Health has an allocated budget of £2.363m for a six-month winter period for FY2023/24. £0.299m has been allocated to April 2023 with a remaining balance of £2.015m for its response to winter pressures over the period November 2023 to March 2024. This includes a dedicated winter ward to be staffed by a mix of substantive staff, bank and agency locums.

For comparison, the Trust spent £2.256m on winter in the financial year 2022/23 (£2.101m FY2021/22).

This plan assumes the opening of additional beds both on a dedicated winter ward and in escalation areas as detailed in the below table.

	Core	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Medicine	332	356	356	356	356	356
Surgery	103	103	103	103	103	103
Total	430	453	452	452	461	461

The following additional schemes are also noted which will support.

Additional Supporting Schemes:	**Value of Scheme (£m)**
Urgent and Emergency Capacity Scheme	£1.472m
Virtual Wards	£0.922m
Ageing Well	£0.522m
Total	**£2.916m**

The bed number modelling informing the financial forecast reflects necessary adjustments in relation to other NHSE winter capacity monies in 2022/23 as detailed below:

Additional Winter Capacity Schemes:	**Value of Scheme (£)**
Front of house team to support admission prevention	114,730
Spot purchase of care home beds	388,800
Additional PTS vehicle for discharge via QEF	46,200
Weekend discharge support teams	186,340
Total	**736,070**

11. Conclusion

In conclusion, Gateshead Health has identified that Winter 2023-24 is expected to be particularly challenging and anticipate the need to respond to unprecedented demand for services.

However, our winter planning has allowed the Trust to forecast pressures, to provide mitigation and to assure our patients that they will continue to receive safe and effective care. A strong governance framework at Trust, local and place level is in place to collaboratively manage the impact of winter across multiple providers and sectors.

The plan will continue to evolve dynamically to organisational and clinical risk. Formal evaluation will take place in April 2024 and will be fedback into the relevant elements of the organisation to inform future changes and plan developments / delivery.

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 8

Report Title:	Patient Safety Incident Response Plan			
Name of Meeting:	Trust Board			
Date of Meeting:	Wednesday 27 September 2023			
Author:	Patient Safety Leads /Head of Risk and Patient Safety			
Executive Sponsor:	Gill Findley - Chief Nurse			
Report presented by:	Gill Findley - Chief Nurse			
Purpose of Report	**Decision:** ☒	**Discussion:** ☐	**Assurance:** ☐	**Information:** ☐
	The Patient Safety Incident Response Plan (PSIRP) sets out our intention as to how we will balance individual learning responses with quality improvement, to maximise learning and improvement over the next 12-18 months, in line with the Patient Safety Incident Response Framework (PSIRF).			
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:	N/A			
Key issues:				
Recommended actions for this meeting:	Consider the Plan for approval			
Trust Strategic Aims that the report relates to:	**Aim 1** ☒	We will continuously improve the quality and safety of our services for our patients		
	Aim 2 ☒	We will be a great organisation with a highly engaged workforce		
	Aim 3 ☒	We will enhance our productivity and efficiency to make the best use of resources		
	Aim 4 ☒	We will be an effective partner and be ambitious in our commitment to improving health outcomes		

Gateshead Health NHS Foundation Trust

	Aim 5 ☒	We will develop and expand our services within and beyond Gateshead			
Trust corporate objectives that the report relates to:					
Links to CQC KLOE	Caring ☒	Responsive ☒	Well-led ☒	Effective ☒	Safe ☒
Risks / implications from this report (positive or negative):					
Links to risks (identify significant risks and DATIX reference)					
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒		

Gateshead Health NHS Foundation Trust

Patient Safety Incident Response Plan

Effective date: September 2023

Estimated refresh date: December 2024

	NAME	TITLE	SIGNATURE	DATE
Author	**Ashleigh Jack**	**Patient Safety Lead**		**June 2023**
Reviewer	**Shelley Dyson**	**Head of Patient Safety**		**July 2023**
Authoriser	**Gill Findley**	**Chief Nurse and Professional Lead for Midwifery and Allied Health Professionals/ Deputy Chief Executive**		**…**

Foreword

"*The introduction of this framework represents a significant shift in the way the NHS responds to patient safety incidents, increasing focus on understanding how incidents happen - including the factors which contribute to them.*" (Aidan Fowler, National Director of Patient Safety, NHS England)

The Patient Safety Incident Response Framework (PSIRF) does not mandate investigation as the only method for learning from patient safety incidents; nor does it prescribe what to investigate. PSIRF supports organisations to respond to incidents in a way that maximises learning and improvement rather than basing responses on arbitrary and subjective definitions of harm.

On this basis the Trust will explore patient safety incidents relevant to our context and the populations we serve rather than exploring only those that meet a certain nationally defined threshold. We will embrace the cultural shift to evidence we are *continually* learning and improving by balancing those individual responses where we feel we need to learn more to direct improvement, with working on meaningful improvement in areas we feel we have already learned a lot. Our plan will be a live document that will evolve and keep being developed in response to new insights, on a never ending journey in pursuit of keeping our patients safe.

PSIRF asks us to consider how we engage meaningfully with our patients, families and carers to ensure that their voice is equal to that of our staff in any of our patient safety learning responses, on the basis that their perspectives are crucial to our full understanding. Our Patient Safety Partners will help us to redress this balance, and ensure that the patient voice is present in all of our patient safety systems, processes and activities.

Our Trust's journey towards a restorative and just culture underpins how we will approach our incident responses, including a culture whereby people feel psychologically safe enough to highlight incidents or concerns without fear of retribution, and to speak freely about the work as it is done by those who do it. We will engage, listen and empower our people to make meaningful change as experts in their fields.

Gateshead Health NHS Foundation Trust

Contents

Introduction

This Patient Safety Incident Response Plan sets out how Gateshead Health NHS Foundation Trust (hereafter referred to as GHFT) intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent rule that cannot be changed, in response to new or evolving insights. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

The plan will be underpinned by our Patient Safety Incident Response Policy, which is currently being drafted in line with the Patient Safety Incident Response Framework and will be published alongside the plan on the Trust's website when the approval and ratification process is complete.

Our services

GHFT provide services in the hospital, the community and at people's homes, and is registered with the Care Quality Commission to provide services at the following locations, all of which are in the Gateshead area.

- Queen Elizabeth Hospital (including inpatient beds, outpatient and screening services, emergency care centre, pathology centre of excellence and surgery centre)
- Blaydon Primary Care Centre (walk-in appointments and care for minor injuries and ailments, as well as emergency contraception)
- Bensham Hospital (community services available at this hospital include occupational therapy, Rapid Response Service, Speech and Language Therapy and Podiatry)
- Cleadon Park Primary Care Centre (Breast screening and Acute Aortic Aneurysm (AAA) screening)
- Grindon Lane Primary Care Centre (Breast screening and AAA screening)
- Breast Screening Unit at Sunderland Royal Hospital

Further information about our organisation can be found on the GHFT website: Gateshead Health NHS Foundation Trust

Gateshead Health NHS Foundation Trust

Defining our patient safety incident profile

Stakeholder Engagement

In order to identify the patient safety issues most prevalent and pertinent to our organisation, the Patient Safety Team have engaged with stakeholders to define our incident profile as well as triangulate with the following sources of insight; some of which have been reported to us by our staff and our patients, families and carers.

- Incidents: 2020 – 2023 (reported by staff)
- Complaints: last 12 months (reported by patients, families and carers)
- Claims: 2012 - 2022 (reported by patients, families and carers)
- Risks
- Mortality (including Medical Examiner Service)
- Getting it Right First Time (GIRFT)
- Clinical Audit
- Quality Accounts

The Trust will incorporate wider patient perspectives into our future patient safety incident response planning through the introduction of our Patient Safety Partners and through meaningful engagement with our patients, families and carers involved in patient safety incident responses over the next 12 - 18 months. More information regarding the framework for involving patients in patient safety can be found here: NHS England » Framework for involving patients in patient safety

Defining our Profile

The above activities, together with an exercise to define our patient safety improvement profile (page 8 and Appendix A) have allowed us to distinguish between learning required to inform improvement and improvement based on existing learning, and where individual assessment would be required to determine our required response. Our local profile is detailed on pages 13 – 16. The nationally mandated learning response profile is outlined on pages 9 – 12.

Learning to inform improvement: where an incident type is a recognised significant issue for the organisation but contributory factors are not well understood and local improvement work is minimal, a Patient Safety Incident Investigation (PSII) is required to fully understand the context and underlying factors that influenced the outcome.

Learning from these individual reviews would inform existing or future quality improvement workstreams and the evolvement of our Patient Safety Incident Response Plan (PSIRP).

Improvement based on learning: where a safety issue or incident type is well understood (e.g. because previous incidents of this type have been thoroughly investigated and national or local improvement plans targeted at contributory factors are being implemented and monitored for effectiveness) resources are better directed at improvement rather than repeat investigation.

Assessment to determine required response: for issues or incidents where it is not clear whether a learning response is required. All incidents where there is potential for *new* learning or significant concern would be presented to the Trust's Safety Triangulation Group (STG) for discussion and consideration of whether an individual learning response is required to better understand the contributory factors, and the most appropriate tool to do this. This group will also consider the allocation of Family Liaison Officer resource where appropriate.

Duty of Candour requirements remain the same in relation to levels of harm, regardless of whether an individual learning response will be undertaken. Views of the patient/family/carers should always be taken into account as part of this assessment.

Gateshead Health NHS Foundation Trust

Defining our patient safety improvement profile

Our patient safety improvement profile has been identified and agreed via insights from our patient safety incident profile, alongside a scoping exercise undertaken to consolidate a list of all improvement and service transformation work with an impact on patient safety underway or planned across the organisation; this list is not exhaustive however and it is acknowledged that a large proportion of quality improvement activity that is undertaken in our services is not formalised or identified on a centralised record (see below and Appendix A). The Trust's latest Quality Account has also been taken into account as part of this exercise (Appendix B).

- Rapid Process Improvement Work (RPIW) as follows:
  - Urgent and Emergency Care pathways
  - ICE test results (Pathology)
  - Medication rounds
  - Stop Smoking
  - Cancer waiting lists
  - Nursing Professional Development
  - Physiotherapy equipment
  - Audiology service pathways and capacity/demand
  - Well organised hospital
- 'Supervisory band 7' project
- Quality Account (Appendix B)

Gaps have been identified where strengthening of existing workstreams/improvement work is required, as well as identification of where there is no current workstream/improvement work underway and establishment will be required based on learning from our local patient safety incident profile and qualitative intelligence from those involved in patient safety investigation over the last 3 years and beyond.

Gateshead Health NHS Foundation Trust

Our Patient Safety Improvement Plan: national requirements

Some events in healthcare require a specific type of response as set out in policies or regulations. These responses include mandatory PSII in some circumstances or review by, or referral to, another body or team, depending on the nature of the event. The below table summarises the guidance on nationally mandated responses to certain categories of event and sets out whether that mandated response needs to be a PSII or some other response type, including referring the event to another organisation to manage.

For clarity, incidents meeting the Never Events criteria (2018) or its replacement, and deaths thought more likely than not to have been due to problems in care (i.e. incidents meeting the learning from deaths criteria for PSII) require a locally-led PSII by GHFT. (More information relating to national event response requirements can be found here: Guide to responding proportionately to patient safety incidents).

	National Priority	Response	Improvement
1	Incidents that meet the criteria set out in the Never Events list 2018	Locally led PSII by GHFT	Respond to recommendations as required and feed actions into the system improvement plan/quality improvement strategy
2	Deaths clinically assessed as more likely than not due to problems in care	Locally led PSII by GHFT as well as Mortality Council review	
3	Maternity and neonatal incidents meeting HSIB criteria as follows. • Intrapartum stillbirth: the baby was thought to be alive at the start of labour but was born showing no signs of life. • Early neonatal death: the baby died, from any cause, within the first week of life (0 to 6 days). • Potentially severe brain injury diagnosed in the first seven days of life and the baby was diagnosed with grade III hypoxic–ischaemic encephalopathy; or was 25 | Guide to responding proportionately to patient safety incidents therapeutically cooled (active cooling only); or – had decreased central tone, was	Refer to HSIB for independent PSII. Local learning response is not required, however any immediate actions will be identified as necessary to avoid and/or mitigate further serious and imminent danger to patients, staff and the public. In relevant cases, the organisation will also use the Perinatal Mortality Review Tool (in parallel with and with the assistance of HSIB as it works through its independent investigation).	Respond to recommendations from external referred agency/organisation as required and feed actions into the system improvement plan/quality improvement strategy

	comatose and had seizures of any kind. • Maternal deaths: death while pregnant or within 42 days of the end of the pregnancy from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes (excludes suicides).		
4	Child deaths	Refer for Child Death Overview Panel review. Locally-led PSII (or other response) may be required alongside the Panel review if clinically assessed as more likely than not due to problems in care. These are also reviewed by the Mortality Council.	
5	Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR). Locally-led PSII (or other response) may be required alongside the Panel review if clinically assessed as more likely than not due to problems in care. These are also reviewed by the Mortality Council.	
6	Safeguarding incidents in which: Babies, child and young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse / violence. Adults (over 18 years old) are in receipt of care and support needs by their Local Authority The incident relates to FGM, Prevent (radicalisation to terrorism); modern slavery & human trafficking or domestic abuse / violence.	Refer to local authority safeguarding lead. Healthcare providers must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any safeguarding reviews (and enquiries) as required to do so by the Local Safeguarding Partnership (for children) and local Safeguarding Adults Boards.	
7	Incidents in screening programmes	Refer to local Screening Quality Assurance Service for consideration of locally led learning response.	Respond to recommendations as required and feed actions into a system improvement plan/quality improvement strategy

		See: Guidance for managing incidents in NHS screening programmes	
8	Deaths in custody (e.g., police custody, in prison, etc.) where health provision is delivered by the NHS	In prison and police custody, any death will be referred (by the relevant organisation) to the Prison and Probation Ombudsman (PPO) or the Independent Office for Police Conduct (IOPC) to carry out the relevant investigations. Healthcare providers must fully support these investigations where required to do so.	Respond to recommendations from external referred agency/organisation as required and feed actions into the system improvement plan/quality improvement strategy
9	Deaths of patients detained under the Mental Health Act (1983), or where the Mental Capacity Act (2005) applies, where there is reason to think that the death may be linked to problems in care (incidents meeting the Learning from Deaths criteria)	Locally led PSII. These are also reviewed by the Mortality Council.	Respond to recommendations as required and feed actions into the system improvement plan/quality improvement strategy
10	Mental health related homicides	Referred to the NHS England and NHS Improvement Regional Independent Investigation Team for consideration for an independent PSII. Locally led PSII may be required with mental health provider as lead and GHFT participation if required	Respond to recommendations from external referred agency/organisation as required and feed actions into the system improvement plan/quality improvement strategy
11	Domestic Homicide	A Domestic Homicide is identified by the police usually in partnership with the Community Safety Partnership (CSP) with whom the overall responsibility lies for establishing a review of the case. Where the CSP considers that the criteria for a Domestic Homicide Review (DHR) are met, they will utilise local contacts and request the establishment of a DHR Panel. The Domestic Violence, Crime and Victims Act 2004, sets	

		out the statutory obligations and requirements of providers and commissioners of health services in relation to domestic homicide reviews.	

Gateshead Health NHS Foundation Trust

Our Patient Safety Incident Response Plan: local focus

Several system-based learning response methods are available for the Trust to respond to a patient safety incident or cluster of incidents (see Appendix C). We propose that these are applied where contributory factors are not well understood and local improvement work is minimal - that is, there is the greatest potential for new learning and improvement, as outlined in the table below.

Where an incident type is well understood - for example falls, because previous incidents of this type have been thoroughly investigated and national or local improvement plans targeted at the contributory factors are being implemented and monitored for effectiveness - resources may be better directed at improvement rather than repeat investigation (or other type of learning response).

Patient safety incident type or issue	**Planned response**	**Anticipated improvement route**
Falls	Falls triage tool to identify if an individual learning response may be required (where there is potential for new learning or significant concern). When it is indicated, to Safety Triangulation Group (STG) for discussion. Falls learning response tool to be used where indicated.	Create local safety actions and feed these into the falls workstream/quality improvement strategy
Pressure damage	Pressure damage triage tool to identify if an individual learning response may be required (where there is potential for new learning or significant concern). When it is indicated, to Safety Triangulation Group (STG) for a decision and tool to be used.	Create local safety actions and feed these into a tissue viability workstream/quality improvement strategy

Medication incidents	Local review by Business Unit/Medicines Management Team to identify if an individual learning response may be required (where there is potential for new learning or significant concern). When it is indicated, to Safety Triangulation Group (STG) for a decision and agreement on tool to be used (After Action Review (AAR), Case/Peer Review, Learning Team, Thematic Review)	Create local safety actions and feed these into the medicines workstream/quality improvement strategy
Maternity incidents	Local review by Maternity Safety Team to identify if an individual learning response may be required (where there is potential for new learning or significant concern). When it is indicated, to Safety Triangulation Group (STG) for a decision and agreement on tool to be used (After Action Review (AAR), Case/Peer Review, Learning Team, Thematic Review)	Create local safety actions and feed these into the Maternity workstream/quality improvement strategy Local workstream will link to regional PS learning network and MatNeo SIP network
Infection Prevention & Control	Local review by Business Unit/IPC Team to identify if an individual learning response may be required (where there is potential for new learning or significant concern). When it is indicated, to Safety Triangulation Group (STG) for a decision and agreement on tool to be used (After Action Review (AAR), Case/Peer Review,	Create local safety actions and feed these into a IPC workstream/quality improvement strategy

	Learning Team, Thematic Review)	
Digital/IT inc pathology/radiology and sample/reporting issues and medication issues and consenting procedures	Local review by Business Units to identify if an individual learning response may be required (where there is potential for new learning). When it is indicated, to Safety Triangulation Group (STG) for a decision and agreement on tool to be used (After Action Review (AAR), Case/Peer Review, Learning Team, Thematic Review)	Create local safety actions and feed these into a digital/IT workstream/quality improvement strategy
Diagnosis/treatment delay	PSII to understand contributory factors	Create local safety actions and feed these into a PSII SIP related to this incident category to inform PSIRP, or existing workstreams where applicable (e.g. digital)
Admission/transfer/discharge issues resulting in deterioration	PSII to understand contributory factors	Create local safety actions and feed these into a PSII SIP related to this incident category to inform PSIRP, or existing workstreams where applicable (e.g. digital)
Maternity incidents that occur in theatre	PSII to understand contributory factors	Create local safety actions and feed these into a PSII SIP related to incident type to inform PSIRP, or existing Maternity workstream
Unexpected incidents that are so significant in nature/pose such a risk to patient safety/the organisation	PSII	Create local safety actions and feed these into PSIRP insights, or existing workstreams where applicable (e.g. digital)

Incidents of any harm level or category not listed above where potential for new learning is identified or significant concern	AAR, Case/Peer Review, Thematic Review, Learning Team	Create local safety actions and feed these into PSIRP insights, or existing workstreams where applicable (e.g. digital)

Development of safety actions

The Trust will follow an integrated process for developing, implementing, and monitoring safety actions. We will seek to reduce duplicative and/or disconnected safety actions, for example, by maintaining a wider safety improvement plan for each workstream and PSII category type and not adding what is already there. Actions will be taken from all other types of learning responses and will feed into any relevant existing system improvement plan; any actions that sit outside of these plans will be collated onto a separate system improvement plan to inform future development of the PSIRP.

Appendices

Appendix A: Safety Improvement Profile

Appendix A - Improvement Plan.d

Appendix B: Trust Quality Account 2023-24

Quality Account 22-23 - final.docx

Appendix C: Learning Response Methods/Tools

After Action Review.docx

Case Review.docx

Patient Safety Learning Team Templ

PSII-Report-Template -v1.1.docx

Themed review template Aug 2022.dc

Falls Review Tool V4.2.docx

Gateshead Health NHS Foundation Trust

Assurance Report Agenda Item: 9i

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☐
Committee Reporting Assurance:	Finance and Performance Committee			
Name of Meeting:	Board of Directors			
Date of Meeting:	Tuesday 29 August 2023			
Author:	Mrs K Mackenzie, Group Director of Finance & Digital			
Executive Lead:	Mrs K Mackenzie, Group Director of Finance & Digital			
Report presented by:	Mr M Robson, Chair of Committee			
Matters to be escalated to the Board:	Community Diagnostic Update Concerns on the lack of assurance of the actual costs, timescales for delivery of the project and engagement with the ICB. Escalation has not yet taken place as outstanding actions remain to quantify the risk and associated exit strategy. It was agreed to declare the risks to the project as part of the SOF 3 meeting with NHSE. Agreed to escalate to the Trust Board and as part of the escalation process to write to QE Facilities to formally communicate concerns.			
Executive Summary: ***(outline assurances and gaps including mitigating actions)***	Transformation Board Update The verbal update informed it was to be proposed to formally close the existing arrangements of the Transformation Board and to be managed within the Delivery Oversight Group. It was noted a closure report will be brought to the next meeting. QE Facilities Report Deferred. Sustainability (Green Plan) Report Deferred. Leading Indicators The report was presented informing there are 9 identified leading indicators supported by 13 breakthrough objectives. It was noted that the 52 week performance narrative in the report does not provide the same assurance as the feedback from the performance clinics and an action was taken for further assurance at the Senior Management Team to take through the performance clinics.			

	It was noted that the leading indicators are still being developed and further iterations of the report will continue to enhance quality of information provided. <u>Integrated Oversight Report (IOR):</u> The report was presented informing the impact of industrial action meant that 23 theatre sessions, 43 outpatient clinics and 3 endoscopy lists were cancelled resulting in 361 patients being cancelled, re-listed or re-booked. Five serious incidents were reported in July, 4 were categorised as resulting in severe harm and 1 moderate harm. There was slight reduction in the percentage of patients reporting a positive experience. It was noted the 4 hour performance target was 71.8% The RTT 18 weeks has decreased by 1.4% and the main service areas with challenges are Paediatrics, Pain and Trauma and Orthopaedic. <u>Month 4 Financial Report</u> The report was presented informing the Trust has reported an actual deficit of £5.237 which is £105k better that plan but with CRP unachieved at £1.3m. The biggest risk to our year end position is the CRP achievement, impact of industrial action, upcoming winter and bank and agency usage. It was noted there is a deterioration in the cash position of £44m with a year-end forecast balance of £31m. The internal capital schemes are on plan and forecasting to spend on plan at the end of the financial year. <u>Community Diagnostic Centre Update</u> Concern raised relating to assurance of the actual costs and timescales for delivery. Challenge with ICB engagement and it was agreed to raise further at the SOF 3 meeting with NHSE. <u>Sustainability Update</u> The report was presented informing the first Delivery Oversight Meeting met on 17 August 2023 confirming the key work streams required to support delivery of the sustainability programme with an SRO along with an Executive sponsor and clinical sponsor. A task and finish group was set up to determine our vision for the Northern Centre of Excellence for Women's Health and a visioning session was held on 27 July 2023. A full review of the estate was conducted focusing on estate owned by the Trust and an analysis is underway to understand usage.

	Internal Audit Reports None. Supply Procurement Committee Report The report was presented informing there were 6 items requesting waiving of standing orders with a total value of £2.622m. Capital Steering Group Update The report was presented informing the group met on 11 August 2023 and focussed on delivery of schemes to date and any risk to year end. HFMA Action Plan Monitoring The intention is not just to meet the actions but to exceed them and actions are being enhanced accordingly. Organisational Risk Register (ORR) The Committee reviewed the ORR noting there are 7 risks from the BAF and ORR that are reflected in the report. Board Assurance Framework (BAF) The Committee reviewed and updated the BAF. NHSPS Proposal The report was presented informing there is a long standing dispute between ourselves and NHS Property Services (NHSPS) in relation to unpaid property invoices dating back to 2017-18. The contractual arrangements in place consist of a tenancy at will document agreed in July 2019 for a small number of properties and there is no formal agreement of rent or service charges in other properties. The Committee supported the ask to make a recommendation to the Trust Board to make an offer to NHSP of £3.182m for the outstanding invoices. Finance and Performance Committee Cycle of Business 2023/24 For information.	
Recommended actions for Board	The Board is requested to note the assurances and risks identified by the Committee and be mindful of this when reviewing and discussing related agenda items.	
Trust Strategic Aims that the report relates to: **(Including reference to any specific risk)**	**Aim 1** ☐	We will continuously improve the quality and safety of our services for our patients
	Aim 2 ☐	We will be a great organisation with a highly engaged workforce
	Aim 3 ☒	We will enhance our productivity and efficiency to make the best use of resources

	Aim 4 ☐	We will be an effective partner and be ambitious in our commitment to improving health outcomes			
	Aim 5 ☒	We will develop and expand our services within and beyond Gateshead			
Financial Implications:	As outlined in the Finance Report paper on the agenda.				
Links to Risks (identify significant risks and DATIX reference)					
People and OD Implications:					
Links to CQC KLOE	Caring ☒	Responsive ☒	Well-led ☒	Effective ☒	Safe ☒
Trust Diversity & Inclusion Objective that the report relates to: (including reference to any specific implications and actions)	**Obj.1** ☐	The Trust promotes a culture of inclusion where employees have the opportunity to work in a supportive and positive environment and find a healthy balance between working life and personal commitments			
	Obj. 2 ☒	All patients receive high quality care through streamlined accessible services with a focus on improving knowledge and capacity to support communication barriers			
	Obj. 3 ☐	Leaders within the Trust are informed and knowledgeable about the impact of business decisions on a diverse workforce and the differing needs of the communities we serve			

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Assurance Report Agenda Item: 9ii

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☒
Committee Reporting Assurance:	Quality Governance Committee August 2023			
Name of Meeting:	Trust Board			
Date of Meeting:	August 2023			
Author:	Mrs A Stabler, Non-Executive Director			
Executive Lead:	Dr G Findley, Chief Nurse			
Report presented by:	Mrs A Stabler, Non-Executive Director			
Matters to be escalated to the Board:	The Committee noted the rise in workload and strongly recommend to the Trust Board to seek a contract management meeting with the ICB to review the Looked After Children service provision. The Committee noted concerns have been identified with the difficulty of tracking trauma patients and we are not meeting the trauma rehabilitation standards as identified in the Trauma Audit Research Network (TARN) Report. We are reviewing how we get assurance in relation to the QEF work outside the Gateshead Trust contract. We have agreed that QEF will present to QGC for assurance in the first instance.			
Executive Summary:	**Items received for assurance:** **Health Inequalities** The report was presented informing that inequality work is ongoing across the Trust and have identified a member of staff in the Medical Directorate to complete a mapping exercise. The Health Inequalities Board need to identify the gap so that we can identify the key priorities of focus from a development needs to ensure maximum effect to delivering the Health Inequalities Strategy. It was noted that discussions are ongoing regarding including Health Inequalities on the cover sheets of papers. **Mental Health Update** The report was presented informing we are undertaking a significant piece of work to review all of the patients who have been identified as over 18 week waiters on RTT with an issue around validation and work is being done to address this. There has been one serious incident in July which is currently under investigation to review the decision			

	making relating to the admission of a patient to Sunniside which identified no significant learning. It was noted that the PMVA training figures do not seem accurate therefore are in the process of a manual cross check as this is not pulling though the ESR dashboard and the Committee will receive feedback at the next meeting on the 47% compliance. **Health and Safety Quarterly Report** In the period April to July 2023 there were 8 RIDDORS reported to HSE within the permissible 15 day reporting timeframes and compared to this quarter in 2022 there was an increase of 1 RIDDOR. The Committee agreed an action to clarify how long the QE Facilities assurance visits on COSHH assessments are to be stood down Matrons' walkabouts which also address health and safety issues are still taking place. **QEF Pharmacy Report** The report was presented informing that the waiting times and dispensing errors report through Datix We share good practice and have continuous improvement through QEF. The Committee asked to receive the 12 month rolling data, the scale to be next to the dispensing errors so trends can be identified and a SPC of the data rather than simple graphs. **Integrated Oversight Report (IOR)** The report was presented informing we are moving to the Leading Indicators and will still receive the IOR to look at the detailed figures. The plan is to have no 52 week waiters but there is a lot of validation to do that will emerge over the next quarter. The Committee asked for assurance on the quality impact on our patients of the long waits being quantified and for the risk to patients waiting is adequately covered on the risk register to be checked. **Maternity Oversight Report** The report was presented showing the Maternity Dashboard 2023/24 including some SPC charts. Emergency and elective sections have seen a significant increase in June and early indication are that theatre activity will also be high in July. The business unit is planning to do a deep dive of the caesarean rate using the Robson standard to assess whether women are receiving optimal care. It was noted that the number of neonatal deaths is not currently an indictor within the Maternity IOR. This will be added going forward.

	Objectives Delivery Report The report was presented informing there are 4 strategic objectives mapped to the Committee and all areas were proceeding as planned. **Patient Safety Report** The report has been changed to reflect the 3 'I's of the Patient Safety Strategy. A total of 671 incidents were reported in July 2023 of which 543 were patient safety incidents; this was a decrease of 25 incidents reported in June 2023 and there has been an increase of moderate harm incidents. There has been a significant increase in discharge and transfer incidents and the Primary Care report incidents have increased in which there is an issue with CareFlow and duplication of discharge letters. It was noted that 987 patient safety incidents and 308 actions remain overdue in Datix although significant progress has been made in the last few months to reduce these and have closed 971 incidents in July. **Assurances from Strategic SafeCare Risk and Safety Council** The report was presented informing at the July meeting there was a discussion about low compliance with Resus trolley checks. The matrons have focussed on this to improve compliance. Falls is the number one reported incident and issue in terms of PSIRP and will be a focus for improvement work going forward. At the August meeting there was a discussion on the InPhase actions and recommended for approval of the PSIRFP to go to the Trust Board in September. The PSIRP and the associated incident policy were tabled for discussion. It was agreed for a Chairs action to review the plan and content of the PSIRP and policy and feedback to the Committee by Tuesday 5 September 2023 before submission to the ICB on behalf of the Trust Board. **Patient Experience Annual Report** The report presented a summary position on complaints, themes and learning including revision of reopened complaints. **Serious Incidents Report** The report was presented informing that falls continues to be the highest volume reported serious incident and has been a dip in the two day reporting compliance. The number of overdue incidents remain small and there are a significant number of overdue actions that cannot be closed by the

	PST as assurance of their completion or alternative explanation required. It was noted that during quarter 1 there were 17 serious incidents reported which include 10 falls and 2 QE Facilities Pharmacy issues. These have been to the SI Panel and signed off that will be discussed at the next SI Panel on 21 September 2023 with the ICB. **Safer Staffing Report** The report was presented and the areas of concern were discussed. The red flags data have been included in the report. **Complaints Update** The report was presented informing the number of informal complaints received remain stable on SPC with 59 in June and 58 in July. The top themes combined include communication, facilities and appointments including delays and cancellations. **Northern Trauma Network Peer Review Feedback** The report was presented informing we have identified concerns in difficulty of tracking trauma patients and we are not meeting the trauma rehabilitation standards. We have actions and looking at how we best establish the reporting to the Trauma Network and work is ongoing. **Feedback from Risk Escalation Meeting** The verbal update provided informed that no meeting has took place, this has been escalated 3 times to the ICB to ask for a date for this meeting. **PROMS Hip and Knee Replacements Final Data 21/22** The report was presented informing there is a lot of detail in the report and objective evidence that we are improving outcomes to patients. **Looked After Children Annual Report** The report was presented informing there has been a significant increase in the workload and number of Looked After Children in the period. Overall number of children in care were 531 compared to 483 on 2021/22 and 228 were placed outside the borough. 38% of the initial health assessments were completed within the timescale and 427 review health assessments were completed. It was noted we are using bank staff to fill the gaps and there is a gap for a Named Doctor for Looked after Children with discussions ongoing. We have escalated to Mr R Scott, Director of Nursing at NENC ICB, who has promised to look at the work but have not received feedback.

<table>
<tr><td></td><td colspan="6">It was agreed to strongly recommend to the Trust Board that we are seeking a contract management meeting with the ICB to review the service provision.

Items received by the Committee for information:

• Mental Health Act Compliance Minutes – May, June and July 2023
• Cycle of Business</td></tr>
<tr><td>Recommended actions for Board</td><td colspan="6">Board are asked to note the work of the Committee and the assurances received and note the areas of risk identified but note the actions in place to resolve.</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to: (Including reference to any specific risk)</td><td>Aim 1
☒</td><td colspan="5">We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>Aim 2
☐</td><td colspan="5">We will be a great organisation with a highly engaged workforce</td></tr>
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☐</td><td colspan="5">We will enhance our productivity and efficiency to make the best use of resources</td></tr>
<tr><td>Aim 4
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<tr><td>Aim 5
☒</td><td colspan="5">We will develop and expand our services within and beyond Gateshead</td></tr>
<tr><td>Financial Implications:</td><td colspan="6">None to Note</td></tr>
<tr><td>Links to Risks (identify significant risks and DATIX reference)</td><td colspan="6">ORR Risks, 2879 – Maternity, 2779 CQC Compliance/ Improvement, 2868 – Further wave of Covid, 2880</td></tr>
<tr><td>People and OD Implications:</td><td colspan="6">Gaps in workforce in nursing, midwifery and mental health.</td></tr>
<tr><td>Links to CQC KLOE</td><td>Caring
☒</td><td>Responsive
☒</td><td>Well-led
☒</td><td>Effective
☒</td><td colspan="2">Safe
☒</td></tr>
<tr><td rowspan="3">Trust Diversity & Inclusion Objective that the report relates to</td><td>Obj.1
☐</td><td colspan="5">The Trust promotes a culture of inclusion where employees have the opportunity to work in a supportive and positive environment and find a healthy balance between working life and personal commitments</td></tr>
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<tr><td>Obj. 3
☐</td><td colspan="5">Leaders within the Trust are informed and knowledgeable about the impact of business decisions on a diverse workforce and the differing needs of the communities we serve</td></tr>
</table>

Gateshead Health NHS Foundation Trust

Assurance Report Agenda Item: 9iii

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☐
Committee Reporting Assurance:	Digital Committee			
Name of Meeting:	Board of Directors			
Date of Meeting:	Wednesday 2nd August 2023			
Author:	Mr N Black, Chief Information Officer			
Executive Lead:	Mrs K Mackenzie, Group Director of Finance & Digital			
Report presented by:	Mr A Moffat, Chair of Committee			
Matters to be escalated to the Board:	None			
Executive Summary: ***(outline assurances and gaps including mitigating actions)***	The 2 August Digital Committee meeting did not meet the quoracy requirements. As such the meeting ran in shadow form, reviewing the papers that had been prepared. <u>Organisational Strategic Objectives – Digital</u> Digital Committee reviewed the six 23/24 objectives that include the re-baselined objectives from 22/23. Five objectives are on track to meet their replanned dates and continue to be monitored by the Committee. Some risk was flagged around the KPI refinement work – specifically the need to embed data quality indicators into the business unit performance review meetings. <u>Digital Delivery Plan</u> The Digital Delivery Plan was presented to the Committee. Four projects were reported as complete, twenty four on track, six indicated as operating under some risk and three reported as overdue. Those projects at risk or overdue all have mitigations documented to address the risk and are being managed via formal change control at DTG. Cross cutting risks that continue to impact the overall programme were flagged: • Insufficient resource to deliver the digital transformation programme and maintain business as usual. • Single point of failure due to technical expertise. To mitigate these risks, DTG is actively managing the programme change control based on the agreed prioritisation matrix, with any new requests following the			

	formal process. Additional work is underway to benchmark the service and to understand where additional resource could be allocated to mitigate the risks. The risk recorded on Datix around the capacity of the digital team has been increased to a rating of 12, to reflect the current 20% vacancy rate across the digital team. <u>Integrated Electronic Patient Record plan</u> The business case development and procurement plan were presented. The first step in the updated plan is the market engagement event for EPR/system suppliers scheduled for 3 October (subsequently rearranged to 13 December due to the consultant and junior doctor strikes). The OBC was planned to be updated by the end of November (but will now slip into 2024 due to the strikes). <u>Digital Service Key Performance Indicators</u> The KPI report was presented in a new format, that did not easily track back to the previous indicators. Additional work continues refine the KPIs and the escalation actions should a KPI go off track. It was agreed to split out the digital operational service KPIs from organisational performance and assurance KPIs; then review at the October meeting. <u>Regulatory and Governance</u> The internal audit actions were reviewed. There are currently no overdue actions, all are on track for delivery. The DSPT Final Assessment report rated at an unsatisfactory assurance level was presented. This audit presents a snapshot position mid-year in the DSPT annual cycle. The committee noted the current position and the progress made in the year end submission (30 June) with the Trust showing that the required standards had been met. The year end submission has subsequently been reviewed by NHS England and the standard met return has been confirmed. <u>Digital Transformation Group and Digital Assurance Group Assurance Reports & minutes of last meetings</u> The DTG Assurance Report was received and there were no additional items for escalation to the DC reported. The DAG Assurance Report was received and there were no items for escalation to the DC reported. Clarity on the subgroup escalation processes was requested. <u>Organisational Risk Register</u> The three digital corporate risks were reviewed.

	Risk 1490 – DC noted that to mitigate the risk, the digital team are sourcing additional staff to help the IAOs across the Trust complete their returns. Risk 1797 – DC noted that this risk would be addressed by standardising clinical practice, which will be achieved through the implementation of the EPR. Risk 1636 – Assurance was provided on cyber risk and the actions to maintain the risk level.					
Recommended actions for Board	The Board is requested to note the assurances and risks identified by the Committee and be mindful of this when reviewing and discussing related agenda items.					
Trust Strategic Aims that the report relates to: (Including reference to any specific risk)	**Aim 1** ☐	We will continuously improve the quality and safety of our services for our patients				
	Aim 2 ☐	We will be a great organisation with a highly engaged workforce				
	Aim 3 ☒	We will enhance our productivity and efficiency to make the best use of resources				
	Aim 4 ☐	We will be an effective partner and be ambitious in our commitment to improving health outcomes				
	Aim 5 ☒	We will develop and expand our services within and beyond Gateshead				
Financial Implications:	None to note					
Links to Risks (identify significant risks and DATIX reference)	There are no significant risks on Datix relating to the business conducted at this meeting.					
People and OD Implications:	None to note					
Links to CQC KLOE	Caring ☒	Responsive ☒	Well-led ☒	Effective ☒	Safe ☒	
Trust Diversity & Inclusion Objective that the report relates to: (including reference to any specific implications and actions)	**Obj.1** ☐	The Trust promotes a culture of inclusion where employees have the opportunity to work in a supportive and positive environment and find a healthy balance between working life and personal commitments				
	Obj. 2 ☒	All patients receive high quality care through streamlined accessible services with a focus on improving knowledge and capacity to support communication barriers				
	Obj. 3 ☐	Leaders within the Trust are informed and knowledgeable about the impact of business decisions on a diverse workforce and the differing needs of the communities we serve				

Gateshead Health NHS Foundation Trust

Assurance Report Agenda Item: 9iv

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☐
Committee Reporting Assurance:	People and OD Committee – 12 September 2023			
Name of Meeting:	Trust Board			
Date of Meeting:	September 2023			
Author:	Amanda Venner, Interim Director of People & OD			
Executive Lead:	Amanda Venner, Interim Director of People & OD			
Report presented by:	Maggie Pavlou, Non-Executive Director			
Matters to be escalated to the Board:	Concerns and plans around the recording of historic recruitment checks. Concerns around racism directed at the international nurse recruits for information.			
Executive Summary: ***(outline assurances and gaps including mitigating actions)***	**Items received for assurance:** **EDS2 Written Stakeholder Engagement Plan:** The report was presented informing that 3 working groups have been established to focus on patient engagement, health and wellbeing and leadership. The report provides an indication of the timescale of re-establishing the working groups and receiving papers at the Committee and the Trust Board. It was suggested for a dedicated task and finish group to focus on EDS and work collectively across the region. **Theatres Initiatives Exit Strategy:** The report was presented informing the Executive Management Team received a report on theatre recruitment retention that included a number of schemes as follows: • Enhanced additional session payments of time plus 70% for theatre staff. • Retention bonus of £1,500 of the difficult to recruit areas. • Band 5 to 6 automatic progression posts. It was noted that the schemes were impactful at the time but are not sustainable and require a theatres roadmap to improve productivity for the medium to long term plan.			

	Junior Doctor and Consultant Strikes: A verbal update was presented informing that the Junior Doctor and Consultant strikes will take place together and the Co-ordination Cell continues to run. It was acknowledged there has been frustration from colleagues on the lack of support from the Medical Staffing Team, work is ongoing and an update will be received at the next meeting. **EDI Strategy – KPI's:** The report was presented informing we will be the first Trust across the UK to have an EDI Strategy and there is an ongoing debate of the national strategy. The Strategy was shared with national colleagues which was well received and had a meeting to ensure the KPI metric can be embedded into everything we said we would do. It was suggested to pull out specific actions in the EDI action plan and acknowledge these are part of the wider piece of work to avoid duplication of work. **Leading Indicators:** The report was presented informing there are 1 leading indicator and 2 breakthrough objectives. Staff vacancy levels continue to be below the 5% threshold set for the year standing at 3.7% and sickness absence remains slightly above the 5% target at 5.3% in July. It was noted that the staff engagement score is 5.92% which is below the target of 6.9% and the staff survey is due to be launched on 2 October 2023. **Historic Pre-Employment Checks:** The report was presented informing we have widened the scope to pre-employment checks and a spot check audit has identified a gap with a completion date of 16 weeks. We have identified a dedicated resource to complete this work to ensure all 3,610 records are to be taken with 2,409 clinical records for prioritisation. It was noted we are in the final stages of the DBS checks with 5 requiring ID checks and the target date for completion is Tuesday 19 September 2023. **Integrated Oversight Report:** The report was presented informing that sickness absence remains static with a slight increase in QE Facilities that is linked to employment cases. There is a slight uptake in COVID which is being monitored through the Operational Winter Planning so may see in future metrics. Appraisals have seen a slight decrease to 81% and QE Facilities are above target with work continuing in the Business Units.

	It was noted we have refreshed the agency protocols in place and no off framework agency is to be used unless approved by strategic on call. In relation to vacancy rates, the time to hire has increased due to an increase in medical recruitment. **People and OD Additional Metrics:** The Committee received an update which highlighted the key areas of focus across the 4 portfolio areas of the directorate. <u>People Services:</u> • 17 Employee Relations cases are ongoing with 1 live suspension. • 63 individuals were recruited and 57.14% of individuals revalidated. <u>Leadership OD and Staff Experience:</u> • The July Pulse Survey has achieved a 2% response rate with 68 response overall and the colleague engagement score was 5.9%. • The annual Staff Survey is launching in October. <u>Education, Learning and Development:</u> • Challenge around the Managing Well Programme being stood down due to strikes. <u>People Planning, Performance and Quality:</u> • Had a lack of dedication focus on retention work due to ongoing sickness in the team, however this will be picked up in the scope of the Workforce work stream as part of the Strategic Delivery Oversight Group. **WRES and WDES Annual Submission – Action Plans:** The report was presented informing we require an overarching human rights quality action plan that is generic and there is an issue on page 11 of the indictors which has been rectified therefore will be addressed at the next meeting. The WRES indicators have increased to 77%. It was noted there is negativity associated with the international nursing team on where they come from and racism. An update will be received at the next meeting along with the anti-racism charter. **Annual Revalidation Report:** The report was presented informing there were approximately 244 medical staff with completed appraisals within a 12 month period with 75 who have missed appraisals within the year. At present the Trust have 35 trained appraisers for approximately 225 Senior

<table>
<tr><td></td><td colspan="6">Medical Staff and approximately 90 Locally Employed Doctors.

It was noted at least 2 to 3 Doctors have come forward to become appraisers within the next 12 months and plans are in place to improve more women appraisers.

NHS Staff Survey Update – 2022 Action Plan Updates and 2023 Launch Plan:
The report was presented informing the people action plans flow through the oversight boards which is a separate action to pick up to follow up. There are links between you said and we did. The barriers are staffing resource, winter pressures and a lot of things we ask our teams to do.

People and OD Organisational Risk Register:
The report was presented informing there are 2 risks from the BAR/ORR and 2 risks have been removed. There is an emerging risk identified which is to be approved by the Executive Risk Management Group with a score of 20.

Items received by the Committee for information:

• Pulse Survey Results – July 2023
• Industrial Action Update
• Internal Audit Reports – GHE 2022-23/08 Recruitment: Pre-employment checks
• Cycle of Business</td></tr>
<tr><td>Recommended actions for Board</td><td colspan="6">Note main assurances against the strategic People and OD themes detailed and key associated risks.</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:
(Including reference to any specific risk)</td><td>Aim 1
☐</td><td colspan="5">We will continuously improve the quality and safety of our services for our patients</td></tr>
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☐</td><td colspan="5">We will develop and expand our services within and beyond Gateshead</td></tr>
<tr><td>Financial Implications:</td><td colspan="6">No significant new financial implications to highlight to the Board.</td></tr>
<tr><td>Links to Risks (identify significant risks and DATIX reference)</td><td colspan="6">ORR Risks, 3095 risk to quality of care, 2764 risk of not having a clearly agreed workforce plans and 3272 historic checks.</td></tr>
<tr><td>People and OD Implications:</td><td colspan="6">As set out</td></tr>
<tr><td>Links to CQC KLOE</td><td>Caring</td><td>Responsive</td><td>Well-led</td><td>Effective</td><td colspan="2">Safe</td></tr>
</table>

	☒	☒	☒	☒	☒
Trust Diversity & Inclusion Objective that the report relates to: (including reference to any specific implications and actions)	**Obj.1** ☒	The Trust promotes a culture of inclusion where employees have the opportunity to work in a supportive and positive environment and find a healthy balance between working life and personal commitments			
	Obj. 2 ☐	All patients receive high quality care through streamlined accessible services with a focus on improving knowledge and capacity to support communication barriers			
	Obj. 3 ☒	Leaders within the Trust are informed and knowledgeable about the impact of business decisions on a diverse workforce and the differing needs of the communities we serve			

Gateshead Health NHS Foundation Trust

Assurance Report Agenda Item: 9v

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☐
Committee Reporting Assurance:	Audit Committee Assurance Report from Meeting held on 7 September 2023			
Name of Meeting:	Audit Committee			
Date of Meeting:	7 September 2023			
Author:	Mrs K Mackenzie, Group Director of Finance and Digital			
Executive Lead:	Mrs K Mackenzie, Group Director of Finance and Digital			
Report presented by:	Mr A Moffat, Non – Executive Director			
Matters to be escalated to the Board of Directors:	None			
Executive Summary: ***(outline assurances and gaps including mitigating actions)***	<u>Executive Risk Management Group Update & Assurance Report</u> Two meetings have taken place with focussed discussion on 15+ & 12+ risks with agreed defined actions. Reported that work continues to reduce the number of risks and the top 3 risks were agreed as: • Finance - control targets • Reputation - note the Trust is now SOF 3 • Performance Following an Audit One review, Business Units are to review their own risks and have processes in place for review and escalation of risk. Committee members were assured that the work of the ERMG is ongoing. <u>Board Assurance Framework (incl. Corporate Objective processes)</u> The paper provided the Audit Committee with an overview of the controls in place and the process for the development and review of the BAF for 2023/24. The BAF continues to be reviewed regularly by each Board committee and the full Board. There are no fundamental changes made to the format. The Good Governance Institute (GGI) have provided good feedback for this, so no major changes were needed although some training has been developed and implemented.			

	Internal Audit Progress Report Ten final reports from the 2022/23 Group Internal Audit Plan were presented within this report. 2 substantial, 5 good, 2 reasonable (pre-employment checks & policy management) and 1 limited (WHO (World Health Organisation) surgical checklist). There are a further seven reports from 2022/23 and one report from 2023/24 at draft stage. **Follow up on previous recommendations:** 18 previous recommendations remain overdue with revised target dates. There were two overdue recommendations without a recent status update / revised target date provided. Audit One Effectiveness Review Good assurance was provided from this effectiveness review. Some suggestions were made as to how the Trust / QEF and AuditOne can work together to enhance delivery further over this financial year. This result was positive in relation to AuditOne. Quality of the audits are good, with some helpful suggestions and good alignment of feedback. External Audit Completion Report The Mazars audit report was issued on the 29th June 2023 and they gave their opinion on the financial statements as 'unqualified' including the Value for Money audit findings. Accounts are now formally closed, submitted, and awaiting feedback ready for Parliament re-opening, with confirmation that submission has been received. External Audit Effectiveness Review Positive feedback was received in respect of the relationships between Mazars and the Trust / QEF, as well as the effectiveness of the delivery of the audit. With no material issues or concerns to bring to the attention of the Committee. Counter Fraud Progress Report The 2022/23 Annual Report was received, noting the reporting period runs from July to June. The 2022/23 Report included the following appendices. • Counter Fraud Annual Report • Annual Counter Fraud Survey Report • Annual Fraud Awareness Presentation Report • Local Proactive Exercise concluding report.

	4 remaining open referrals including 2 new referrals both relating to the national fraud initiative. No open Counter Fraud recommendations. <u>Audit Committee Effectiveness Review</u> The majority of responses were to 'agree' or 'strongly agree' that the Audit Committee is effective. The most varied responses were in relation to the timeliness of the completion of audit recommendations. The TORs have been mapped out items this committee have considered, and good compliance is visible. No changes to the Committee's ToR is proposed as they currently adhere to national standards. <u>Non-Audit Services Policy</u> A gap in compliance with the Code of Governance was identified due to a non-audit services policy, which exists to safeguard the independence of the external auditors. A draft policy was shared with the Audit Committee as part of its consultation process. <u>Schedule of Losses and Special Payments</u> Report presented covered Q1 2023/24. It detailed the following: Cat 4 & Cat 7 losses total £6523.12 over 8 separate cases, with no special payments. The Committee approved the Schedule of Losses on behalf of the Board.	
Recommended actions for the Board of Directors	The Board is requested to take assurance from the work of the Committee and note the assurances, actions and decisions of the Committee in framing related items on the Board agenda.	
Trust Strategic Aims that the report relates to: (Including reference to any specific risk)	**Aim 1** ☒	We will continuously improve the quality and safety of our services for our patients
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	Aim 5 ☐	We will develop and expand our services within and beyond Gateshead
Financial Implications:	None to note	
Links to Risks (identify significant risks and DATIX reference)	There are no significant risks on Datix relating to the business conducted at this meeting.	
People and OD Implications:	None to note.	

Links to CQC KLOE	Caring ☐	Responsive ☐	Well-led ☒	Effective ☐	Safe ☒
Trust Diversity & Inclusion Objective that the report relates to: (including reference to any specific implications and actions)	**Obj.1** ☐	The Trust promotes a culture of inclusion where employees have the opportunity to work in a supportive and positive environment and find a healthy balance between working life and personal commitments			
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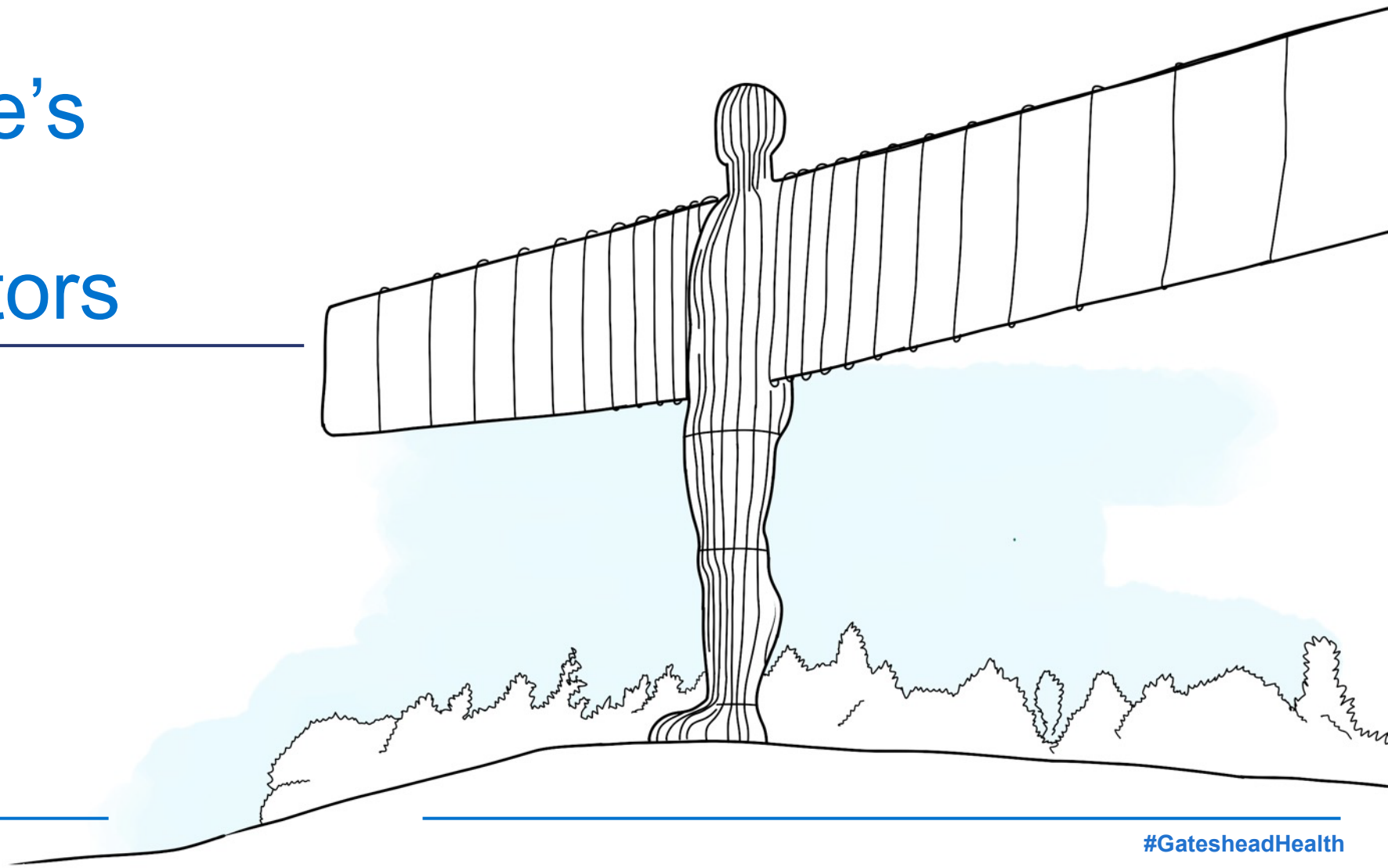
NHS
Gateshead Health
NHS Foundation Trust

Chief Executive's Update to the Board of Directors

Trudie Davies

27 September 2023



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

Gateshead Health NHS Foundation Trust

- Pioneered a new **dietetics service** for those living with cancer in partnership with Macmillan. There is already evidence of better outcomes through improved nutrition extending both the length and quality of life for patients.
- The North East and Cumbria Learning Disability Network have been shortlisted for the Strengthening the Foundation award in the Patient Experience Network National Awards (PENNA) for the **Learning Disability Diamond Acute Care Standards**. The supporting evidence submitted by the network was provided by Amy Cole, our Lead Nurse for Learning Disabilities, who shared a case study about the use of the diamond standards at Gateshead.
- Opened our new **ward 28** in the Peter Smith Surgery Centre to accommodate elective orthopaedic patients at the end of August. This provides a high-quality ring-fenced service to support reducing the number of long waiting patients for elective orthopaedic surgery.
- An **Ockenden assurance visit** to maternity took place in partnership with the Local Maternity and Neonatal System North East and North Cumbria, North Tees and NHS England. 16 inspectors attended with positive feedback received.
- We have received a **Regulation 28 (Prevention of Future Deaths) Report** from the Gateshead and South Tyneside Coroner, alongside Newcastle Hospitals. This relates to ensuring that there is a consistent understanding between hospital and community teams on the procedures post-discharge when complications arise following specialist surgery. Our Community team are responding to ensure that we improve our communications and embed the learnings to safeguard our care to patients.

Engagement, involvement and visits:

- Theatres
- Robot event
- Safety triangulation meeting
- Maternity visit

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

NHS Gateshead Health NHS Foundation Trust

- It is with deep sadness that we share that our colleague, Rodica Raican, a healthcare support worker from ward 8, unexpectedly passed away. Rodica was a cherished friend and colleague who demonstrated dedication, compassion and care to her patients and her colleagues. Our thoughts are with her beloved husband Mario, who is also a colleague on ward 9, her family, friends and colleagues.
- We are shocked and saddened by the actions of Lucy Letby at the Countess of Chester and our thoughts are with the victims and families. As a Board we produced an immediate response for our colleagues, providing assurance and encouragement that we will always listen to concerns, anxieties and worries. Our full time **Freedom to Speak Up Guardian** commences in post in October, and alongside our Champions, this will strengthen our Freedom to Speak Up structures and capacity. The Chair and Chief Executive attended a national NHS England meeting with colleagues from all trusts to ensure that appropriate learnings and improvements are made to safeguard our colleagues and patients.
- **Industrial action** continued in respect of junior doctors and consultants including the first joint strike day on 20 September.
- Welcomed our **new doctors in training** at the beginning of August.
- The **NHS staff survey** is about to be launched on 2 October. Feedback from this survey is very important for helping us to understand where we need to improve and make changes.
- Our **Allied Health Professional Conference** was held on the 12 September, including excellent presentations and sessions on health inequalities, health and wellbeing and clinical services.
- Celebrated the first year of **international recruitment** with our valued colleagues.

Engagement, involvement and visits:

- Cragside
- St Bede's
- Maternity
- IVF
- Staff Governor meeting

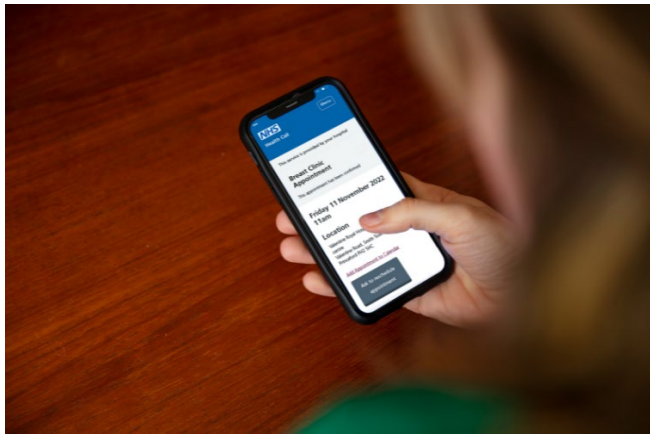
Strategic Aim 3: We will enhance our productivity and efficiency to make the best use of resources

NHS Gateshead Health NHS Foundation Trust

- Under the NHS **System Oversight Framework**, NHS England has confirmed a change in the Trust's classification from segment two to **segment three**, with an identified need for mandated support. This relates to our planned deficit position. We are looking carefully at our costs and productivity, and remain committed to our core strategic ambitions, which will be key to financial sustainability.
- Launched our **Sustainability Programme** with a dedicated Delivery Oversight Group. Each of the eight workstreams will have an Executive Lead and Clinical Sponsor.
- Celebrated the first anniversary of the use of our **robot** in theatres. 136 patients have been treated so far and four surgeons are fully trained to operate it.
- Launched a **new innovative digital patient engagement service** designed to reduce our reliance on paper and provide patients with a quick and easy way to accept, cancel or amend an appointment and view correspondence. It will also offer reminders and help to reduce non-attendance. It is being piloted in breast services before being rolled out to all clinical areas.
- Launched our **'back to basics'** programme across the Trust which aims to improve our services for patients and staff by ensuring that we are getting the things right that make a difference.
- Received recurrent funding from NHS England's specialised commissioning function to recruit to a **locum post** on a permanent basis for gynae-oncology.
- Our **breast surgery team** have successfully implemented a novel technique of pre-pectoral implant-based reconstruction, offering a single-stage immediate breast reconstruction procedure for suitable patients. This has resulted in 95-100% of cases being performed as day cases. By minimising the emotional impact of breast loss and enhancing the quality of life, patients experience shorter recovery periods and improved overall wellbeing.

Engagement, involvement and visits:

- ❖ Winter planning event at Gateshead Council



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

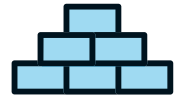
Gateshead Health NHS Foundation Trust

- Dr Andy Lowes, Staff Governor and Consultant in Anaesthetics and Critical Care, chairs our Organ Donation Committee. He has worked closely with **local schools** to encourage pupils to develop artwork to **raise awareness of organ donation**. Andy dedicated a significant amount of his own time to make this happen, delivering an amazing display of artwork. Governors and colleagues were invited to vote and the winning artwork will be displayed in the Trust. Thank you to Andy and all the pupils who took part!
- Our **Governor elections** are underway, with the nomination period closing on 27 September.
- **Gateshead College students** have developed a mural to help alleviate distress among patients with dementia at our Cragside unit. The artwork evokes a sense of home and familiarity for dementia patients, encouraging discussions and fostering a relaxed environment.
- Established a new service in partnership with Gateshead Council's Public Health team. The 14 week **Strength and Balance classes** are provided for over 65 year olds living with mild to moderate frailty and a history of falls, reduced confidence, independence or social isolation. Excellent feedback has been received from participants.
- We continue to work closely with colleagues in primary care including via a **primary care access meeting** on 20 September.

Engagement, involvement and visits:

- MP meeting
- Executive Team to Executive Team meeting with Northumbria Healthcare
- Provider Collaborative meetings
- CEO Leadership Group

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



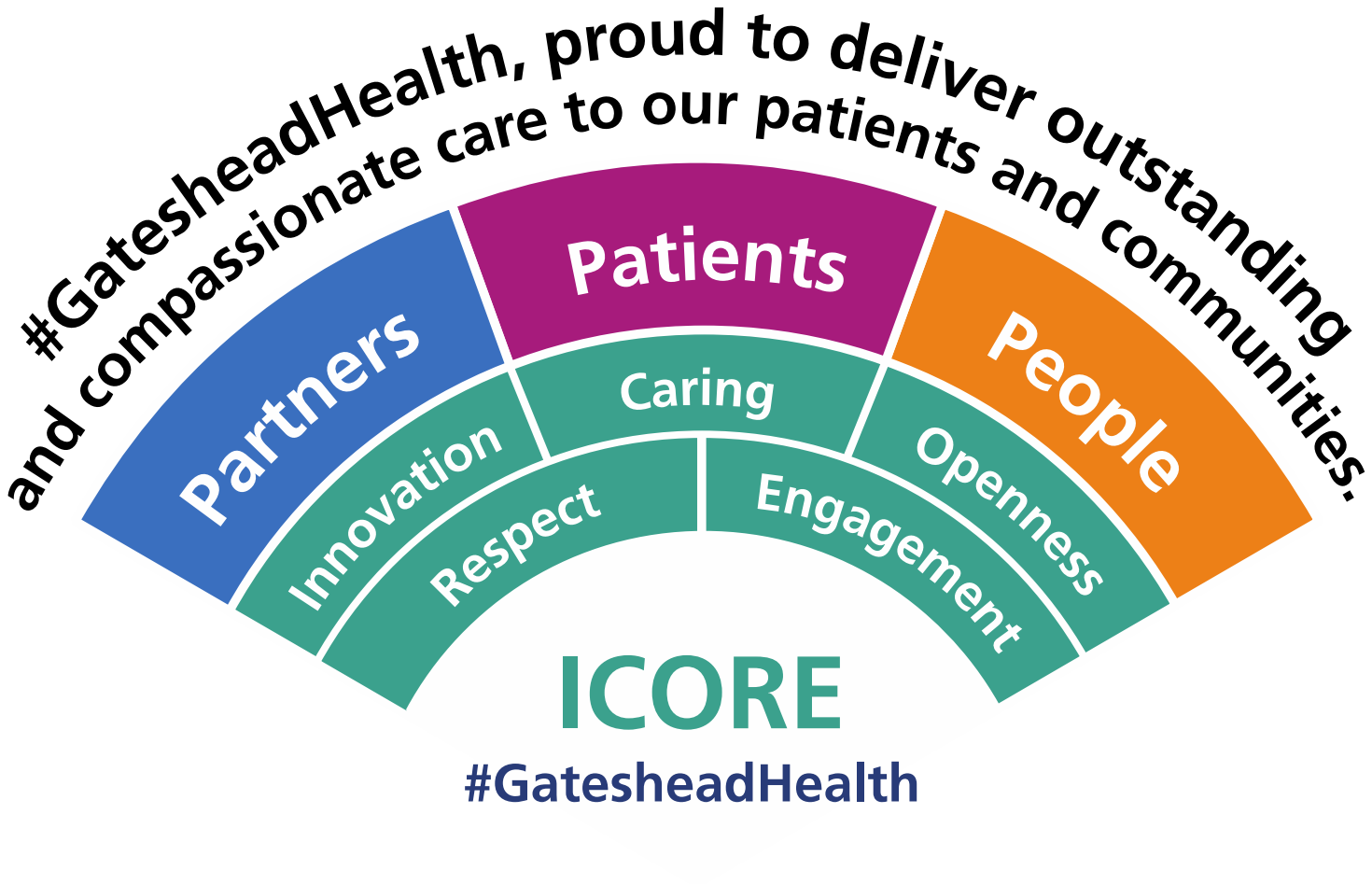
NHS Gateshead Health NHS Foundation Trust

- **QE Facilities' Pharmacy** provision are working to support the Trust Pharmacy with the dispensing and delivery of medicines to a greater number of Trust patients. This allows the Trust Pharmacy to focus skills and resource to the clinical pharmacy services and offer additional prescribing support for future winter bed pressures.
- Our Executive Team met with the **QE Facilities' Executive Team** to collaboratively develop an outline strategy for QE Facilities. This will support QE Facilities to be able to further develop services going forwards to benefit Gateshead patients.
- We continue to share our strategy and strategic intent around being a **Centre of Excellence for Women's Health.** We submitted 18 abstracts for consideration at the ICBs Women's Health Conference scheduled for 19th October with a number of us registered to attend. With support from the system, we are leading the Gateshead Place expression of interest to develop a **Women's Health Hub**. Under the Women's Health Strategy for England each ICS is expected to have at least one health hub to improve access to services and health outcomes.
- We are reviewing our resources to enable us to respond to **national tenders** and other commercial opportunities**.**
- We are in discussion with the Academic Health Science Network (AHSN) around their **Health and Life Science Pledge**. *"The purpose of the Health and Life Science Pledge is to bring together the Health and Life Science infrastructure in the NENC to enable Health and Social Care Innovation to grow, accelerate and ultimately flourish"* (AHSN).

Engagement, involvement and visits:

- Executive Team time out with QE Facilities' Executive Team

NHS
Gateshead Health
NHS Foundation Trust



Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 10i

Report Title:	**Strengthening the Clinical Voice**			
Name of Meeting:	Board of Directors			
Date of Meeting:	27 September 2023			
Author:	Andy Beeby, Medical Director			
Executive Sponsor:	Trudie Davies, Chief Executive			
Report presented by:	Andy Beeby, Medical Director			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☐	**Information:** ☒
	As part of the thematic review at Gateshead Health FT, it has been identified that there is an organisational perception that clinical leadership needs to be strengthened with greater emphasis placed on recognising and hearing the clinical voice in decision making.			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☐ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☒
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*				
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	The CEO at Gateshead health FT undertook a thematic review, supported by executive directors, to plan the work program for the year and to address concerns raised in a number of key fora. A theme throughout this work was the need to move to a "clinically led and management supported" ethos which gives more time, focus and structure to the clinical leadership agenda. In addition, it has been agreed that the Trust strategic ambition to have more visibility in Place requires strengthening. This brief paper describes how the Medical Directors office is responding to these challenges and what this means for the organisation.			
Recommended actions for this meeting:	There are a number of key actions being taken to address these areas.			

<table>
<tr><td>Outline what the meeting is expected to do with this paper</td><td colspan="6">1. At Place. In order to increase visibility and leadership at Place, Mr Beeby will direct increased time to external facing activities.

2. At Trust Board, the clinical voice will be strengthened with the additional presence of the Medical Director for Operations.

3. In day-to-day activities, a number of actions have been taken.</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>
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<tr><td>Aim 5
☐</td><td colspan="5">We will develop and expand our services within and beyond Gateshead</td></tr>
<tr><td>Trust corporate objectives that the report relates to:</td><td colspan="6">SA1.2 – continuous quality improvement plan
SA4.1 – addressing health inequalities
SA.4.2 – working collaboratively as part of Gateshead Cares</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">-</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>

Changes to the Medical Director Leadership Team and Strengthening the Clinical Voice
Situation

1. Introduction

1.1. As part of the thematic review at Gateshead Health FT, it has been identified that there is an organisational perception that clinical leadership needs to be strengthened with greater emphasis placed on recognising and hearing the clinical voice in decision making.

2. Background

2.1. The CEO at Gateshead health FT undertook a thematic review, supported by executive directors, to plan the work program for the year and to address concerns raised in a number of key fora. A theme throughout this work was the need to move to a “clinically led and management supported” ethos which gives more time, focus and structure to the clinical leadership agenda.

2.2. In addition, it has been agreed that the Trust strategic ambition to have more visibility in Place requires strengthening. This brief paper describes how the Medical Director’s office is responding to these challenges and what this means for the organisation.

3. Assessment

3.1. It is agreed that the clinical voice needs to be strengthened at Place, at Trust Board and within the day-to-day operational activities of the organisation.

4. Recommendation

4.1. There are a number of key actions being taken to address these areas.

- **At Place.** In order to increase visibility and leadership in Place, Mr Beeby, Medical Director, will direct increased time to external facing activities. This means he will lead and develop relationships with local provider networks and GP practices in order to optimise opportunities to influence health inequalities, health promotion, prevention and demand management and transformation. The MD is maintained as the Trust Responsible Officer and keeps all Board level responsibilities that are designated to this role.

- **At Trust Board**, the clinical voice will be strengthened with the additional presence of the Medical Director for Operations. Neil Halford will undertake this role. His focus will be on influencing and shaping internal Trust activity and leading internal transformation programs alongside the Chief Operating Officer and Chief Nurse. He will attend Board and Executive committees but will not have voting rights associated with an executive director unless he is deputising for the MD. Terms of reference will be adjusted to take into account his role and subsequent quoracy. The MD and MD for Operations will be clear on who will attend which Tier One committee to ensure consistency and transparency.

In addition, the Deputy CEO role has been appointed to and will be held by the Chief Nurse. The Chief Nurse will strengthen the team supporting her to enable time to undertake this role and therefore, increasing further the clinical voice at Trust Board.

- **In day-to-day activities**, a number of actions have been taken. The Heads of Clinical Services have had time allocation to undertake the role increased in order to enable them to be more present and visible in leadership activities.
  The Deputy CEO is leading a review of structures and nomenclature, alongside the COO and MD operations, to ensure that the structures enable clarity of Board to Ward processes.

4.2. This will consider feedback from the GGI review of meetings that is taking place.

4.3. The MD has reinvigorated the Clinical Strategy meetings and Medical Staffing Committee to influence and support decision making.

4.4. In addition, there will be an additional associate medical director to shape and influence medical workforce issues, including appraisal / revalidation, the role and function of Medical Staffing department, support to Doctors in difficulty and with medical workforce strategy for new roles in the future. This post is currently in the recruitment process.

5. Conclusion

5.1. This paper outlines briefly the challenges and solutions that have been put in place or are in progress.

5.2. There is no action required as this is for information only.

5.3. The new post of Medical Director for Operations does not fall within the remit of the Group Remuneration Committee and therefore decisions related to pay and terms and conditions will be managed via Trust Policy.

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 11

Report Title:	**Disclosure and Barring Service Checks (Update)**			
Name of Meeting:	Trust Board			
Date of Meeting:	27th September 2023			
Authors:	Amanda Venner, Interim Executive Director of People & OD			
Executive Sponsor:	Amanda Venner, Interim Executive Director of People & OD			
Report presented by:	Gill Findlay, Deputy Chief Executive/Chief Nurse and Professional Lead for Midwifery and AHPs			
Purpose of Report	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☒
	This paper provides an update on the work underway and the reducing risk in relation to historic DBS clearances formally recorded in the Electronic Staff Record.			
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:	Previous DBS Paper considered by EMT – 20 March 2023 EMT – 2 May 2023 POD Committee – May 2023, July 2023 and September 2023 Trust Board – March 2023, May 2023 and July 2023			
Key issues:	**Key Issues** • Following an internal review, some gaps were Identified in historical DBS records (either no record or record at lower level than required for job role). • Assurance has been gained that post the implementation of the recruitment system Trac (July 2021), all employment checks are in place. • DBS task and finish group established with executive oversight. • Robust process established and developed to support identified staff to obtain new DBS clearance. • Reporting progress tracked to date with executive oversight. • Future process agreed by the executive team that the Trust will move to the DBS update system, starting with			

<table>
<tr><td></td><td colspan="5">newly appointed staff. Conversations commenced with trade union colleagues on the most appropriate way to implement.
• DBS policy to be updated incorporating the update system as Trust approach to manage risk around DBS checks.

Position Status
After initial audit 977 staff and volunteer records had DBS either missing or incomplete.

Current position is:
• 863 checks complete.
• 1 check outstanding (Trust volunteer).
• 59 staff have left the organisation
• 10 found to be not required.
• 20 long term sick/maternity.
• 24 in progress (with the DBS or for internal checking).

There is 1 check outstanding for a Trust volunteer who is aware that they will not be able to undertake volunteering duties for the Trust until this check is complete.</td></tr>
<tr><td>Recommended actions for this meeting:</td><td colspan="5">To note the work underway, the next steps and the reducing risk in relation to historic DBS clearances formally recorded in the Electronic Staff Record.</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:</td><td>Aim 1
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☒</td><td>Effective
☐</td><td>Safe
☒</td></tr>
<tr><td colspan="6">Risks / implications from this report (positive or negative):</td></tr>
<tr><td>Links to risks (identify significant risks and DATIX reference)</td><td colspan="5">Historical DBS clearances have not been fully recorded on ESR resulting in an inability to provide assurance as to compliance with DBS and NHS employment standards

• Consequence 4
• Likelihood 3
• Score 12

Quality and potential safety impact under review with Deputy Chief Executive/Chief Nurse and Professional Lead for Midwifery and AHPs and Executive Medical Director</td></tr>
</table>

	Risk remains under review with score reduced from 20 to 16 down to a 12 with increased control and assurance and reducing number of outstanding DBS.		
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒

1. Introduction

An internal audit in May 2023 identified that some staff did not have a DBS check recorded on their records or that their DBS check was not at the correct level of assurance. This related mainly to staff who had been employed in the organisation for many years and who had not moved to new roles within the organisation. They were therefore either employed before DBS checks were required or their records were incomplete. A task and finish group chaired by the Interim Director of People and Organisational Development and the Chief Nurse has met weekly to manage the correction of this situation. This task and finish group has reported to the People and OD committee. As soon as the situation became apparent to the Trust on 19th May 2023, the Care Quality Commission, the Integrated Care Board and NHS England were notified of the position and the plan to address it.

It became apparent early within this process that this was an historical issue arising prior to the implementation of the TRAC system in July 2021. It is acknowledged where the TRAC system has been used for recruitment activity, we were able to give assurance of full compliance with the DBS employment standard, and this was reported to the People and OD Committee and Trust Board. Previous risks relating to any locally owned recruitment processes have also been shared with the Committee.

2. Actions Taken

The task and finish group is nearing completion with the weekly oversight meetings still in place. The group has comprised a range of stakeholders across the trust and QE Facilities (QEF). Its focus was to establish an initial work plan, scope the baseline position and oversee the completion of the checking process. The initial action plan for the group is shown below.

Initial Action Plan

Establish baseline DBS position across the Trust and QEF	(Complete) baseline figure: 616 for trust and 361 for QEF)
Confirm compliance with requirements for DBS checks for new starters to Gateshead Health and employees who move around in employment.	(Complete) Note: since implementation of TRAC, all recruitment actioned via TRAC shows DBS checks complete; consistent compliance since July 2021.Internal Moves outlined actions within policy.
Review level of checks required for job roles across the Trust and QEF	(Complete) Note: reviewed and signed off by Deputy CEO
Confirm compliance with requirements for DBS for Board and Fit and Proper Persons	(Complete) Note: Fully compliant with current process, will move to an annual check by end Q2
Identify Priority Target Areas (Inclusive of Length of Service)	(Complete) Note: Areas identified Trust • Paediatrics • Maternity • Front facing wards (note inclusive of OTs, pharmacists etc) • Mental Health wards QEF • Porters • Security staff • Domestic staff
Operational process Agreed – Supporting Staff to obtain correct level of DBS.	(Complete) Note: Operational process fully mobilised

• Business Unit Briefing • SOP developed • DBS Clinic set up • Employee Letters sent	Business Unit discussions completed by 31st May 2023 Staff to complete DBS application process by 30th June DBS Clinics extended to 14th July to allow for overspill x2 mail shots sent out directly to staff
Engagement with trade unions	(Complete) Note: Engagement and partnership working is ongoing trade unions part of oversight group.
Identify quality and safety risks	(Complete) Note: Risk Register updated, score of 20 and reduced to 16. Risk Assessment SOP Developed as part of project.
Brief CQC on position and plan	(Complete) Note: External Escalation board also informed. Ongoing updates with both CQC and Escalation Board.
Agree recommendations for next steps on whether we have a rolling program or an update or self-declaration system.	(Complete) Note: Agreed on 18th September to move to using the update service for all new staff with a phased plan to be worked on for ensuring all staff move to using the service in future.
Policy update	(In process) Note: Policy to be updated following discussion with trade unions on the EMT recommendation of the update service

3. Areas of risk

The main risk related to the historic and accurate recording of DBS checks and the potential that staff without the relevant checks were working within the organisation. A risk was added to the risk register at initial score of 20. This was later reduced to 12 as the work progressed and all staff engaged with the process. As detailed above, the process of checking new applications was targeted to the highest risk areas first (paediatrics, maternity and any areas where staff were working in isolation), followed by all other areas.

This current risk on the risk register is currently being reviewed as the project reaches its conclusion and will be moved to a managed risk at the next Executive Risk Management Group.

4. Outcomes

Trust starting position
616 employees and volunteers were identified as have either no check recorded, the incorrect level recorded or partial information regarding their check recorded.

QEF starting position
361 have either no check recorded, the incorrect level or partial information recorded.

Group Outcome from **977** outstanding DBS, as at 18th September 2023, broken down as follows:

- 863 checks complete.
- 1 check outstanding (Trust volunteer)
- 59 people have left the organisation
- 10 not required (in date DBS found)
- 20 long term sick/maternity
- 24 in progress (with the DBS or for internal checking).

A process is in place for any relevant people returning from sick leave or maternity leave to complete a new DBS check.

It was confirmed that all Trust Board members including the company secretary had appropriate DBS checks recorded within their records at the time of appointment.

15 individuals either self-declared or were found to have cautions/convictions on their DBS check. Any convictions declared by colleagues during the process or notified by the DBS service were risked assessed locally and signed off as low risk by the Deputy Chief Executive/Chief Nurse and Professional Lead for Midwifery and AHPs and Interim Executive Director of People and OD. There have been no formal procedures necessary as a result of information received from the DBS.

DBS checks continue to be carried out on all necessary new starters to the Trust as well as staff who move internally to a different role that requires a DBS check in line with the Group policy.

5. Next steps

The task and finish group is drawing to a close, however strategic oversight continues jointly led by the Interim Executive Director of People and OD and the Deputy Chief Executive/Chief Nurse and Professional Lead for Midwifery and AHPs.

There is one outstanding DBS check and this colleague has been approached by their line manager. They have engaged with the process but the trust is awaiting the production of documentation to support the process. The individual will not work within the Trust until this process is completed.

As the final DBS checks come through from the national system any identified cautions/convictions will be risk assessed and managed in line with group policies.

6. Recommendations

Trust Board is asked to receive this paper for assurance that the position on DBS checks has significantly improved. The remaining actions are for the final DBS to be completed and for any outstanding DBS checks coming back into the organisation to be managed in line with the policy.

Most up to date reporting information (as at 18th September 2023) is shown at **Appendix 1.**

Amanda Venner
Interim Director of People and OD
19/09/23

Appendix 1 - DBS Report as at 18th September 2023

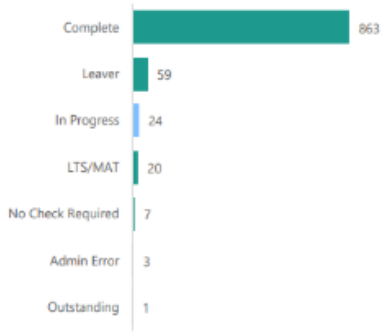
DBS Status Report

Report Date: 18-Sep-2023 13:00

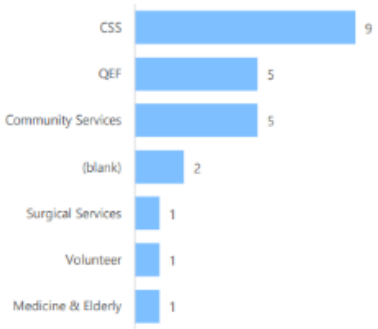
Overall % outstanding: 0.1%

NHS Gateshead Health NHS Foundation Trust

Employee Status

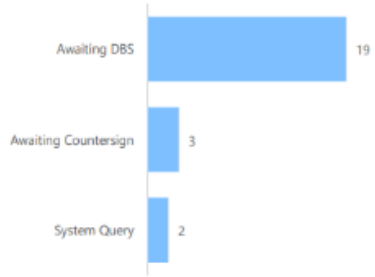


In progress by BU



In progress by Broad Staff Group

In progress sub status



	Outstanding	In progress	Complete	Leaver	LTS/MAT	No check req.	Admin error	Total
28-Jun	**122** - 12%	222 - 23%	545 - 56%	46 - 5%	32 - 3%	7 - 1%	3 - 0%	977
3-Jul	**103** - 11%	206 - 21%	580 - 59%	46 - 5%	32 - 3%	7 - 1%	3 - 0%	977
5-Jul	**62** - 6%	189 - 19%	639 - 65%	47 - 5%	30 - 3%	7 - 1%	3 - 0%	977
10-Jul	**47** - 5%	148 - 15%	689 - 71%	51 - 5%	32 - 3%	7 - 1%	3 - 0%	977
12-Jul	**32** - 3%	157 - 16%	693 - 71%	51 - 5%	34 - 3%	7 - 1%	3 - 0%	977
17-Jul	**23** - 2%	161 - 16%	698 - 71%	51 - 5%	34 - 3%	7 - 1%	3 - 0%	977
19-Jul	**13** - 1%	159 - 16%	708 - 72%	51 - 5%	36 - 4%	7 - 1%	3 - 0%	977
24-Jul	**12** - 1%	159 - 16%	709 - 73%	51 - 5%	36 - 4%	7 - 1%	3 - 0%	977
26-Jul	**8** - 1%	145 - 15%	726 - 74%	51 - 5%	37 - 4%	7 - 1%	3 - 0%	977
1-Aug	**8** 1%	141 14%	730 - 75%	51 - 5%	37 - 4%	7 - 1%	3 - 0%	977
7-Aug	**0** - 0%	58 - 6%	821 - 84%	54 - 6%	34 - 3%	7 - 1%	3 - 0%	977
4-Sep	**0** - 0%	52 - 5%	830 - 85%	54 - 6%	31 - 3%	7 - 1%	3 - 0%	977
11-Sep	**1** - 0%	33 - 3%	849 - 87%	56 - 6%	28 - 3%	7 - 1%	3 - 0%	977
13-Sep	**1** - 0%	23 - 2%	860 - 88%	56 - 6%	27 - 3%	7 - 1%	3 - 0%	977
18-Sep	**1** - 0%	24 - 2%	863 - 88%	59 - 6%	20 - 2%	7 - 1%	3 - 0%	977

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 12

Report Title:	**Healthcare Support Workers Updated National Profiles**			
Name of Meeting:	Board of Directors			
Date of Meeting:	27/09/23			
Author:	Mr Drew Rayner, Deputy Chief Nurse and Ms Gemma Rutherford, Interim Deputy Director of People and OD			
Executive Sponsor:	Dr Gill Findley, Chief Nurse and Professional Lead for Midwifery and Allied Health Professionals			
Report presented by:	Dr Gill Findley, Chief Nurse and Professional Lead for Midwifery and Allied Health Professionals			
Purpose of Report	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☐	**Information:** ☒
	The purpose of the report is to provide information about the updated national profiles for Healthcare Support Workers working at band 2 and band 3 and the potential impact of these changes for banding of healthcare support workers across the Trust.			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☐ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☒
Paper previously considered by:	Executive Management Team			
Key issues:	• In July 2021 the national job profiles for band 2 and band 3 healthcare support workers were updated. It has become apparent that when matched against these job roles, some staff at band 2 within the organisation may be operating at band 3 level. • 697 WTE substantive staff and 179 bank staff are potentially affected by this issue. • Costs of any banding changes is yet to be quantified but is likely to be substantial. • Some staff may be entitled to significant amounts of back pay. • This change affects staff who are currently employed within the Trust. • This change allows us the opportunity to review entry level roles and potentially expand opportunities for apprentices and school leavers • Trade unions are involved in the discussions			

<table>
<tr><td>Recommended actions for this meeting:</td><td colspan="5">The Board of Directors is asked to note the contents of the report and the actions being undertaken to address the identified disparity in grades for our people.</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:</td><td>Aim 1
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☒</td></tr>
<tr><td colspan="6">Risks / implications from this report (positive or negative):</td></tr>
<tr><td>Links to risks (identify significant risks and DATIX reference)</td><td colspan="5"></td></tr>
<tr><td>Has a Quality and Equality Impact Assessment (QEIA) been completed?</td><td colspan="2">Yes
☐</td><td colspan="2">No
☒</td><td>Not applicable
☐</td></tr>
</table>

Healthcare Support Workers Updated National Profiles

1. PURPOSE OF REPORT

The purpose of the report is to provide information about the updated national profiles for Healthcare Support Workers working at band 2 and band 3. Changes to the national profiles have a direct impact on the current roles and responsibilities of our staff in post. The paper also discusses options under consideration for Gateshead Health NHS Foundation Trust to address the disparity between the national profiles and current job descriptions.

2. BACKGROUND

NHS pay modernisation (Agenda for Change) was introduced to ensure equal pay for equal work value and every effort was made to ensure the NHS Job Evaluation Scheme was fair and non-discriminatory. Each job role has a nationally agreed profile which is used as part of the banding process.

At national level, concerns were raised that the duties and tasks for the Healthcare Support Workers had changed significantly over time and job descriptions may not have been reviewed regularly and updated.

Initiatives and programmes for this group of staff have been implemented in recent years:

- The Care Certificate, introduced by NHS England, and takes several months to complete.
- Skills for Health have been running the Talent for Care programme to support development.
- Career development frameworks and pathways have emerged.
- The HEE Maternity support work competency, education, and career development framework.

Nationally Clinical Support Worker profiles were revised and updated in July 2021 to ensure that local job evaluation processes and historical job matching profiles remain reliable, accurate, fair, and consistent.

The scope of these profiles covers a breakdown in roles and responsibilities outlines for both the band 2 Clinical Support worker role and the band 3 Clinical Support Worker Higher Level role.

3. DETAILS

The electronic Staff Record has identified that there are approximately 697 band 2 substantive Healthcare Support Workers in the trust and 179 bank Healthcare Support Workers.

Gateshead Health NHS Foundation Trust were in a receipt of a petition from Unison requesting changes to Healthcare Support Worker pay in August 2023.

Unison are also working with their members on the potential submission of a collective grievance in relation to this.

3.1 Job Descriptions

Attached is the current job description for a Nursing Assistant (the Gateshead name for the Healthcare Support Worker role) and also the national job profile for a band 2 Clinical Support Worker and a Nursing: Clinical Support Work (Higher level).

HCA Job+Description (1).

Combined-nursing-profiles-Jul-21 (1).pc

The initial cross referencing of the national profile to the Trust's job description for band 2 Healthcare Support Worker identifies a significant number of tasks carried out by our current workforce at band 2 are listed in the national job profiles as Nursing: Clinical Support Worker (Higher Level) band 3 duties.

For example, national job profile job statements indicate:

Nursing: Clinical Support Worker (band 2)

Job Statement:
1. Undertakes personal care duties for patients in the community, in hospital or other settings
2. Supports patients / clients with toileting, bathing, dressing, and meals
3.. Records patient information

Nursing: Clinical Support Worker Higher Level (band 3)

Job Statement:
1. Undertakes a range of delegated clinical care duties in hospital, community, or other settings
2. Records patient observations and changes to patient clinical conditions
3. Carries out limited clinical care duties

On review of 35 clinical areas across the Trust, it has been identified that all band 2 Healthcare Support Workers are carrying out some duties outlined in the national job profiles as Clinical Support Worker Higher Level (band 3). If we are to follow the national job profile this may result in the need to re-band a significant number of staff.

3.2 Impact Scoping

The Trust's electronic staff record has identified:

697 (607.5 FTE) substantive healthcare support worker staff in scope for the review and 179 healthcare support workers (bank only) in scope for review.

3.3 Future Cost

Basic Pay

Table 1 shows the difference between pay rates for band 2 and band 3 staff at each point of the payscale. Table 2 shows the difference in enhanced rates of pay for the two bands.

Table 1: The difference in salary between the Band 2 and Band 3:

Pay Band	2	3
Entry Step Point	£22,383	£22,816
Top Step Point	£22,383	£24,336

Table 2: The difference in the enhancement rates at Band 2 and Band 3:

Pay band	All time Saturday (midnight to midnight) and any week day after 8pm and before 6am	All time on Sundays and Public Holidays (midnight to midnight)
1	Time plus 50%	Double Time
2	Time plus 44%	Time plus 88%
3	Time plus 37%	Time plus 74%
4 - 9	Time plus 30%	Time plus 60%

Source: Agenda for Change handbook

The difference in the enhancement payment percentage has the potential to have an impact on those staff moving from a band 2 to band 3, dependent on the enhancements received. Potentially, staff who are bottom of scale could be marginally worse off if their shift patterns are heavy on nights or weekends. Top of scale staff are marginally better off. Please note that this is gross pay to the employee and not the cost to the organisation.

All the current band 2 staff receive the same salary of £22,383 since the introduction of the 2023/24 pay deal. Applying Agenda for Change terms and conditions, all current band 2 Healthcare Support Workers would move to the like for like pay scale step as part of the of the band 3 pay scale, only moving to top of band after two years' service.

Table 3:Gross costs comparison

Pay Band	2	3	Diff	Nos	Impact
Entry	£22,383.00	£22,816.00	£433.00	697	£301,801.00
Top	£22.00	£24,336.00	£1,953.00	697	£1,361,241.00

Table 4 Actual cost comparison

Pay Band	B2	B3	Diff	Nos	Impact
Entry	27,572	28,130	558	697	**£388,783**
Top	27,572	30,088	2,516	697	**£1,753,563**

3.4 Backdated Costs Initial options

As staff have been undertaking these roles for some time, the issue of back pay arises. There is no national agreement in relation to back pay, although all organisations are looking at this issue. Options are as follows:

Option 1: Date of national profile change

The national profile was updated in July 2021. If this position were to be agreed the organisation would be facing additional resource pressures of **£1,944,630** . The Trust could determine any date between July 2021 and the date when agreement is reached about any change of banding as the date to which pay will be backdated. Options could include the date when Unison raised their concerns with the Trust (2022) or the date of receipt of the petition (August 2023).

Option 2: Date of job evaluation
The Trust could opt to agree a date in the future when the Gateshead job description is agreed by the internal banding panel. This would be one agreed job description for all band 2 and band 3 staff. Therefore, the effective date of change would be the date the job description is received into the People and OD for evaluation. This is the preferred option.

3.5 Other Considerations

Had the Trust enacted the changes to pay grades at the time when the new national job profiles were published many of the staff would now be at the top of the band 3 pay scale. This needs to be factored into discussions with the trade unions.

Once the date for any back pay has been identified the Trust will need to consider any non-recurrent bonus payments that have been applied during the period. This will be an additional cost for the Trust.

3.6 Pay Protection

Following previous pay changes there is an anomaly in enhancements for band 2 and band 3 staff, which means that for some staff who work a lot of enhanced rate hours, moving to a band 3 will actually cause a decrease in take home pay. It is suggested that a “no detriment” approach is adopted so that no one is adversely affected by this change. This mean that an individual conversation is likely to be required for each member of staff to identify any detriment and an element of pay protection may be required.

3.7 Regional Position

From discussions with Regional Deputy Directors of HR and Heads of Nursing the regional position is as follows:

- South Tyneside is currently in the scoping phase with a preferred option of a no detriment approach.
- TEWV have not yet commenced and have had little or no contact from trade unions, either regional or local.
- CDDFT are looking at the number of staff to be reviewed but had not progressed further, no scoping work has commenced. CDDFT have also not had any contact from Trade Unions.
- North Tees who have agreed to make back dated payments to July 2021.
- Newcastle have now agreed their position with Staff Side and have communicated that they are making the payment to staff. Their agreed backdated pay date is 1 February 2022, the date when the job description was job evaluated and they have also negotiated a 'no detriment' policy.

4. Next Steps

Further work needs to be undertaken to agree the national profile and Trust job description working in partnership with trade union colleagues. The agreed approach in relation to back pay must also be agreed with trade unions. We anticipate this work will be completed by the end of November 2023.

This paper has discussed options for staff already in post. There is further work required to agree the approach for staff who join the Trust at entry level and who will not necessarily have all the skills required for the band 3 role. This is an opportunity to review approached such as apprenticeships and innovative new roles.

Collaborative working with Healthcare Support worker colleagues to identify opportunities for role amendments, educational support and to establish a career pathway to transition future staff through Healthcare Support Worker, to Clinical Support Worker (higher level) and beyond into advanced educated roles such as Nursing Associates and Registered Nurses.

Trust Board will receive further updates as this work progresses.

Gateshead Health NHS Foundation Trust

Job Description

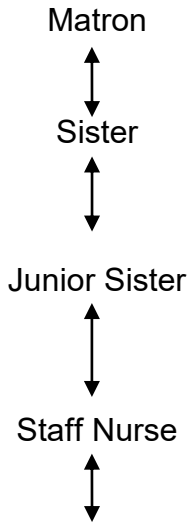
Job Details	
Job Title:	Nursing Assistant
Directorate:	Trust Wide
Accountable to:	Ward Manager
Location	Gateshead NHS Foundation Trust
Pay Band:	Band 2

Main Purpose of the Job

- To undertake personal care duties for patients in hospital.
- To support all members of the MDT to deliver high quality, safe patient care.
- To ensure a safe working environment.
- To assist the registered staff to care for patients.

Organisation Chart

Please highlight job and show colleagues on same level and two levels above and below



Communications and Relationships

Please specify information being communicated and the level of complexity entailed and to whom, the skills required to motivate, negotiate, persuade, and empathise, and breaking bad news sensitively and provide reassurance.

- Communicates information to staff, patients, relatives and carers.
- Communicates information in an empathetic and reassuring way where there may be barriers to communication/understanding i.e. speech/language/hearing difficulties.
- Communicates with patients, clients, relatives and staff whose first language may not be English.
- Is able to communicate effectively using written and oral skills.
- Establish and maintain effective relationships with patients, relatives and colleagues.
- Provide and receive routine information requiring tact or persuasive skills; barriers to understanding.
- Exchanges factual information with patients using persuasion, reassurance, tact, empathy, may overcome barriers to understanding e.g. patient has physical or mental disabilities.

Knowledge, Skills, Training and Experience

Please include theoretical, practical, professional, special knowledge etc, required to fulfil the job satisfactorily at entry level. Please include educational level normally expected or equivalent level of practical experience.

Essential

- Experience of working and communicating with people.
- Minimum of level 2 functional skills in English.
- Minimum of level 2 functional skills in Mathematics.

Desirable

- Experience in hospital or care environment
- Experience in using I.T.
- Range of routine work procedures requiring job training
- Knowledge of personal care and related procedures through on the job training.
- NVQ training or equivalent experience.

Analytical and Judgemental Skills

Please include analytical & judgemental skills required for the post e.g. making judgements in situations where information is either difficult to obtain / understand or medical notes/information on history is unavailable.

- Able to judge when to involve senior staff
- Able to assess own ability
- Able to assess when a patient may cause harm to themselves or other patients
- Make Judgements involving facts or situations, some requiring analysis.
- Prioritise which duties to respond to first.
- Report patient conditions.

Planning and Organisational Skills

Examples include; planning or organising clinical or non-clinical services, departments, rotas, meetings, conferences and for strategic planning.

- Able to prioritise the delivery of care to patients under the instruction of qualified staff.
- Able to assist with the planning and discharge of patients in a timely manner
- Able to assist with the timely transfer of patients
- Able to ensure that patients attend departments in a timely manner
- Able to organise own day to day work tasks or activities.

Physical Skills (manual dexterity)

Examples Include: hand-eye co-ordination, sensory skills, (sight, hearing, touch, taste, smell etc), dexterity, manipulation, speed and accuracy, keyboard and driving skills.

- Be able to operate machinery such as patient hoists.
- Be able to stand for prolonged periods of time and mobilise for periods up to 12 hours.
- Be able to respond with speed when required in emergency situations.
- Be able to perform repetitive actions such as bending.
- Be able to use a keyboard.
- Hand eye co- ordination for manoeuvring wheelchairs, bathing patients, using hoists.

Patient/Client care:

Please specify the level of involvement in the provision of care to patients/clients and including how responsibility is shared with others.

- To assist other nursing staff in attending to physical, psychological and spiritual needs of the patient.
- To take and record patients vital signs and input into Vital Pac.
- To be able to recognize a deteriorating patient.
- To maintain patient confidentiality.
- To undertake and record urinalysis results and report accurately.
- To undertake and record blood sugar results and report accurately.
- To prepare patients for meals
- To assist patients with meals
- To practice safely within infection, prevention and control measures
- Provides personal care to patients/clients and undertakes personal care duties e.g. bathing, toileting.

Policy and Service Development:

Level of involvement in the implementation of policy and contribution to the decision making process both within own department and other functions.

- Be able to contribute to the decision making process to improve service delivery.
- Follows policies in own role, may be required to comment.
- Follows policies, may participate in discussions on proposed changes to procedures.

Financial and Physical Resources e.g. budget, stock and equipment:

Responsibility for cash, budgets, and physical assests, vehicles, plant and machinery including the security of equipment.

- To ensure that all equipment that is not safe to use is quarantined.
- To carry out safety checks on equipment as required under the instruction of the qualified staff.
- Duty of personal care in relation to handling patient cash/ valuables.
- Maintain stock control under the instruction of the qualified staff.
- Orders ward supplies as appropriate.

Human Resources
Responsibilities of the job for the training and development of employees/students/trainees. In addition responsibility for the operational management of staff such as recruitment, discipline, appraisal, and career development.
• To engage in the yearly CONTACT appraisal. • To act as a buddy for newly appointed Health Care Assistants • To act as a role model for student nurses • To carry out continued professional and personal development as identified by ward manager.

Information Resources:
Level of responsibility for either paper based or computerized records and systems, responsibility for information systems both hardware and software, plus the generation and creation of information
• Requirement to complete paper based patient records. • Requirement to use I.T. systems to arrange patient transport input vital signs and order equipment. • Records personally generated information. • Contributes to updating of patient records.

Research and Development:
Responsibility for informal or formal clinical or non-clinical R & D including audit.
• To assist with audit and research projects as requested to support improvement in practice. • Undertake surveys or audits of own work as necessary. • Occasionally participates in audits, surveys, and research and development activities.

Freedom to Act
Please specify the level of autonomy and accountability, the level of discretion in the role and where guidance is available from e.g. supervisor, departmental procedures / NHS Guidance/legislation.
• Work under supervision and a set of defined parameters to deliver patient care. • Responsible for maintaining own professional and personal standards. • Well established procedures, supervision close by at all times.

Physical Effort
Please describe activities, frequency and the degree of effort required
• Frequent moving and handling of patients and equipment • Frequent moderate effort for several short/long periods. • Turns, manoeuvres patients for toileting and bathing using aids. • Occasional requirement to move patients on trolleys.

Mental Effort
Please describe the scope, circumstances and frequency of concentration & interruptions
• Frequent interruptions while carrying out tasks • Frequent conflicting demands on time and resources. • Frequent concentration, work pattern predictable • Concentration for personal care duties follows routine.

Emotional Effort
Please describe the exposure, frequency and involvement in distressing or emotional situations
• Frequent exposure to sensitive and emotional situations. • Required to be able to respond to unpredictable and difficult situations. • Occasional/ frequent distressing or emotional circumstances. • Care of terminally ill/ patient deaths.

Working Conditions
Please describe the type and extent of exposure to unpleasant working conditions/hazards
• Frequent exposure to bodily fluids. • Occasional/frequent highly unpleasant conditions. • Smell, noise, dust/body fluids, faeces, vomit, emptying bed pans. Urinals and catheter bags.

CONTROL OF INFECTION

All Trust staff have a duty to provide a safe environment by considering adherence to infection prevention and control as an integral part of their roles and responsibilities. The individual roles and responsibilities for staff are outlined in the Trust's Control of Infection

policy (IC 1). There should be specific discussion of control of infection within the KSF/Appraisal process and as a minimum all staff must demonstrate good hand hygiene and practice and support the Clean Your Hands Campaign.

PRIVACY & DIGNITY & RESPECT AND EQUALITY OF OPPORTUNITY

The Trust is committed to ensuring that all current and potential staff, patients and visitors are treated with dignity, fairness and respect regardless of gender, race, disability, sexual orientation, age, marital or civil partnership status, religion or belief or employment status. Staff will be supported to challenge discriminatory behavior.

PROFESSIONAL CODE OF CONDUCT (IF APPROPRIATE)

To abide by the Code of Practice of Professional body as published by the relevant regulatory body (if appropriate).

CODE OF CONDUCT FOR SENIOR MANAGERS (IF APPROPRIATE)

To adhere to the Code of Conduct for NHS Senior Managers.

Signed:	**(Job Holder)**
Date:	
Signed:	**(Manager/Head of Service)**
Date:	

Appendix 1

Note to Managers: - Please complete this form clearly, providing as much information as possible to candidates.

Risk Assessment Indicators for the post

	DUTIES AND RISK FACTORS OF THE POST	Yes	*No*
1.	Exposure Prone Procedures (EPP's)*	☐	☐
2.	Manual Handling Operations	☐	☐
3.	Dust, Dirt, Smells	☐	☐
4.	Chemicals, Fumes or Gasses (Glutaraldehyde, fixer, anaesthetic gases, reconstitution/handling of cytotoxic drugs)	☐	☐
5.	Patient Contact	☐	☐
6.	Babies/Children Contact	☐	☐
7.	Food handling / Preparation	☐	☐
8.	Driving	☐	☐
9.	Fork Lift Truck Driving	☐	☐
10.	User of Display Screen Equipment	☐	☐
11.	Noise	☐	☐
12.	Infestation	☐	☐
13.	Blood and Body Fluids/Waste/Samples/Foul Linen	☐	☐
14.	Excessive Cold	☐	☐
15.	Excessive Heat	☐	☐
16.	Inclement weather	☐	☐
17.	Radiation	☐	☐
18.	Laser Use	☐	☐
19.	Working at Heights over 2 metres	☐	☐
20.	Confined Spaces	☐	☐
21.	Vibration i.e. Power Tools	☐	☐
22.	Using machinery with moving/exposed parts	☐	☐
23.	Shift work	☐	☐
24.	Use of latex products	☐	☐
25.	Physical violence / aggression	☐	☐
26.	Any other hazards please specify	☐	☐
27.	**Other**	☐	☐

If any hazard is identified above please give details below.

Hazards Identified:-

*Definition of Exposure Prone Procedures (EPP's)

Exposure prone procedures are those where there is a risk that injury to the Health Care Worker may result in the exposure of the patient's open tissues to the blood of the HCW. These procedures include those where the HCW's gloved hands may be in contact with sharp instruments, needle tips and sharp tissue (spicules of bones and teeth) inside a patients open body cavity, wound or confined anatomical space where the hands or fingertips may not be completely visible at all times.

Combined nursing profiles

Please note:

These profiles can be used alongside the existing published profiles in Other. Profiles in Nursing Services and Community Services have either been archived or incorporated into this group where they could not be combined with other profiles.

Band 2
Nursing: Clinical Support Worker

Nursing Services:	Clinical Support Worker Nursing (Hospital)
Community Services:	Clinical Support Worker Nursing (Community)

Combined nursing profiles

Profile Label: **Nursing: Clinical Support Worker**

Job Statement:
1. Undertakes personal care duties for patients in the community, in hospital or other settings
2. Supports patients / clients with toileting, bathing, dressing and meals
3.. Records patient information

Factor	Relevant Job Information	JE Level	Score
1. Communication & Relationship Skills	**Provide and receive routine information requiring tact or persuasive skills; barriers to understanding** Exchanges factual information with patients using persuasion, reassurance, tact, empathy; may overcome barriers to understanding, e.g. patient/client has physical impairment, mental health condition or learning disabilities	3a	21
2. Knowledge, Training & Experience	**Range of routine work procedures, requiring job training** Knowledge of personal care and related procedures, vocational qualification at level 2 or equivalent relevant experience	2	36
3. Analytical & Judgemental Skills	**Judgements involving facts or situations, some requiring analysis** Assesses patient's health, safety and wellbeing while undertaking personal care, deciding whether to refer to other staff as appropriate	2	15
4. Planning & Organisational Skills	**Organises own day to day work tasks or activities** Prioritises own work activities	1	6
5. Physical Skills	**Physical skills obtained through practice** Hand eye co-ordination for manoeuvring wheelchairs, bathing patients/clients, using hoists; standard driving	2	15
6. Responsibility for Patient/Client	**Provides personal care to patients/clients** Undertakes personal care duties, e.g. bathing, toileting, dressing, support with meals and assisting patients with their appearance	3(a)	15
7. Responsibility for Policy/Service Development	**Follow policies in own role, may be required to comment** Follows policies, may participate in discussions on proposed changes to procedures	1	5
8. Responsibility for Financial & Physical Resources	**Personal duty of care in relation to equipment, resources/Handle cash, valuables; safe use of equipment other than equipment used personally; maintain stock control** Careful use of equipment/handles patient/client valuables; ensure equipment used by others, e.g. hoists, is safe and properly used; orders supplies	1-2abc	5-12
9. Responsibility for Human Resources	**Demonstrate own activities to new or less experienced employees** Demonstrates own duties to new starters	1	5
10. Responsibility for information Resources	**Record personally generated information** Contributes to updating patient records eg,by recording basic patient information such as fluid balance (intake and output) and nutrition, height, weight and age	1	4
11. Responsibility for Research & Development	**Undertake surveys or audits, as necessary to own work** Occasionally participates in audits, surveys, research and development activities	1	5
12. Freedom to Act	**Well-established procedures, supervision close by/Standard operating procedures, someone available for reference** Carries out routine personal care duties, supervision available/ Acts on own initiative when delivering personal care, supervision accessible	1-2	5-12
13. Physical Effort	**Frequent moderate effort for several short periods/ frequent moderate effort for several long periods; occasional intense effort for several short periods**	3c-4bc	12-18

Combined nursing profiles

	Turns, manoeuvres patients/clients for toileting, bathing using aids; toileting, bathing without mechanical aids		
14. Mental Effort	**Frequent concentration; work pattern predictable** Concentration for personal care procedures, standard driving. Follows routine	2a	7
15. Emotional Effort	**Occasional/frequent distressing or emotional circumstances** Care of patients/clients with chronic illness/conditions, terminally ill and deaths	2a-3a	11-18
16. Working Conditions	**Occasional highly unpleasant conditions/ frequent highly unpleasant conditions** Foul linen, body fluids	3b-4b	12-18
JE Score/Band		**Band 2**	179-212

Profiles used:

Nursing Services: Clinical Support Worker Nursing (Hospital)
Community Services: Clinical Support Worker Nursing (Community)

Band 3
Nursing: Clinical Support Worker Higher Level

Nursing Services: Clinical Support Worker Higher Level Nursing (Mental Health)
Nursing Services: Clinical Support Worker Higher Level Nursing (Hospital)
Community Services: Clinical Support Worker Higher Level Nursing (Community)

Combined nursing profiles

Profile Label: **Nursing: Clinical Support Worker Higher Level**

Job Statement:
1. Undertakes a range of delegated clinical care duties in hospital, community or other settings
2. Records patient observations and changes to patient clinical conditions
3. Carries out limited clinical care duties

Factor	Relevant Job Information	JE Level	Score
1. Communication & Relationship Skills	**Provide and receive routine information; barriers to understanding** Exchanges factual information with patients using persuasion, reassurance, tact, empathy; may overcome barriers to understanding, e.g. patient/client has physical impairment, mental health condition or learning disabilities	3a	21
2. Knowledge, Training & Experience	**Range of work procedures and practices; base level of theoretical knowledge** Knowledge of care and related procedures, clinical observations, relevant legislation; short courses to undertake patient and clinical care duties, completion of a competency based workbook or equivalent relevant experience to vocational qualification level 3	3	60
3. Analytical & Judgemental Skills	**Judgements involving facts or situations, some requiring analysis** Assess patient/client condition through observations/ test results, assess comfort of patient/client, instigate emergency procedures	2	15
4. Planning & Organisational Skills	**Organise own day to day work tasks or activities;** Plans own work activities:	1	6
5. Physical Skills	**Physical skills obtained through practice/ Developed physical skills; manipulation of objects, people; narrow margins for error; Highly developed physical skills, accuracy important; manipulation of fine tools, materials** Hand eye coordination required when using test equipment, e.g. blood glucose monitors, psychometric testing, manipulating wheelchairs, driving/Restraint of patients/clients; venepuncture, neonatal blood spot screening.	2-3ab	15-27
6. Responsibility for Patient/Client	**Implement clinical care/ care packages** Undertakes a limited range of delegated clinical care duties relevant to the services provided/work area; record patient observations , e.g. taking blood pressure, blood glucose monitoring, pregnancy testing, routine maternal and neonatal observations, observing patients for signs of agitation or distress, wound observations and simple wound dressings, removal of peripheral cannula, urinalysis, removal of catheter	4a	22
7. Responsibility for Policy/Service Development	**Follow policies in own role, may be required to comment** Follows policies, may participate in discussions on proposed changes to procedures	1	5
8. Responsibility for Financial & Physical Resources	**Personal duty of care in relation to equipment, resources/Handle cash, valuables; safe use of equipment other than equipment used personally; maintain stock control** Careful use of equipment/handles patient/client valuables; ensure equipment used by others, e.g. hoists, is safe and properly used; orders supplies	1-2abc	5-12
9. Responsibility for Human Resources	**Demonstrate own activities to new or less experienced employees/ Day to day supervision** Demonstrates own duties to new starters/ supervises work of students and junior staff	1-2	5-12
10. Responsibility for information Resources	**Record personally generated information** Contributes to updating patient records	1	4
11. Responsibility for Research & Development	**Undertake surveys or audits, as necessary to own work** Occasionally participates in audits, surveys, research and development activities	1	5
12. Freedom to Act	**Standard operating procedures, someone available for reference** Acts on own initiative when delivering patient/client care, supervision accessible	2	12
13. Physical Effort	**Frequent moderate effort for several short periods/ Frequent moderate effort for several long periods; Occasional intense effort for several short periods**	3c-4bc	12-18

	Turns, manoeuvres patients/clients for toileting, bathing using aids, restrains patients/clients, active participation in physical activities, e.g. sports activities; toileting, bathing without mechanical aids		
14. Mental Effort	**Frequent concentration; work pattern predictable/unpredictable** Concentration required for clinical and personal care procedures, predictable/ Unpredictable when responding to emergency situations, e.g. patient/client restraint	2a-3a	7-12
15. Emotional Effort	**Occasional distressing or emotional circumstances/ Frequent distressing or emotional circumstances; Occasional highly distressing or emotional circumstances** Care of patients/clients with chronic illness/conditions, terminally ill and deaths, challenging behaviour	2a-3ab	11-18
16. Working Conditions	**Frequent unpleasant conditions; Occasional highly unpleasant conditions/ Some exposure to hazards; Frequent highly unpleasant conditions** Foul linen, body fluids; physically aggressive behaviour	3ab-4ab	12-18
JE Score/Band	**Band 3 = 216-270**		217-267

Profiles used:

Nursing Services: Clinical Support Worker HL Nursing (Mental Health)
Clinical Support Worker HL Nursing (Hospital)
Community Services: Clinical Support Worker HL Nursing (Community)

Band 4
Nursing: Associate Practitioner/Nursery Nurse

Nursing Services:	Nurse Associate Practitioner Acute
	Nursery Nurse (Neonatal Unit)
Community Service:	Nurse Associate Practitioner (Community)
	Nurse Associate Practitioner (Mental Health)
	Nursery Nurse (Community)

Combined nursing profiles

Profile Label: **Nursing: Associate Practitioner/Nursery Nurse**

Job Statement:

1. Implements care packages under the supervision of registered clinical practitioners in a range of settings
2. Carries out nursing care programmes, e.g. clinical observations, participates in social inclusion and/or parenting support activities
3. May supervise/assess clinical support workers
4. May participate in case conferences and case review meetings, e.g. safeguarding

Factor	Relevant Job Information	JE Level	Score
1. Communication & Relationship Skills	**Provide and receive routine information requiring tact or persuasive skills; Provide and receive complex or sensitive information; Provide advice, instruction or training to groups/ Provide and receive complex, sensitive information; barriers to understanding** Provides information on e.g. test results; receives sensitive patient/client-related information; delivers training, e.g. parentcraft classes, to groups of parents or carers/ Communicates with patients/clients and carers, using empathy and reassurance and where there are barriers to understanding, e.g. learning disabilities or language	3abc-4a	21-32
2. Knowledge, Training & Experience	**Range of work procedures and practices, majority non-routine; intermediate level theoretical knowledge** Diploma or equivalent appropriate qualification, e.g. foundation degree; or NVQ3 level qualification plus short courses or relevant experience to diploma level	4	88
3. Analytical & Judgemental Skills	**Judgements involving facts or situations, some requiring analysis/Range of facts or situations requiring analysis; comparison of a range of actions** Makes judgements which require assessment of facts, e.g. sleep problems, nutrition, emergency situations, wound care/ Deciding on implementation of care programmes where there is a number of options	2-3	15-27
4. Planning & Organisational Skills	**Plan and organise straightforward activities, some ongoing** Organises own workload, which includes e.g. home visits, social inclusion activities, planning parentcraft classes	2	15
5. Physical Skills	**Physical skills obtained through practice/ Developed physical skills; manipulation of objects, people; narrow margins for error; Highly developed physical skills**, **accuracy important**; **manipulation of fine tools, materials** Hand eye coordination required e.g. when using test equipment, manoeuvring wheelchairs, resuscitation, driving/ Safe restraint of patients/clients; venepuncture	2-3ab	15-27
6. Responsibility for Patient/Client	**Implement clinical care/ care packages;** Carries out care packages, including providing advice to patients/clients or carers	4a	22
7. Responsibility for Policy/Service Development	**Follow policies in own role, may be required to comment** May comment on proposed changes to policies	1	5
8. Responsibility for Financial & Physical Resources	**Personal duty of care in relation to equipment, resources/ Handle cash, valuables; Maintain stock control** Safe use of equipment/ Handles patient/client valuables; orders supplies, equipment, activity materials	1-2ac	5-12
9. Responsibility for Human Resources	**Demonstrate own activities to new or less experienced employees/ Day to day supervision; Day to day supervision; Undertake basic workplace assessments** Demonstrates tasks to less experienced or new staff/ Day-to-day supervision; clinical supervision of students; undertakes NVQ assessments	1-2abc	5-12
10. Responsibility for information Resources	**Record personally generated information** Maintains patient/client records	1	4

Combined nursing profiles

11. Responsibility for Research & Development	**Undertake surveys or audits, as necessary to own work** May participate in R&D and clinical trials or complete staff surveys	1	5
12. Freedom to Act	**Standard operating procedures**, s**omeone available for reference** Follows procedures and treatment plans, supervision/advice available	2	12
13. Physical Effort	**Frequent sitting or standing in a restricted position; Occasional / Frequent moderate effort for several short periods** Standing, sitting in a restricted position e.g. when undertaking sustained activities at an incubator; manoeuvring patients/clients, pushing wheelchairs, trolleys / Lifting equipment, babies, safe patient/client restraint	2ad-3c	7-12
14. Mental Effort	**Frequent concentration; work pattern predictable** Concentration on patient/client treatment, care plans, observations	2a	7
15. Emotional Effort	**Occasional distressing or emotional circumstances/ Frequent distressing or emotional circumstances; Occasional highly distressing or emotional circumstances/ Occasional traumatic circumstances** Care of patients/clients with chronic illnesses, conditions/ Terminally ill patients/clients or dealing with difficult family circumstances; occasional/ frequent exposure to safeguarding issues or severely challenging patient/client behaviour	2a-3ab-4b	11-18-25
16. Working Conditions	**Some exposure to hazards: Frequent highly unpleasant conditions** Physical aggression; contact with body fluids, foul linen	4ab	18
JE Score/Band	**Band 4 = 271-325**		255*-323

Profiles used:

Nursing Services:	Nurse Associate Practitioner Acute Nursery Nurses (Neonatal Unit)
Community Services:	Nursing Associate Practitioner (Community) Nursing Associate Practitioner (Mental Health) Nursery Nurse (Community)

Band 5
Nursing: Nurse

Nursing Services:	Nurse
	Nurse (Mental Health)
Community Services	Nurse (Community)
	Nurse (Schools)
	Nurse (GP Practice)
	Nurse (Learning Disabilities)

Combined nursing profiles

Profile Label: **Nursing: Nurse**

Job Statement:

1. Assesses patients/clients/children; plans, develops or implements programmes of care; provides advice; in a variety of settings; maintains associated records
2. Carries out nursing procedures
3. May provide clinical supervision to other staff, students
4. May provide health promotion information, advice

Factor	Relevant Job Information	JE Level	Score
1. Communication & Relationship Skills	**Provide and receive complex, sensitive information; barriers to understanding; persuasive, motivational, negotiating, training skills are required** Communicates sensitive, confidential information concerning patients/clients requiring empathy, persuasion and reassurance. Some may have special needs	4a	32
2. Knowledge, Training & Experience	**Expertise within specialism, underpinned by theory** Professional, clinical knowledge acquired through training to degree/diploma level	5	120
3. Analytical & Judgemental Skills	**Range of facts or situations requiring comparison of a range of options** Judgements on problems requiring investigation, analysis, e.g. assessment of condition	3	27
4. Planning & Organisational Skills	**Plan and organise straightforward activities, some ongoing** Plans provision of care for patients/clients/children, e.g. clinics, health education. May organise staff	2	15
5. Physical Skills	**Physical skills obtained through practice/ Developed physical skills; manipulation of objects, people; narrow margins for error; Highly developed physical skills, accuracy important; manipulation of fine tools, materials** Driving, carries out immunisations/ Restraint of patients/clients using approved techniques; Dexterity and accuracy required for, e.g. intravenous injections, syringe pumps and infusion, insertion of catheters and removal of sutures	2-3ab	15-27
6. Responsibility for Patient/Client	**Develop programmes of care/care packages; Provide specialised advice in relation to care** Assesses, plans, implements and evaluates clinical care of patients/clients; gives specialist advice to clients/carers	5ac	30
7. Responsibility for Policy/Service Development	**Follow policies in own role, may be required to comment** Follows policies, makes comments on proposals for change	1	5
8. Responsibility for Financial & Physical Resources	**Personal duty of care in relation to equipment, resources/ Handle cash, valuables; Maintain stock control; Authorised signatory, small payments** Responsible for equipment used/ Handles patient valuables; orders supplies; signs timesheets	1-2acd	5-12
9. Responsibility for Human Resources	**Demonstrate own activities to new or less experienced employees/ Day to day supervision; Professional /clinical supervision** Demonstrates duties to new starters/ Supervises work of others; clinical supervision of staff, students.	1-2ab	5-12
10. Responsibility for information Resources	**Record personally generated information** Maintains work-related records	1	4
11. Responsibility for Research & Development	**Undertake surveys or audits, as necessary to own work/ Regularly undertake R & D activity; clinical trials** Occasional participation in R&D activity/ Undertakes R&D activity; clinical trials	1-2ab	5-12

Combined nursing profiles

12. Freedom to Act	**Clearly defined occupational policies**, **work is managed, rather than supervised** Works within codes of practice and professional guidelines	3	21
13. Physical Effort	**Light physical effort for short periods/ Frequent light effort for several short periods/ Frequent moderate effort for several short periods/ Frequent moderate effort for several long periods** Walks, sits and stands/ Walks and stands most of shift; kneels and crouches to e.g. dress wounds/ Manoeuvres patients, lifts substantial equipment, bathes patients	1-2b-3c4b	3-7-12-18
14. Mental Effort	**Frequent concentration; work pattern predictable/Unpredictable** Concentrates in providing clinical care, e.g. immunisation, calculating drug dosages for infusion, carrying out tests/ Interruptions to deal with unpredictable patient/client behaviour	2a-3a	7-12
15. Emotional Effort	**Occasional distressing or emotional circumstances/ Frequent distressing or emotional circumstances; Occasional highly distressing or emotional circumstances/ Frequent highly distressing or emotional circumstances** Imparts unwelcome news, care of terminally ill/ safeguarding issues, e.g. child abuse. Some challenging behaviour	2a-3ab4b	11-18-25
16. Working Conditions	**Frequent unpleasant conditions; Occasional/ Frequent highly unpleasant conditions** Body odours, dust, noise/ Body fluid, verbal aggressions	3ab-4b	12-18
JE Score/Band	**Band 5 = 326-395**		312*-390

Profiles used:

Nursing Services:	Nurse
	Nurse (Mental Health)
Community Services:	Nurse (Community)
	Nurse (Schools)
	Nurse (GP Practice)
	Nurse (Learning Difficulties)

Combined nursing profiles

Band 6
Nurse Specialist

Nursing Services:	Nurse Specialist
Community Services:	Nurse Specialist (Community)
	Nurse Specialist (Learning Disabilities)
	Nurse Specialist (GP Practice)
	Nurse Specialist (Schools)
	Nurse Specialist (Special Schools)
	Nurse Specialist (Mental Health, Community)

Nurse Team Leader

Nursing Services:	Nurse Team Leader
Community Services:	Nurse Team Leader (Learning Disabilities)

It was not possible to combine the two Team Leader profiles within the rules of genericising, so they are included separately in this group..

Combined nursing profiles

Combined nursing profiles

Profile Label: **Nurse Specialist**

Job Statement:
1. Assesses patients; plans, implements and monitors care; provides advice. This may be carried out in a specialist area and/or using specialist nursing skills
2. Provides day-to-day supervision and/or clinical supervision to others

Factor	Relevant Job Information	JE Level	Score
1. Communication & Relationship Skills	**Provide and receive complex, sensitive information; barriers to understanding/ Provide and receive highly complex, sensitive or contentious information; barriers to understanding; Provide and receive complex, sensitive or contentious information; hostile, antagonistic or highly emotive atmosphere** Communicates sensitive/ highly sensitive, confidential information concerning patients/clients requiring empathy, persuasion and reassurance. Some may have special needs; patients/clients may be hostile, antagonistic	4a-5ac	32-45
2. Knowledge, Training & Experience	**Specialist knowledge across range of procedures underpinned by theory** Professional knowledge acquired through degree supplemented by diploma level specialist training, experience, short courses	6	156
3. Analytical & Judgemental Skills	**Complex facts or situations requiring analysis, interpretation, comparison of a range of options** Skills for assessing and interpreting complex needs of patients/clients	4	42
4. Planning & Organisational Skills	**Plan and organise straightforward activities, some ongoing** Plans provision of care for patients/clients, e.g. clinics, health education. May organise staff	2	15
5. Physical Skills	**Physical skills obtained through practice/ Developed physical skills; manipulation of objects, people; narrow margins for error; manipulation of fine tools, materials** Driving, carries out immunisations/ Restraint of patients/clients using approved techniques; Dexterity and accuracy required for, e.g. intravenous injections, syringe pumps and infusion, insertion of catheters and removal of sutures	2-3ab	15-27
6. Responsibility for Patient/Client	**Develop programmes of care/care packages; Provide specialised advice in relation to care/ Develop specialised programmes of care/ care packages; provide highly specialised advice** Assesses, plans, implements and evaluates clinical care of patients/clients; gives specialist advice to patients/clients/carers/ Develops and implements specialist programmes of care	5ac-6a	30-39
7. Responsibility for Policy/Service Development	**Follow policies in own role, may be required to comment/ Implement policies and propose changes to practices, procedures for own area** Follows policies, makes comments on proposals for change/Implements policies and proposes changes to working practices or procedures in own work area	1-2	5-12
8. Responsibility for Financial & Physical Resources	**Personal duty of care in relation to equipment, resources/ Handle cash, valuables; Maintain stock control; Authorised signatory, small payments** Responsible for equipment used/ Handles patient valuables; orders supplies; signs timesheets	1-2acd	5-12
9. Responsibility for Human Resources	**Day to day supervision; Professional /clinical supervision** Supervises work of others; clinical supervision of staff, students; provides training to others	2abc	12
10. Responsibility for information Resources	**Record personally generated information** Maintains work-related records	1	4
11. Responsibility for Research & Development	**Undertake surveys or audits, as necessary to own work** Occasional participation in R&D activity	1	5
12. Freedom to Act	**Clearly defined occupational policies, work is managed, rather than supervised/ Broad occupational policies** Works within codes of practice and professional guidelines/ lead specialist, area or team; may manage a caseload in the community	3-4	21-32

Combined nursing profiles

13. Physical Effort	**Light physical effort for short periods/ Frequent light effort for several short periods/ Frequent moderate effort for several short periods** Walks, sits and stands/ Walks and stands most of shift; kneels and crouches to e.g. dress wounds/ Manoeuvres patients, lifts substantial equipment	1-2b-3c	3-7-12
14. Mental Effort	**Frequent concentration; work pattern predictable/ Unpredictable** Concentrations in providing clinical care, e.g. immunisation, calculating drug doses for infusion, carrying out tests/ Interruptions to deal with unpredictable client behaviour	2a-3a	7-12
15. Emotional Effort	**Occasional distressing or emotional circumstances/ Frequent distressing or emotional circumstances; Occasional highly distressing or emotional circumstances** Imparts unwelcome news, care of terminally ill/ safeguarding issues, e.g. child abuse. Some challenging behaviour	2a-3ab	11-18
16. Working Conditions	**Frequent unpleasant conditions; Occasional/ Frequent highly unpleasant conditions** Body odours, dust, noise/ Body fluid, verbal aggression	3ab-4b	12-18
	Band 6 = 396-465		375*-461

Profiles used:

Nursing Services:	Nurse Specialist
Community Services:	Nurse Specialist (Community)
	Nurse Specialist (Learning Disabilities)
	Nurse Specialist (GP Practice)
	Nurse Specialist (Schools)
	Nurse Specialist (Special Schools)
	Nurse Specialist (Mental Health, Community)

Combined nursing profiles

Profile Label: **Nurse Team Leader**

Job Statement:

1. Assesses patients, plans, implements care, provides advice; maintains associated records
2. Carries out nursing procedures
3. Provides clinical and managerial leadership to nursing and support staff, may ensure effective running of ward, unit in the absence of Nurse Team Manager

Factor	Relevant Job Information	JE level	JE Score
1. Communication & Relationship Skills	**Provide and receive complex, sensitive information; barriers to understanding** Communicates sensitive information concerning patient's medical condition, requires persuasive, reassurance skills; some patients have special needs, learning disabilities	4(a)	32
2. Knowledge, Training & Experience	**Specialist knowledge across a range of work procedures, underpinned by theory** Professional knowledge acquired through degree/diploma supplemented by specialist clinical, managerial training, CPD to PGD level	6	156
3. Analytical & Judgemental Skills	**Complex facts or situations, requiring analysis, interpretation, comparison of a range of options** Skills for assessing and interpreting acute and other patient conditions, appropriate action	4	42
4. Planning & Organisational Skills	**Plan and organise straightforward activities, some on-going/plan, organise complex activities or programmes, requiring formulation, adjustment.** Organises own time and that of junior staff and learners, plans staff off duty rota/undertakes discharge planning involving co-ordinating other agencies	2–3	15-27
5. Physical Skills	**Highly developed physical skills, accuracy important; manipulation of fine tools, materials** Dexterity and accuracy required for e.g. intravenous injections, syringe pumps and infusions, insertion of catheters, removal of sutures	3(b)	27
6. Responsibility for Patient/Client Care	**Develop programmes of care/care packages** Assesses, plans, implements and evaluates clinical care of patients	5(a)	30
7. Responsibility for Policy/Service Development	**Implement policies and propose changes to practices, procedures for own area** Contributes to policy and practice changes arising from e.g. audits, complaints	2	12
8. Responsibility for Financial & Physical Resources	**Handle cash, valuables; maintain stock control; authorised signatory, small payments/authorised signatory** Handles patient valuables; orders supplies when necessary; signs agency time sheets/authorises overtime for nursing and support staff.	2(a)(c)(d) – 3(a)	12-21
9. Responsibility for Human Resources	**Day to day supervision; management** Leads team and allocates work/recruits, manages and develops staff	2(a)–3(a)	12-21
10. Responsibility for Information Resources	**Record personally generated information** Maintains patient records	1	4
11. Responsibility for Research & Development	**Undertake surveys or audits, as necessary to own work/regularly undertake R&D activity; clinical trials; equipment testing, adaptation** May undertake/undertakes R&D activity; clinical trials, equipment testing	1–2(a) (b) (c)	5-12
12. Freedom to Act	**Clearly defined occupational procedures, work is managed rather than supervised** Works within codes of practice and professional guidelines	3	21
13. Physical Effort	**Occasional/frequent moderate effort for several short periods** Moves, manoeuvres patients from bed to chair, wheels patients	2(d) – 3(c)	7-12
14. Mental Effort	**Frequent concentration, work pattern predictable/unpredictable** Concentration for checking documents, calculating drug dosages/responds to frequently changing patient, staff needs	2(a)–3(a)	7-12
15. Emotional Effort	**Occasional/frequent distressing; occasional highly distressing or emotional circumstances** Deals with distressed relatives, care of terminally ill/ consequences of terminal illness, victims of abuse, relatives of deceased patients	2(a) – 3(a)(b)	11-18

Combined nursing profiles

16. Working Conditions	**Frequent unpleasant; occasional/frequent highly unpleasant conditions** Smell, noise, dust/body fluids, faeces, vomit, emptying bed pans and urinals, catheter bags	3(a), (b) 4(b)	12-18
JE Score/Band	**JE Score 393*–465**	**Band 6**	

Combined nursing profiles

Profile label: **Nurse Team Leader (Learning Disabilities)**

Job statement:

1. Assesses care needs, implements and monitors care plans, administers medication, provides advice in specialist area for patients/clients with Learning Disabilities
2. Forms a supportive relationship with Learning Disability clients to facilitate care
3. Initiates and promotes practice development
4. Supervises and allocates staff, co-ordination of staff duty rotas, clinical leadership; may manage staff in absence of team manager

Factor	Relevant Job Information	JE Level	JE Score
1. Communication & Relationship Skills	**Provide and receive complex, sensitive information; barriers to understanding/hostile, antagonistic or emotive atmosphere** Communicates with clients and relatives to explain clinical issues and daily living procedures/use of special communication techniques eg uses de-escalation techniques when dealing with clients with learning disabilities.	4a–5c	32-45
2. Knowledge, Training & Experience	**Specialist knowledge across range of procedures underpinned by theory** Professional knowledge to degree level or equivalent, plus diploma level training or equivalent in specialist area and experience.	6	156
3. Analytical & Judgmental Skills	**Complex facts or situations requiring analysis, interpretation, comparison of a range of options** Assessment of client need and condition, determines appropriate response when dealing with clients with learning disabilities.	4	42
4. Planning & Organisational Skills	**Plan and organise straightforward activities, some ongoing** Plans daily clinical provision and training for clients on daily living skills, staff education and rostering.	2	15
5. Physical Skills	**Developed physical skills, manipulation of objects, people, narrow margins for error; highly developed physical skills, accuracy important; manipulation of fine tools, materials** Formal restraint training; insertion of catheters, special feeding techniques.	3(a)(b)	27
6. Responsibility for Patient/Client Care	**Develop programmes of care/care packages; provide specialised advice in relation to client care** Assesses patient needs and implements programmes of care; provides advice to clients, carers.	5(a)	30
7. Responsibility for Policy/Service Development	**Implement policies and propose changes to practices, procedures for own area** Implements, comments and proposes changes for policies for own work area.	2	12
8. Responsibility for Financial & Physical Resources	**Personal duty of care in relation to equipment, resources/handle cash, valuables; maintain stock control** Personal duty of care/safekeeping of clients' cash and valuables; ordering and the safe storage of medications.	1-2(a)(c)	5-12
9. Responsibility for Human Resources	**Day to day co-ordination of staff; professional/clinical supervision; provide training in own discipline/day to day management** Day to day supervision, clinical supervision and practical training/day to day management.	2abc–3(a)	12-21
10. Responsibility for Information Resources	**Record personally generated information** Records personally generated observations and updates client records.	1	4
11. Responsibility for Research & Development	**Undertake surveys or audits, as necessary to own work/regularly undertakes R&D; clinical trials** Undertakes surveys or audits as necessary/undertakes research, clinical trials, lead clinical audit in own area.	1–2(a)(b)	5-12
12. Freedom to Act	**Clearly defined occupational policies, work is managed, rather than supervised/broad occupational policy** Work is managed, manager is available for guidance if required/leads team.	3-4	21-32
13. Physical Effort	**Frequent sitting or standing in a restricted position/frequent moderate effort for several short periods** Walks, stands for most of shift/moving patients for treatment or personal care, use of hoists.	2(a)–3(c)	7-12
14. Mental Effort	**Frequent concentration; work pattern predictable/frequent concentration; work pattern unpredictable** Concentration for patient assessment and observation, ward rounds, team discussions; interruptions to attend client needs; deals with staff issues.	2 (a)/3(a)	7-12
15. Emotional Effort	**Occasional/frequent distressing or emotional circumstances** Deals with client anxieties, challenging behaviours from distressed clients.	2(a)–3(a)	11-18
16. Working Conditions	**Frequent unpleasant, occasional highly unpleasant conditions** Verbal aggression/ body fluids.	3(a)(b)	12
JE Score/Band	**JE Score 398–462**	**Band 6**	

Combined nursing profiles

Band 7
Nurse Advanced

Nursing Services:	Nurse Advanced
Community Services:	Nurse Advanced (Schools)

Nurse Team Manager

Nursing Services:	Nurse Team Manager
Community Services:	Nurse Team Manager (MH, Comm)
	Nurse Team Manager (Schools)
	Nurse Team Manager (Community)
	Nurse Team Manager (Learning Disabilities)

Combined nursing profiles

Profile Label: **Nurse Advanced**

Job Statement:

1. Assesses patients/clients, plans, implements care in a variety of settings, provides highly specialist advice; maintains associated records
2. Lead specialist in a defined area of nursing care
3. Provides specialist education and training to other staff, students and/or patients/clients
4. Undertakes research and leads clinical audits in own specialist area

Factor	Relevant Job Information	JE Level	Score
1. Communication & Relationship Skills	**Provide and receive complex, sensitive information; barriers to understanding/ Provide and receive highly complex, sensitive or contentious information; barriers to understanding; Present complex, sensitive or contentious information to large groups** Communications condition related information to patients/clients and carers/Communicates very sensitive, complex condition related information to patients, relatives, empathy and reassurance; presentations to groups on sensitive issues	4a-5ab	32-45
2. Knowledge, Training & Experience	**Highly developed specialist knowledge, underpinned by theory and experience** Professional knowledge acquired through degree supplemented by post graduate diploma specialist training, experience, short courses plus further specialist training to masters equivalent level	7	196
3. Analytical & Judgemental Skills	**Complex facts or situations requiring analysis, interpretation, comparison of a range of options** Skills for assessing and interpreting specialist patient/client conditions, appropriate action; skills for development of specialised programmes	4	42
4. Planning & Organisational Skills	**Plan and organise complex activities or programmes, requiring formulation, adjustment** Plans specialised nursing service provision and/or specialised health and education programmes; coordinates multi-disciplinary groups in specialist are	3	27
5. Physical Skills	**Physical skills obtained through practice/ Highly developed physical skills, accuracy important, manipulation of fine tools, materials** Dexterity coordination for driving, immunisation/ Dexterity and accuracy required for e.g. intravenous injections, syringe pumps and infusions, insertion of catheters, removal of sutures	2-3b	15-27
6. Responsibility for Patient/Client	**Develop specialised programmes of care/ care packages; Provide highly specialised advice concerning care** Assesses, develops and implements specialist nursing care programmes and/or specialised health and education programmes; highly specialist advice to patients/clients, carers, relatives and other professionals	6ac	39
7. Responsibility for Policy/Service Development	**Propose policy or service changes**, **impact beyond own area** Develops protocols for specialist area, impact on other disciplines	3	21
8. Responsibility for Financial & Physical Resources	**Personal duty of care in relation to equipment, resources/ Maintain stock control**; **Authorised signatory, small payments** Personal duty of care/ Orders specialist supplies; authorises overtime, agency nurse payments	1-2cd	5-12
9. Responsibility for Human Resources	**Professional /clinical supervision; Provide training in own discipline/ Teach/deliver specialist training** Supervises other nurses, students; provides training/ Specialist training	2bc-3c	12-21
10. Responsibility for information Resources	**Record personally generated information** Maintains work-related records	1	4
11. Responsibility for Research &	**Regularly undertake R & D activity; clinical trials; equipment testing, adaptation/ R&D activities as major job requirement**	2ab-3	12-21

Combined nursing profiles

Development	Undertakes research, leads clinical audit in own area		
12. Freedom to Act	**Broad occupational policies** Accountable for own professional actions, lead specialist for defined area	4	32
13. Physical Effort	**Combination of sitting, standing, walking/ Occasional moderate effort for several short periods** Some lifting, e.g. training equipment/ Moves. Manoeuvres patients	1-2d	3-7
14. Mental Effort	**Frequent concentration; work pattern predictable** Concentration on patient assessments, injections, schedule of visits, reports, meetings, data analysis	2a	7
15. Emotional Effort	**Occasional distressing or emotional circumstances/ Frequent distressing or emotional circumstances; Occasional highly distressing or emotional circumstances** Challenging behaviour from patients/clients/ Imparts news of terminal illness, bereavement	2a-3ab	11-18
16. Working Conditions	**Frequent unpleasant conditions/Occasional/ Frequent highly unpleasant conditions** Body odours, dust, noise/ Body fluid, verbal aggression	3ab-4b	12-18
JE Score/Band	**Band 7 = 466-539**		465*-537

Profiles used:

Nursing Services: Nurse Advanced
Community Services: Nurse Advanced (Schools)

Combined nursing profiles

Profile Label: **Nurse Team Manager**

Job Statement:

1. Provides leadership and management for nursing specialist and associated staff
2. Assesses patients/clients, plans, implements care, provides specialist advice; maintains associated records
3. May liaise with other agencies in planning programmes of care and/or health and education programmes
4. May hold budget

Factor	Relevant Job Information	JE Level	Score
1. Communication & Relationship Skills	**Provide and receive complex, sensitive information; barriers to understanding/ Provide and receive highly complex, sensitive or contentious information; barriers to understanding; hostile, antagonistic or highly emotive atmosphere** Communicates sensitive/highly sensitive, confidential information concerning patients/clients requiring empathy, persuasion and reassurance. Some may have special needs; patients/clients may be hostile, antagonistic	4a-5ac	32-45
2. Knowledge, Training & Experience	**Specialist knowledge across range of procedures underpinned by theory** Professional knowledge acquired through degree supplemented by diploma level specialist training, experience, short courses	6	156
3. Analytical & Judgemental Skills	**Complex facts or situations requiring analysis, interpretation, comparison of a range of options** Skills for assessing and interpreting complex needs of patients/clients and staffing issues	4	42
4. Planning & Organisational Skills	**Plan and organise complex activities or programmes, requiring formulation, adjustment** Plans delivery of specialist nursing care, allocation and deployment of staff, coordinates multi agency activities	3	27
5. Physical Skills	**Developed physical skills; manipulation of objects, people; narrow margins for error; manipulation of fine tools, materials** Restraint of patients/clients using approved techniques; Dexterity and accuracy required for, e.g. intravenous injections, syringe pumps and infusion, insertion of catheters and removal of sutures	3ab	27
6. Responsibility for Patient/Client	**Provide specialised advice in relation to care/ Develop specialised programmes of care/ care packages; Provide highly specialised advice concerning care; accountable for direct delivery of sub-division of a clinical, clinical technical or social care service(s)** Assesses, develops and implements nursing care programmes/ Specialist nursing care programmes; provides highly specialist advice; responsibility for delivery of a service for a geographical area	5a-6acd	30-39
7. Responsibility for Policy/Service Development	**Implement policies and propose changes to practices, procedures for own area/ Propose policy or service changes, impact beyond own area** Contributes to policy and practice changes arising from e.g. audits, complaints/ Contributes to policies which impact on other areas	2-3	12-21
8. Responsibility for Financial & Physical Resources	**Authorised signatory; Hold delegated budget/Budget holder for department/service** Authorises overtime for nursing and support staff, responsible for supplies; holds delegated budget/ Holds budget	3ad-4a	21-32
9. Responsibility for Human Resources	**Day to day management; Allocate, place and supervise staff or students/ Line manager for single function or department** Manages staff; organises student placements or allocates placement and supervision of staff, students/ Line management	3ab-4a	21-32
10. Responsibility for information Resources	**Record personally generated information** Maintains work-related records	1	4
11. Responsibility for Research & Development	**Undertake surveys or audits, as necessary to own work/ Regularly undertake R & D activity; clinical trials; equipment testing** May undertake/ Undertakes R&D activity; clinical trials; equipment testing	1-2abc	5-12

Combined nursing profiles

12. Freedom to Act	**Broad occupational policies** Accountable for own professional actions, manages team and interprets policy	4	32
13. Physical Effort	**Combination of sitting, standing, walking/ Frequent light effort for several short periods; occasional moderate effort for several short periods/ Frequent moderate effort for several short periods** Walks, sits and stands/Walks and stands most of shift; kneels and crouches to e.g. dress wounds/Manoeuvres patients, lifts substantial equipment	1-2bd-3c	3-7
14. Mental Effort	**Frequent concentration; work pattern predictable/ Unpredictable** Concentration in providing clinical care, e.g. immunisation, calculating drug doses for infusion, carrying out tests/ Interruptions to deal with unpredictable client behaviour, staffing issues	2a-3a	7-12
15. Emotional Effort	**Occasional distressing or emotional circumstances/ Occasional/frequent highly distressing or emotional circumstances/** Imparts unwelcome news, care of terminally ill/ Safeguarding issues, e.g. child abuse. Some challenging behaviour	2a-3a-4b	11-18-25
16. Working Conditions	**Occasional/Frequent unpleasant conditions/Occasional/ Frequent highly unpleasant conditions** Body odours, dust, noise/ Body fluid, verbal aggression	2a-3ab-4b	7-12-18
JE Score/Band	**Band 7 = 466-539**		**437*-536**

Profiles used:

Nursing Services: Nurse Team Manager
Community Services: Nurse Team Manager (MH, Comm)
Nurse Team Manager (Schools)
Nurse Team Manager (Community)
Nurse Team Manager (Learning Disabilities)

Band 8
Modern Matron

Nursing Services: Modern Matron
Community Services: Modern Matron (Community)

Band 8-9
Nurse Consultant

It was not possible to combine the Nurse Consultant and Nurse/Midwife Consultant Higher Level profiles, so these are included separately in this group.

Combined nursing profiles

Profile Label: **Modern Matron**

Job Statement:

1. Manages and provides leadership for managers and specialist nurses/midwives and other staff
2. Ensures patient/client/carer involvement in development of services, e.g. promoting better health, standards of cleanliness, social care and medicines management
3. Provides specialist education and training to other staff
4. Maintains compliance with, and develops, policies, procedures and guidelines

Factor	Relevant Job Information	JE Level	Score
1. Communication & Relationship Skills	**Provide and receive highly complex, sensitive or contentious information; barriers to understanding; Present complex, sensitive or contentious information to large groups** Communicates service-related information to senior managers, staff, patients/clients, carers, external agencies: requires negotiating, persuasive, motivational, reassurance skills; gives formal presentations	5ab	45
2. Knowledge, Training & Experience	**Highly developed specialist knowledge, underpinned by theory and experience** Professional knowledge acquired through degree supplemented by post graduate diploma specialist training, experience, short courses plus further specialist training to masters equivalent level	7	196
3. Analytical & Judgemental Skills	**Complex facts or situations requiring analysis, interpretation, comparison of a range of options** Skills for analysis of service, patient/client, organisation, staffing issues and case management	4	42
4. Planning & Organisational Skills	**Plan and organise broad range of complex activities; formulates, adjusts plans or strategies** Planning of strategies which impact across the service and sector, e.g. care coordination, infection control	4	42
5. Physical Skills	**Physical skills obtained through practice/ Developed physical skills; manipulation of objects, people; narrow margins for error; manipulation of fine tools, materials** Driving, carries out immunisations/ Restraint of patients/clients using approved techniques; dexterity and accuracy required for, e.g. intravenous injections, syring pumps and infusion, insertion of catheters and removal of sutures	2-3ab	15-27
6. Responsibility for Patient/Client	**Provide highly specialised advice concerning care; Accountable for direct delivery of sub-division of a clinical, clinical technical or social care service** Delivers highly specialised case management advice to the multi disciplinary team across sectors; accountable for service delivery	6cd	39
7. Responsibility for Policy/Service Development	**Responsible for policy implementation and development for a service** Develops and implements integrated care policies across primary and acute settings	4	32
8. Responsibility for Financial & Physical Resources	**Authorised signatory; Purchase of some assets; monitoring budgets** Signs off expenses; orders supplies; oversees management of budget	3abc	21
9. Responsibility for Human Resources	**Line manager for single function or department; Teach, devise training and development programmes, major job responsibility** Manages own staff, including recruitment, development, performance; devises training packages and teaches other groups of staff	4ab	32
10. Responsibility for information Resources	**Record personally generated information** Maintains work-related records	1	4
11. Responsibility for Research & Development	**Undertake surveys or audits, as necessary to own work** Undertakes audits of complaints, clinical incidents; trails of equipment	1	5
12. Freedom to Act	**General policies, need to establish interpretation** Responsible for establishing how policies should be interpreted	5	45

Combined nursing profiles

13. Physical Effort	**Combination of sitting, standing, walking/ Frequent light effort for several short periods; occasional moderate effort for several short periods** Light physical effort/ Effort required for carrying out clinical duties	1-2bd	3
14. Mental Effort	**Frequent concentration; work pattern unpredictable** Concentration for writing reports, meetings, patient/client assessment, interruptions to deal with service issues	3a	12
15. Emotional Effort	**Occasional distressing or emotional circumstances/ Frequent distressing or emotional circumstances; Occasional highly distressing or emotional circumstances** Deals with staff problems, patient complaints, conveys unwelcome news/ Care of the terminally ill; unexpected deaths	2a-3ab	11-18
16. Working Conditions	**Occasional/ Frequent unpleasant conditions; Occasional highly unpleasant conditions** Body odours, dust, noise/ Body fluid, verbal aggression	2-3ab	7-12
JE Score/Band	**Band 8a = 540-584**		**551-579**

Profiles used:

Nursing Services: Modern Matron
Community Services: Modern Matron (Community)

Combined nursing profiles

Profile Label: **Nurse Consultant**

Job Statement:

1. Provides expert professional advice to patients, carers and colleagues
2. Undertakes research in a specialist area
3. Provides education and training to other staff, students
4. Ensures the maintenance of clinical excellence

Factor	Relevant Job Information	JE level	JE Score
1. Communication & Relationship Skills	**Provide and receive highly complex, sensitive or contentious information, barriers to understanding/present complex information to large groups** Communicates very sensitive, complex condition related information to patients, relatives, empathy, reassurance required; presents specialist information to large groups of staff	5(a)/5(b)	45
2. Knowledge, Training & Experience	**Highly developed specialist knowledge, underpinned by theory and experience** Professional knowledge acquired through degree/diploma supplemented by specialist training, experience, short courses, to master's level equivalent	7	196
3. Analytical & Judgemental Skills	**Complex/highly complex facts or situations, requiring analysis, interpretation, comparison of a range of options** Makes operational judgements, manages conflicting views/ reconciles inter and intra professional differences of opinion	4/5	42-60
4. Planning & Organisational Skills	**Plan and organise complex activities, programmes, requiring formulation, adjustment** Plans specialist nursing service provision, including education and training	3	27
5. Physical Skills	**Highly developed physical skills, accuracy important, manipulation of fine tools, materials/highly developed skills, high degree of precision** Dexterity and accuracy required for e.g. intravenous injections, syringe pumps and infusions, insertion of catheters, remove of sutures/undertakes suturing, endoscopies	3(b)–4	27-42
6. Responsibility for Patient/Client Care	**Develop highly specialised programmes of care; care packages; provide highly specialised advice concerning care** Develops and implements specialist care packages; provide clinical advice in specialist area	6(a) (c)	39
7. Responsibility for Policy/Service Development	**Propose policy or service changes, impact beyond own area/responsible for policy implementation, development for a service** Develops protocols for specialist area, impact on other disciplines/develops policies for specialist service	3–4	21-32
8. Responsibility for Financial & Physical Resources	**Personal duty of care in relation to equipment, resources/safe use of equipment other than equipment used personally; authorised signatory, small payments/authorised signatory; holds delegated budget** Personal duty of care/responsible for ensuring the safe use of specialist equipment; authorised signatory for overtime payments/delegated budget holder for specialist budget	1/2(b)(d) / 3(a)(d)	5-12-21
9. Responsibility for Human Resources	**Teach, deliver core training, range of subjects/teach, devise training and development programmes, major job responsibility** Provides specialist training and education /develops education programmes	3(c)–4(b)	21-32
10. Responsibility for Information Resources	**Records personally generated information** Maintains patient/client records, records research results	1	4
11. Responsibility for Research & Development	**R&D activities as major job requirement/co-ordinate, implement R&D activity as job requirement/initiate, develop R&D activities** Conducts research in specialist area/member of audit, research steering group developing trust wide research	3/4/5	21-32-45
12. Freedom to Act	**General policies, need to establish interpretation** Responsible for establishing how policies should be interpreted	5	45
13. Physical Effort	**Occasional moderate effort for several short periods** Moves, manoeuvres patients	2(d)	7
14. Mental Effort	**Frequent concentration, work pattern unpredictable** Concentration for patient care; interruptions for patient, staff needs	3(a)	12

Combined nursing profiles

15. Emotional Effort	**Frequent distressing or emotional circumstances; occasional/frequent highly distressing or emotional circumstances** Works with terminally ill patients/imparts unwelcome news to staff, patients	3(a)(b)/4	18-25
16. Working Conditions	**Occasional /frequent exposure to highly unpleasant conditions** Body fluids, faeces, vomit, smells and foul linen	3(b)–4(b)	12-18
JE Score/Band	**JE Score 542–650**	**Band 8A/8B/8C**	

Combined nursing profiles

Profile Label: **Nurse/Midwife Consultant Higher Level**

Job Statement:

1. Provides expert professional advice to patients/clients, carers and staff
2. Responsible for service development/redesign in own area of expertise
3. Undertakes clinical audit, research in a specialist field
4. Provides education and training to other staff, students: may develop or contribute to development of specialist training, education programmes in own field
5. Ensures the maintenance of clinical excellence

Factor	Relevant Job Information	JE level	JE Score
1. Communication & Relationship Skills	**Provide and receive highly complex, sensitive or contentious information; barriers to understanding/present complex information to large groups** Communicates very sensitive, complex condition related information to patients, relatives, empathy, reassurance required; highly complex service information at board level; presents specialist information to large groups of staff	5 (a)/ 5 (b)	45
2. Knowledge, Training & Experience	**Advanced theoretical and practical knowledge** Professional knowledge acquired through degree/diploma supplemented by specialist training, experience, short courses, to doctorate level or equivalent	8	240
3. Analytical & Judgemental Skills	**Highly complex facts or situations, requiring analysis, interpretation, comparison of a range of options**. Reconciles inter and intra professional differences of opinion, judgements on complex clinical issues	5	60
4. Planning & Organisational Skills	**Plan and organise broad range of complex activities, requiring formulation, adjustment of plans, strategies/ formulate long-term strategic plans, involving uncertainly, impact across the whole organisation** Responsible for service development, education, training in specialist field/ strategic planning for specialist service for region, impacting on external agencies	4-5	42-60
5. Physical Skills	**Highly developed physical skills, accuracy important, manipulation of fine tools, materials/ highly developed skills, high degree of precision** Dexterity and accuracy required for e.g. intravenous injections, syringe pumps and infusions, insertion of catheters, removal of sutures/ undertakes suturing, endoscopies	3 (b) - 4	27-42
6. Responsibility for Patient/Client Care	**Develop highly specialised programmes of care, care packages; provide highly specialised advice concerning care; accountable for direct delivery of sub-division of clinical care** Develops & implements of specialist care packages; provide clinical advice in specialist area; accountable for specialist area of nursing/midwifery	6 (a) (c) (d)	39
7. Responsibility for Policy/Service Development	**Responsible for policy implementation, development for a service** Develops and implements policies for specialist service	4	32
8. Responsibility for Financial & Physical Resources	**Safe use of equipment other than equipment used personally; authorised signatory, small payments/ authorised signatory; holds delegated budget** Responsible for ensuring the safe use of specialist equipment and advising budget holders on best value purchasing; authorised signatory / delegated budget holder for e.g. training	2(b)(d) / 3 (a) (d)	12-21
9. Responsibility for Human Resources	**Teach, deliver core training, range of subjects/ teach, devise training and development programmes, major job responsibility** Provides specialist training & education/ develops education programmes	3 (c) – 4 (b)	21-32
10. Responsibility for Information Resources	**Record personally generated information** Maintains patient/client records, records research results	1	4
11. Responsibility for Research & Development	**R&D activities as major job requirement/ co-ordinate, implement R & D activity as job requirement/ initiate, develop R & D activities** Conducts research in specialist area/member of audit, research steering group developing trust wide research	3/4/5	21-32-45
12. Freedom to Act	**General policies, need to establish interpretation** Responsible for establishing how policies should be interpreted for specialist area	5	45
13. Physical Effort	**Occasional moderate effort for several short periods** Moves, manoeuvres patients	2 (d)	7

14. Mental Effort	**Frequent concentration, work pattern unpredictable** Concentration for patient/client care; interruptions for urgent patient/client, staff needs	3 (a)	12
15. Emotional Effort	**Frequent distressing or emotional circumstances; occasional/ frequent highly distressing or emotional circumstances** Works with critically and/or terminally ill patients/clients/ imparts unwelcome news to staff, patients/clients	3 (a) (b) / 4	18-25
16. Working Conditions	**Occasional/frequent exposure to highly unpleasant conditions** Body fluids, faeces, vomit, smells and foul linen	3 (b)-4(b)	12-18
JE Score/Band		**Band 8c–9**	**637–727**

Gateshead Health NHS Foundation Trust

Agenda Item: 13i

Report Title:	Organisational Risk Register (ORR)			
Name of Meeting:	Board of Directors			
Date of Meeting:	27th September 2023			
Author:	Marie Malone, Corporate and Clinical Risk Lead.			
Executive Sponsor:	Gill Findley, Chief Nurse and Professional Lead for Midwifery and Allied Health Professionals/Deputy CEO			
Report presented by:	Gill Findley, Chief Nurse and Professional Lead for Midwifery and Allied Health Professionals/Deputy CEO			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☒	**Assurance:** ☒	**Information:** ☐
	To ensure the Board and Committees are clearly sighted on those risks that have an organisational -wide impact, the organisational risk register is compiled by the Executive Risk Management Group (ERMG) of those risks that impact on the delivery of strategic aims and objectives. This includes risks included within the Board Assurance Framework (BAF) as well as risks identified by the Group for inclusion as having an organisational impact and impact on delivery of strategic aims and objectives. The supporting report shows the risk profile of the ORR, includes a full register, and provides details of review compliance, and risk movements.			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☒ *No gaps in assurance*	**Partially assured** ☐ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	The attached report is now received in the Executive Team Meeting each week, and at the Executive Risk Management Group meeting every month.			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety*	Risks on the ORR were comprehensively discussed at previous 2 ERMG meetings in August and September, and the following changes agreed. -Financial risks increased to 16 and align with sub risks on the ORR:			

<table>
<tr><td>

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

</td><td>

- **3127 (Finance)** Risk that the trust will not be able to meet the planned trajectory of £12.588m adjusted deficit (16)

- **3128 (Finance)** Risk that the capital cost of delivery of the new operating model continues to increase resulting in revenue implications (16)

There were 0 risks added, 4 risks removed, 2 risks increased, and 1 risk reduced in score.

4 risks removed:
-2759 (POD) *Workforce Health & Wellbeing* (8)- reduced from 12.

-2868 (COO) *Risk to the delivery of the New Operating Model.* (12)

-3212 (POD) *Historical DBS clearances have not been fully recorded on ESR*. (12)

-2779 (NMQ) *Risk that The Trust fails to meet the CQC Fundamental Standards (closed-TRR 6)*

risk reduced:
-2993 (CEO) *Risk of non-compliance with current legislation as a result of policies not being up to date* (16<12)

All risks have associated actions assigned.
5 actions have been completed in period.

Compliance with risks reviews 75%
Compliance with actions reviews 83%

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

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The Board are asked to:

- Review the risks and actions and discuss and seek further information relating to risks as appropriate.
- Take assurance over the ongoing management of risk.
- Be clearly sited on the top 3 risks for the organisation.

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Trust Strategic Aims that the report relates to:

</td><td>

Aim 1 ☒

</td><td>We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>

Aim 2 ☒

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

Organisational Risk Register

Executive Summary

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

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

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

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

Organisational Risk Register – Movements

Following ERMG meetings in August and September 2023, there have been 0 additions to the ORR, although 2 risk has been increased, 4 reduced, 3 removed and 1 closed.

There are currently 16 risks on the ORR, one with a high score of 20, and seven with a score of 16 agreed by the group as per enclosed report.

2 Risks have escalated in score:

- **3127 (Finance)** *There is a considerable risk that the trust will not be able to meet the planned trajectory of £12.588m adjusted deficit* (16)

- **3128 (Finance)** *Risk that the capital cost of delivery of the new operating model continues to increase resulting in revenue implications* (16)

-Both financial risks increased to 16 to align with other financial risks on the ORR.

Risks removed:

- **2868 (COO)** *Risk to the delivery of the new operating model due to the increase in activity and reduced workforce capacity, resulting in an adverse impact on key performance and recovery plans*. (12)

-EMT oversight in place as we move away from the NOM.

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

-Risk Assessment SOP now implemented for the DBS Project as well as clear HR processes agreed via EMT.

- **3148 (COO)** *Risk that the organisation is unable to release staff for mandatory training and medical devices training due to operational pressures and current vacancies in both medical and nurse staffing. This could result in possible patient safety incidents.* (12)

-Significant improvement in compliance demonstrated, and further plans underway with chief matrons to improve further.

Risks Reduced:

- **2993 (CEO)** *Risk of non-compliance with current legislation as a result of policies not being up to date* (12)

-Reduced from 16 to 12 based on current mitigations. Policies continue to be scheduled for PRG and the number of overdue policies has significantly reduced.

- **2759 (POD)** *Workforce Health & Wellbeing - Risk of adverse impact to staff health and wellbeing due to internal working conditions and pressures resulting in increasing physiological and psychological harm* (8)

-Risk reduced from 12 to 8 with Mitigation including implementation of the occupational health improvement plan and review of health and wellbeing strategy.

Risks closed in period:

- **2779 (NMQ)** *Risk that The Trust fails to meet the CQC Fundamental Standards (TRR 6)*

-CQC standards are monitored in quality improvement plan via the quality indicators.

Top 3 category of risks within the ORR agreed at ERMG in September are:

Finance - 4 significant financial risks on the ORR.
Performance – Risk of delivery of performance targets (collective activity)
Workforce – Ongoing long-term impact and time frames are unknown, however several potential risks around patient harm, long waits and staff wellbeing are significant.

1. **Finance:**

- **3127 (Finance)** *There is a considerable risk that the trust will not be able to meet the planned trajectory of £12.588m adjusted deficit*. (16)

-Overarching financial risk, and with 4 financial risks on the ORR, there is significant emphasis on financial implications as an organisation.

2. **Performance:**

- **2945 (CEO)** *Risk of ineffective and inefficient management of services due to availability and access to appropriate and timely business intelligence to deliver and improve service.* (12)

-There has been a significant increase in waiting times and access to various patient services across the organisation which could result in patient harm and reduced quality.

3. **Workforce:**

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

-This risk has potential for significant impact:

- Risk of harm to patients as well as increasing waiting lists/times
- Secondary Financial impact of reduced activity
- Risk of longer -term harm on staff HWB

Current compliance

Risk and action review compliance is currently at 75% and 83% consecutively. This is an improvement on last reporting period.
All risks have associated actions assigned.
Support with reviews continues to be offered by Corporate and Clinical Risk Lead where able.

Recommendations

The Board are asked to:

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

Organisational Risk Register Report

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

Gateshead Health NHS Foundation Trust

Risk Profile (Current/Managed)

Resources - 1

POD 2764 - Risk of not having clearly agreed workforce plans for the next 3, 5 and 10 years. (16)

Business Continuity - 2

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

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

Digital - 1

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

Finance - 4

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

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

FIN 3127 - There is a considerable risk that the Trust is unable to meet the financial projections included in its plan. (16)

FIN 3128 - Risk that the capital cost of delivery of the new operating model continues to increase resulting in revenue implications. (16)

Information Governance - 1

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

Reputation - 1

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

Effectiveness - 2

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

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

Safety - 3

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

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

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

Compliance - 1

CEOL2 2993 - Risk of potential non-compliance with current legislation and guidance as a result of policies not being up to date. (12)

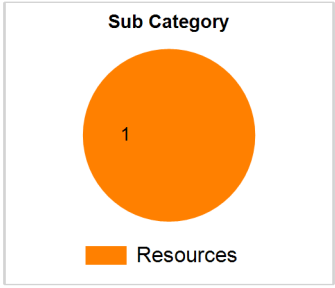
Key: **CRR** - Current Risk Rating **PRR** - Previous Risk Rating
IRR - Initial Risk Rating **TRR** - Target Risk Rating

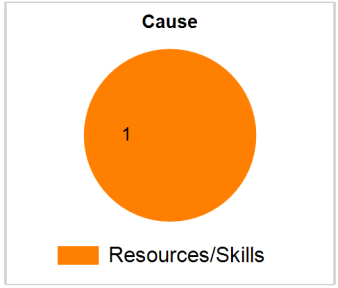
Organisational Risk Register Report

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

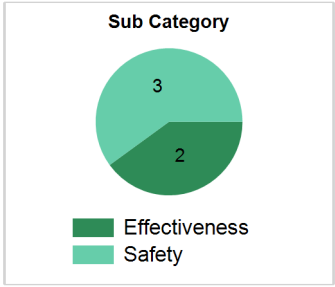
Gateshead Health NHS Foundation Trust

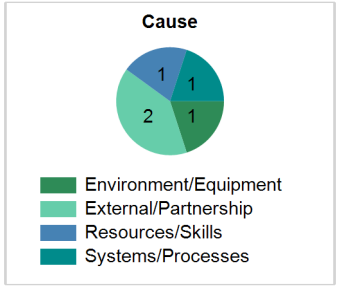
People & Resources



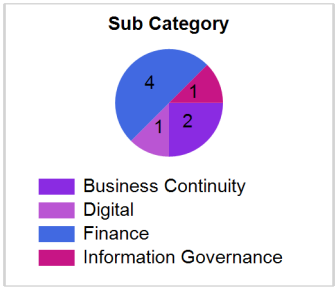


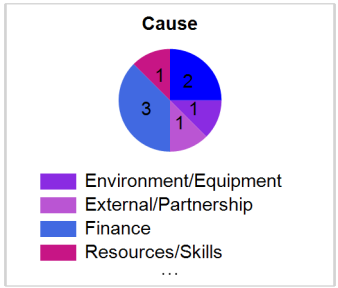
Quality Outcomes



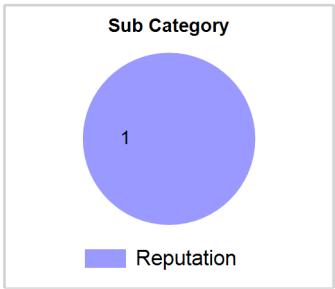


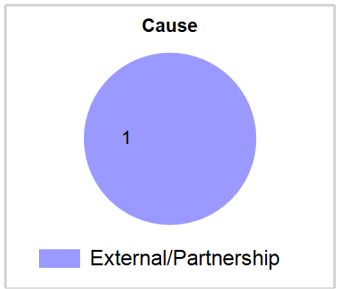
Finance & Efficiency





Regulation & Compliance





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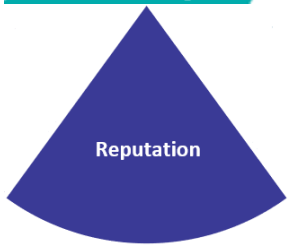
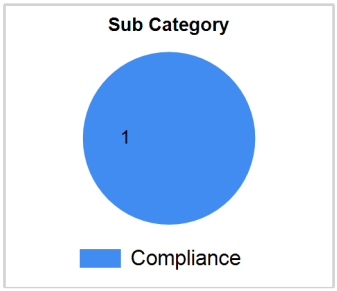
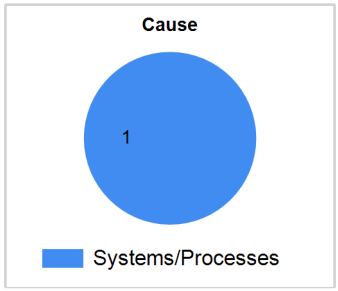
Organisational Risk Register Report

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

Gateshead Health NHS Foundation Trust







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

Organisational Risk Register Report

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

Gateshead Health NHS Foundation Trust

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

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register / Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR	Latest Progress Note
3095 26/07/2022 Amanda Venner People and OD Workforce Development 14/10/2023 BU_DIR EPRR ORG HRC QGC SA1.2 Continuous Quality improvement plan, SA2.1 Protect and understand the health and well-being of our staff by looking after our workforce, SA2.2 Growing and developing our workforce	Risk to quality of care and service disruption due to Industrial Action of various trade unions across various sectors affecting staffing levels and potential impact on patient care, safety and quality.	25	Industrial action working group established and meeting regularly. Focused planning sessions have taken place to explore the planning, response and recovery elements of industrial action with reasonable worse case scenarios considered. A detailed work plan has been produced with a number of actions, lead officers and timescales. Set up of command and control and coordination (wef 12/12/2022). Local strike committee in place (wef 09/05/2022). Citrep position updated daily during period of IA. Business continuity planning, including an EPRR work place that runs along each period of IA. Command and control structure standards up in the event of IA. Close partnership working and regular local discussions with staff-side and respective trade union representatives as part of the IA Internal Working Group and the Sub-group of the JCC. Cancellation of some elective services to reduce need for junior medical staff. Consideration of utilisation of other staffing sources- consultants and/or specialist nurses and pharmacy support. Review of on call teams.	20	Support twice weekly co-ordination cell and fortnightly industrial action Trust wide working group. Implementation of JCC sub- group on industrial action	Amanda Venner 31/12/2023 Amanda Venner (Completed 21/06/2023)	9	discussed at ERMG. remain very high risk, and agreed as a "top 3" risk on ORR.

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

Organisational Risk Register Report

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

Business Intelligence

NHS Gateshead Health NHS Foundation Trust

Handler BU Service Line Next Review Date BAF / Risk Register Objectives						Action Due		
2764 17/11/2020 Natasha Botto People and OD Human Resources 04/09/2023 BAF ORG HRC QGC SA1.1 Continue to improve our maternity services in line with the wider learning from the Ockenden review, SA1.2 Continuous Quality improvement plan, SA2.2 Growing and developing our workforce	Risk that not having a clearly agreed workforce plans for the next 3, 5 and 10 years as a result of a lack of a robust workforce planning framework and agreed approach could result in a lack of a sustainable workforce model that is fit to meet future service needs.	20	International recruitment team established and well embed within the organisation, providing a regular supply pipeline. Domestic recruitment actively pursued and monitored. Recruitment process streamlined (RPIW). Strategy to over recruit to HCSW position. Registered Nurse Degree apprenticeship programme agreed. School and local community supply initiatives in place to attract the Trust's future workforce. Healthcare Academy Approach in Development supporting Health Care Careers across Gateshead. Refreshed absence management policy and focused support absence management rolled out across the Trust to ensure we maximise the availability of our current workforce. Local pay arrangements agreed during times of pressure/areas where we struggle to recruit and retain. Consideration given to a strategic workforce planning approach as part of the work that was undertaken with the Whole Systems Partnership. Operational workforce plan submitted as part of the 2023-24 Operating Planning submission. Focus on growing and developing our workforce in the Trust's People Strategy and in the Trust's Strategic Aim 2.2, with associated actions. NHS Long Term Workforce Plan published to set a direction of travel and commit to an ongoing programme of strategic workforce planning.	16	Health and Care Academy internal development opportunities scoped	Sarah Neilson 01/09/2023	8	d/w AV- Discussed at Board development session on 23/08 and long term NHS workforce plan discussed. Further work to be carried out by the Education, Learning and Workforce Development Group.
					Review current retention offer and scope retention offer moving forward.	Natasha Botto 12/09/2023		
					Work with Director of Strategy, Planning and Partnerships to explore broader approach to planning Trust wide and how we align the workforce planning approach to this	Natasha Botto 27/10/2023		
					Develop systems, processes and comms to support increasing exit interview completion rates across the Trust	Natasha Botto 27/10/2023		
					Transfer Window - establish as is position and action required to progress and operationalise	Sarah Neilson 27/10/2023		

Organisational Risk Register Report

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

Gateshead Health NHS Foundation Trust

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

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR	Latest Progress Note
2982 06/12/2021 Mark Dale Medical Services Medical Services - Divisional Management 13/10/2023 BAF BU_DIR COO FPC ORG SA3.1 Improve the productivity and efficiency of our operational services through the delivery of the New Operating Model and associated transformation plans, SA4.2 Work collaboratively as part of Gateshead Cares system to improve health and care outcomes to the Gateshead population	Risk of delay in transfer to community due to lack of social care provision and intermediate care beds, due to increased numbers of patients awaiting POC up to 30 patients in medical wards. This delay adds significant pressures to acute bed availability, escalation beds being required and significant risk of problems with flow through hospital impacting A&E breach standards and risk of patients being delayed within ambulances. This could result in patients remaining in hospital when medically optimised creating risk to these patients as well as other patients as bed capacity not able to meet demand. There is also a risk of patients deconditioning, resulting in failed discharge secondary to this. This could lead to increased pressures on nursing teams as well as poor patient experience and quality.	**20**	Daily meeting with LA to examine capacity in out of hospital system and match with demand for discharges. Target discharges of 40 per week to keep pace with demand. Monitoring of Delayed transfers of care twice weekly meeting Escalation of delays of care to the community BU and social services at twice weekly meetings. Monitoring of any levels of harm - Datix incidents. Monitoring of Breach levels and times. Monitoring of Ambulance delays. Monitoring increased LOS of medically optimised patients. Escalation of patients requiring social services support raised weekly at Discharge Systems group which includes Social services management and CCG representative. Medically Optimised meeting 2x week, passed to IPC/CCG ECIST work Pilot on 2 wards re improving discharges. Further social care provision for discharge purchased and in place from beginning of June 2022	**16**	Escalation to system partners	Joanna Clark 22/10/2023	**9**	Remains a risk, signiciant challenge remains for Sunderland patients to be discharged

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3102 22/08/2022 Kris MacKenzie Finance Finance 18/10/2023 BU_DIR FPC ORG SA3.2 Achieving financial sustainability	Activity is not delivered in line with planned trajectories, resulting in the Trust having reduced access to core funding.	20	Active and in depth monitoring of activity information underway. Review of business units plans to deliver activity trajectories reviewed as part of monthly oveersight meetings. Activity achievement to be reviewed fortnightly at performance focussed SMT meeting. CRP project in development to strengthen counting and coding.	16	Timley and detailed reporting information Counting and Coding Review	Jane Fay 31/03/2024 Nick Black 31/03/2024	6	reviwewd with KM. No change. remains high
3103 22/08/2022 Kris MacKenzie Finance Finance 18/10/2023 BU_DIR COO FPC ORG SA3.2 Achieving financial sustainability	Efficiency requirements are not achieved.	20	Efficiency delivery closely monitored as part of month end reporting. Weekly CRP working group in place to ensure traction, delivery and ongoing engagement. SMT meeting to focus on performance on a fortnightly basis.	16			9	reviewed with KM. No change. score remains high. remains sub- risk of 3127
3127 17/10/2022 Kris MacKenzie Finance Finance 18/10/2023 BAF BU_DIR FPC ORG SA3.2 Achieving financial sustainability	There is a considerable risk that the trust will not be able to meet the planned trajectory of £12.588m adjusted deficit. Contributory risks include delivery of planned elective activity limiting access to income, delivery of CRP, impact of inflation, realisation of mitigations and cost of ongoing service pressures resulting from unscheduled care activity and further periods of industrial action.	20	Financial performance being managed in line with the financial accountability framework. Accountability for performance part of the divisional oversight meetings discussions.	16	Delivery of financial mitigations inherent in plan Monitoring and modelling of impact of industrial action Comprehensive cost analysis	Jane Fay 31/03/2024 Jane Fay 31/03/2024 Jane Fay 31/03/2024	4	d/w KM to upgrade the risk to 16 to reflect the overarching financial risk position of the organisation- in line with sub risks 3102 and 3103 within the ORR.

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3128 17/10/2022 Kris MacKenzie Finance Finance 14/10/2023 BAF BU_DIR FPC ORG SA3.2 Achieving financial sustainability	There is a Risk that the capital cost of delivery of the new operating model continues to increase resulting in revenue implications.	20	Detailed scrutiny of wider capital programme undertaken to ensure robust forecasting	16	Review of in-year costs with contractor	Paul Swansbury (Completed 14/09/2023)	8	dw KM- agreement to uplift to 16 to align with other financial risks on the ORR.
3255 27/06/2023 Gillian Findley Chief Executive Office Chief Executive Office 07/09/2023 BU_DIR ORG QGC	A number of reports and incidents due to report in the public domain over the next few months. There is a potential for these reports to have an impact on our reputation across the ICS.	20	ICB have been notified and a risk escalation meeting was enacted. The Trust has included these concerns in a thematic review and a delivery plan has been developed.	16	monitor implementation of thematic review delivery plan	Gillian Findley 31/08/2023	8	added to ORR following fomal agreement at ERMG 3/7/23

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1490 11/03/2014 Dianne Ridsdale Digital Digital Transformation and Assurance 02/09/2023 BAF BU_DIR DIGC ORG SA1.2 Continuous Quality improvement plan, SA1.3 Digital where it makes a difference	Risk of inappropriate access/use/disclosure of data. Due to failure to manage the information assets by IAOs across business units and corporate services. Resulting in patient harm, adverse publicity, failure to comply with National standards and contractual requirements.	25	Named System Administrator and Data Manager for every system Actively managed Systems Specific Security Policy (SSSP) for all systems - reviewing user access levels, training, configuration, testing, upgrade management - including business process changes etc Service owned Business Continuity Plan should systems fail Disaster Recovery Plan - how to recover the system Signed user registration forms Formal ITIL best practice change control procedure in place Formal Business case and project acceptance route through Digital Transformation Group Audit programme underway, focussed on critical systems	15	Bring resource in to support services to complete IARs	Dianne Ridsdale 31/08/2023	3	DSPT signed off, and high training levels. Still seeking additional capacity to review information asset registers
					Getting IAOs to take ownership of their information assets	Nick Black 31/03/2024		
					Ensure IAOs complete their Information Risk Management responsibilities	Kris MacKenzie (Completed 27/06/2023)		

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2398 28/12/2018 Kate Hewitson Surgical Services Obstetrics 02/10/2023 BAF BU_DIR COO ORG QGC SA1.1 Continue to improve our maternity services in line with the wider learning from the Ockenden review, SA1.2 Continuous Quality improvement plan	There is a risk of delayed treatment due to maternity estate being a separate building resulting in the potential for severe harm to mothers and babies. This was highlighted by recent HSIB reports reflecting delayed attendance times of emergency multi disciplinary teams to obstetric emergencies. Rising acuity of maternity patients and more frequent use of CCU, theatre staff and Paediatric teams creates additional likelihood of the need for these teams to attend the maternity department and delays to be incurred.	20	Pre-assessment - Women deemed likely to require critical care after elective procedures have their operation in main theatre to allow swift access to critical care. This only applies to elective patients and not emergency procedures or those in spontaneous labour. Any incidents are investigated to identify potential learning.	15	2861 action re looking into estate options	Kate Hewitson 03/06/2024	5	6 litre PPH in maternity theatre requiring attendance of main theatre scrub team, Gynae Onc team and transfer to CCU. Transfer to CCU further delayed due to requirement for bariatric ambulance.
1797 19/01/2016 Mark Smith Digital Health Records 16/10/2023 BAF BU_DIR DIGC ORG SA1.3 Digital where it makes a difference	Risk of failure to review appropriate information across multiple sources of clinical records stored in both system and paper format leading to potential patient harm. The trust has distributed data across a large number of systems and paper. The staff won't know where to look for information on the patient they are treating or won't look everywhere where there may be information [also impact for processes such as SARs/legal Services] The consequence of this is potential patient harm due clinical decisions being made on incomplete data, and the resulting financial effects + non compliance of legislative requirements	25	Systems management audit programme. Structured project management and change control procedures Standard operating procedures for each system	12	Map out current health record sources	Mark Smith 31/03/2024	8	Risk level reviewed, whilst the impact remains a 4, the likelihood has been moved to a 3. There are SOPs for each system, clinicians know where data could be held - so the risk has been accessed as might happen or recur occasionally.
					Implement single Document Store	Adam Charlton 30/09/2024		
					Develop FBC for Clinical System	Nick Black 30/09/2024		

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2945 14/09/2021 Debbie Renwick Chief Operating Officer Planning & Performance 14/10/2023 BU_DIR ORG SA3.1 Improve the productivity and efficiency of our operational services through the delivery of the New Operating Model and associated transformation plans	Risk of ineffective and inefficient management of services due to availability and access to appropriate and timely business intelligence to deliver and improve services	15	Programme of work established to work on improving access to BI and improve board reporting along with service line access to quality performance and workforce data Project Manager appointed to lead on this work with support from NECS. Programme involves 3 projects Static reporting – Look back - this is what we achieved Live reporting – this is how we are doing now and where we need to intervene to prevent poor performance Forecasting – these are the trends to be able to plan services much more effectively to meet demand the later two points need further development Some BI available in sitreps and excel format	12	• Work with the BU managers looking at what is available and start to build what is needed and get rid of what is not used/helpful	Debbie Renwick 31/10/2023	3	reviewed and actions updated
					project groups established and PID developed and plans developed for delivery	David Thompson (Completed 26/06/2023)		
					Improve data quality by working with teams and provide resilience to teams doing the RTT etc	Debbie Renwick (Completed 05/07/2023)		

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2993 28/01/2022 Kirsty Roberton Chief Executive Office Corporate Services & Transformation 11/10/2023 BAF BU_DIR ORG QGC SA1.2 Continuous Quality improvement plan	Risk of potential non-compliance with current legislation and guidance as a result of policies not being up to date, resulting in potential safety events and legislation and compliance breaches which may result in external scrutiny and reputational harm.	16	Policies in place for all key areas of legislation Overall policy management sat with CS&T Department (gap in leads for this work for a period) Policy system (pandora) maintained to manage and publish policies for staff to access Policy for Policies in place to provide clear direction and requirements for policy management Policies have lead 'author' and lead 'executive' Policy Review Group (PRG) in place (from Jan 22) to streamline process and target current backlog Policies include details of legislation and guidance they relate to, and information as to how compliance is monitored. Febraury 2023- starting to Monitor compliance against policies.	12	Begin to address overdue policy backlog Establish process for gaining assurance over policy compliance and embed	Kirsty Roberton 30/11/2023 Kirsty Roberton 30/11/2023	4	agreed at ERMG to reduce the risk to 12 based on current mitigations. policies continue to be scheduled for PRG and the amount of overdue policies has significantly reduced.
3089 25/07/2022 Gillian Findley Nursing, Midwifery & Quality Quality Governance 07/09/2023 BAF BU_DIR ORG QGC SA1.2 Continuous Quality improvement plan	Quality - There is a risk of quality failures in patient care (patient safety, patient experience and effectiveness) due to external causes such as delayed discharges and pressures from other Trusts resulting in patient harm, regulatory action, and reputational impact	15	Daily report provided detailing all delayed discharges within the Trust. regular meetings now established with social care. Discharge liaison staff available to support wards and facilitate earlier discharge.	12	improve flow through hospital	Claire Ellison (Completed 15/09/2023)	6	review date changed in line with policy - 1 month reviews for 12+

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3186 07/02/2023 Philip Glasgow Chief Operating Officer 11/10/2023 BAF BU_DIR COO FPC ORG SA3.1 Improve the productivity and efficiency of our operational services through the delivery of the New Operating Model and associated transformation plans, SA3.2 Achieving financial sustainability	There is a risk to maintaining business continuity of services and recovery plans due to the estate infrastructure, age and backlog maintenance requirements which exceed the Trusts capital allocation	16	Clinically led estates strategy developed and prioritsied on priority versus affordability	12	commission full estates review as part of Bensham retraction programme	Anthony Pratt 31/10/2023	6	No update - progressing with capital programme in 2023-24 and looking at requirements for 2024-25 programme.

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1636 10/11/2014 Dianne Ridsdale Digital Digital Transformation and Assurance 25/10/2023 BU_DIR DIGC MDMG ORG	UCRF R01/R03/R20/R23 Malware such as Ransomware Compromising Unpatched Endpoints, Servers, Equipment or due to Lack of Hardened Build Standards. There is a risk of potential exposure to published critical cyber vulnerabilities. Laptops, workstations and medical devices compromised by ransomware or botnets, due to endpoints being susceptible to compromise through the use of obsolete, old, or unpatched operating systems and third party software, including Java. Endpoints often not monitored for patch status. Endpoints compromised more easily through dangerous browser plugins (such as Java, Flash), or unsupported browsers. Servers compromised by ransomware, due to servers susceptible to compromise through the use of obsolete, old, or unpatched operating systems and software. Servers often not monitored for patch status. Due to failure to maintain all Digital assets, including installing Operating system patches, AV patches or other software and hardware updates across the IT estate, including network equipment and medical devices. Resulting in potential harm to patients, data leaks, impacts on service delivery.	25	AV on all end points AV up to date ATP in place site wide NHSD & Microsoft group policy templates Ongoing updates routinely planned as they are released Patching regime Network fully supported and maintained	10	Review trust asset register for EOL hardware/Software Review trust asset register for EOL hardware/Software	Mark Bell 31/10/2023 David Thompson (Completed 01/08/2023)	5	Chased update for action 19599 from DT and 19546 from MB
								16

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Changes to CRR in Period - Current/Managed Risks

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

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2993 28/01/2022 Kirsty Roberton Chief Executive Office Corporate Services & Transformation 11/10/2023 BAF BU_DIR ORG QGC SA1.2 Continuous Quality improvement plan	Risk of potential non-compliance with current legislation and guidance as a result of policies not being up to date.	16	Policies in place for all key areas of legislation Overall policy management sat with CS&T Department (gap in leads for this work for a period) Policy system (pandora) maintained to manage and publish policies for staff to access Policy for Policies in place to provide clear direction and requirements for policy management Policies have lead 'author' and lead 'executive' Policy Review Group (PRG) in place (from Jan 22) to streamline process and target current backlog Policies include details of legislation and guidance they relate to, and information as to how compliance is monitored. Febraury 2023- starting to Monitor compliance against policies.	12	Begin to address overdue policy backlog Establish process for gaining assurance over policy compliance and embed	Kirsty Roberton 30/11/2023 Kirsty Roberton 30/11/2023	4	agreed at ERMG to reduce the risk to 12 based on current mitigations. policies continue to be scheduled for PRG and the amount of overdue policies has significantly reduced.	16
3127 17/10/2022 Kris MacKenzie Finance Finance 18/10/2023 BAF BU_DIR FPC ORG SA3.2 Achieving financial sustainability	There is a considerable risk that the Trust is unable to meet the financial projections included in its plan.	20	Financial performance being managed in line with the financial accountability framework. Accountability for performance part of the divisional oversight meetings discussions.	16	Delivery of financial mitigations inherent in plan Monitoring and modelling of impact of industrial action Comprehensive cost analysis	Jane Fay 31/03/2024 Jane Fay 31/03/2024 Jane Fay 31/03/2024	4	d/w KM to upgrade the risk to 16 to reflect the overarching financial risk position of the organisation- in line with sub risks 3102 and 3103 within the ORR.	12

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Changes to CRR in Period - Current/Managed Risks

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Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register / Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR	Latest Progress Note	PRR
3128 17/10/2022 Kris MacKenzie Finance Finance 14/10/2023 BAF BU_DIR FPC ORG SA3.2 Achieving financial sustainability	Risk that the capital cost of delivery of the new operating model continues to increase resulting in revenue implications.	20	Detailed scrutiny of wider capital programme undertaken to ensure robust forecasting	16	Review of in-year costs with contractor	Paul Swansbury (Completed 14/09/2023)	8	dw KM- agreement to uplift to 16 to align with other financial risks on the ORR.	9
									3

Risks Moved to Managed in Period

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

Risks Closed in Period

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

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0

Risks Added in Period

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

0

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Risks Removed in Period

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2759 16/11/2020 Laura Farrington People and OD Workforce Development 31/08/2023 BAF BU_DIR	Workforce Health & Wellbeing - Risk of adverse impact to staff health and wellbeing due to internal working conditions and pressures as well as external factors (demand, patient acuity, staffing levels, covid, civil unrest) resulting in increasing physiological and psychological harm.	**16**	Health and Wellbeing team established with Regional funding secured to fund the team until June 2023. Partnered with Talk Works to provide talking therapies and counselling services to reduce waiting times for counselling and psychological support services. Occupational health referral systems(self referral and management referral)and process in place. Occupation Health external review completed, with improvement plan now being implemented. Occupational Health Metrics discussed at POD Quality meeting. Physio appointed 24/7 catering/vending solution now in place and usage is positive Schwartz rounds commenced	**8**	Relaunch Health and wellbeing check ins	Amanda Venner 30/06/2023	**4**	score reduced following discussion with AV. Risk owner to fully review risk and overdue actions 15-08-2023

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2779 01/07/2020 Andrew Rayner Nursing, Midwifery & Quality Quality Governance 07/11/2023 BU_DIR SA1.2 Continuous Quality improvement plan	The Trust fails to meet the CQC Fundamental Standards resulting in potential regulatory action, harm to patients, decline in ratings, and resulting reputational damage.	16	CQC three phased monitoring approach CQC Action plan T&F Group Exec Complinance Group Inspection action plans Nursing Strategy and Safe Staffing planning & delivery Governance Framework Risk Management systems and processes Health & Safety Governance and processes NICE guidance governance processes Learning Disability Support processes Cancer Services delivery plans Scheduled audits of operational safety elements.	6	Ensure any areas of improvement from last inspection are in place Develop a route map to Outstanding	Andrew Rayner (Completed 15/08/2023) Andrew Rayner (Completed 15/08/2023)	6	risk agreed to remove form ORR, reduce and close following ERMG. actions closed 07-08-2023

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2868 27/04/2021 Jo Halliwell Chief Operating Officer Planning & Performance 29/07/2023 BU_DIR COO EPRR	New Operating Model - Risk to the delivery of the new operating model and associated transformation plans due to the increase in activity and reduced workforce capacity, resulting in an adverse impact on key performance and recovery plans.	**20**	EPRR incident response and OPEL plans in place to manage increase in demand Bed modelling completed and associated workforce plans developed winter plan developed, signed off by Board and in place Workforce management plans in place and monitoring of staff absences available Annual review and establishment of safe nursing staffing levels. Safe staffing report (nursing)produced and forecasting robust. Workforce bank in place (see linked risk) Expanded Agency usage (process for approval) Critical staff payment offer approved and in place. Workforce absence etc captured via ESR/ healthroster New operating model aligns staffing requirements to activity and service plans. Volunteers - recruitment and use Deployment Hub to improve use of available resources transformation plans in place to reduce admissions, LOS and improve discharge	**12**	active recruitment to vacanices	Amanda Venner 30/09/2022	**6**	formal agreement at ERMG to remove from the ORR. to manage locally. 15-08-2023
					international recruitment programme	Amanda Venner 30/09/2022		
					complete capital programme to enable delivery of model	Jo Halliwell 29/09/2023		
					a revised focus on reducing overall LOS in medicine	Jo Halliwell 29/02/2024		

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3148 06/12/2022 Jo Halliwell Chief Operating Officer EPRR & Site Resilience 11/10/2023 BU_DIR COO MDMG	There is a risk that the organisation is unable to release staff for mandatory training and medical devices training due to operational pressures and current vacancies in both medical and nurse staffing. This could result in possible patient safety incidents.	20	Receive database from QEF, take training to ward areas promotion of training in the clinical environments	12	Support clinical environment in accessing the learning management system on site	Michael Crowe (Completed 29/06/2023)	9	reviewed at ERMG today. formal agreement to remove from the ORR and manage locally. significant improvement demonstrated, and further plans underway with chief matrons to improve compliance further. 12-09-2023

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3212 16/03/2023 Dean Bosworth People and OD Human Resources 03/09/2023 BU_DIR	Historical DBS clearances have not been fully recorded on ESR resulting in an inability to provide assurance as to compliance with DBS and NHS employment standards for the Group.	**20**	DBS policy review underway. EMT - Reviewed options appraisal for continual DBS checks to occur within employment. The outcome of such was to request employees who require DBS check to sign up to the DBS update service to enable a regular check. Discussions continue with Staffside. ESR to be updated with new records. robust automation process being explored. Business Units and Line managers have given clear briefings to staff to support their actions around this piece of work. Any DBS Clearances remaining outstanding employees have had a supportive follow up letter. Compelte Risk Assessment SOP implemented for the DBS Project. Complete Disciplinary Panels set up with standard panel approach to case management.	**12**	Ensure there is consistent application of appropriate levels of DBS checks for all employees, Policy Review	Dean Bosworth 31/08/2023 Dean Bosworth 31/10/2023	**8**	•Outstanding DBS reduced to 6 in total from 977 across the Group 15-08-2023

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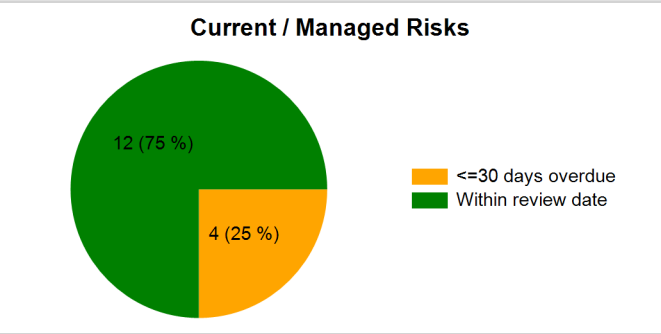
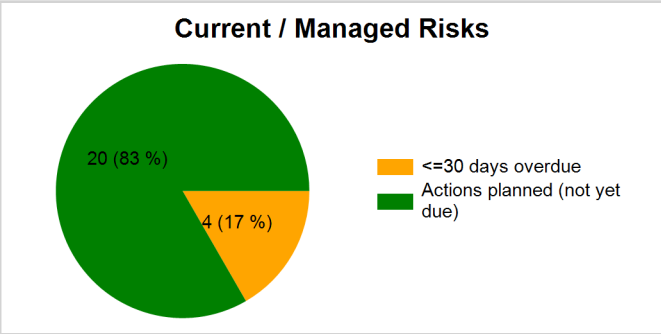
Risk Review Compliance



Risk Action Compliance



Movements in CRR

				CRR		
BU	Service Line	ID	Risk Description	Jul-2023	Aug-2023	Today
Chief Executive Office	Chief Executive Office	3255	Potential reputational damage to the organisation	16	16	16
	Corporate Services & Transformation	2993	Risk of potential non-compliance with current legislation and guidance as a result of policies not being up to date.	16	16	12
Chief Operating Officer		3186	There is a risk to ongoing business continuity of service provision due to ageing trust estate	12	12	12
	Planning & Performance	2945	Risk of ineffective and inefficient management of services due to availability and access to appropriate and timely BI.	12	12	12
Digital	Digital Transformation and Assurance	1490	Risk of inappropriate access/use/disclosure of data	15	15	15
		1636	UCRF R01/R03/R20/R23 - Malware such as Ransomware Compromising Unpatched Endpoints, Servers and Equipment	10	10	10
	Health Records	1797	Multiple sources of clinical records stored in systems and paper format leading to potential patient harm	12	12	12
Finance	Finance	3102	Activity is not deliverved in line with planned trajectories, leading to reduction in income	16	16	16

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

Organisational Risk Register Report

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

Gateshead Health NHS Foundation Trust

Movements in CRR

				CRR		
BU	Service Line	ID	Risk Description	Jul-2023	Aug-2023	Today
Finance	Finance	3103	Risk that efficiency requirements are not met.	16	16	16
		3127	There is a considerable risk that the Trust is unable to meet the financial projections included in its plan.	12	16	16
		3128	Risk that the capital cost of delivery of the new operating model continues to increase resulting in revenue implications.	9	16	16
Medical Services	Medical Services - Divisional Management	2982	Risk of delayed transfers of care and increased hospital lengths of stay	16	16	16
Nursing, Midwifery & Quality	Quality Governance	3089	Quality - Risk of quality failures in patient care due to external causes such as delayed discharges and external pressures.	12	12	12
People and OD	Human Resources	2764	Risk of not having clearly agreed workforce plans for the next 3, 5 and 10 years.	16	16	16
	Workforce Development	3095	Risk of Significant, unprecidented service disruption due to industrial action	20	20	20
Surgical Services	Obstetrics	2398	Risk that MDT are delayed to a maternity emergency/delayed CCU transfers for maternity patients due to separate buildings	15	15	15

NHS
Gateshead Health
NHS Foundation Trust

Report Cover Sheet Agenda Item: 14

Report Title:	**Consolidated Finance Report – Part One**			
Name of Meeting:	Trust Board			
Date of Meeting:	27th September 2023			
Author:	Mrs Jane Fay, Deputy Director of Finance			
Executive Sponsor:	Mrs Kris Mackenzie, Group Director of Finance & Digital			
Report presented by:	Mrs Kris Mackenzie, Group Director of Finance & Digital			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
	The purpose of this paper is to provide assurance against corporate objectives and address financial risks			
Proposed level of assurance – to be completed by paper sponsor:	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☒ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	Not applicable			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity, and inclusion*	The Trust has an approved 2023-24 planned deficit of **£12.588m.** As of August 23, the Trust has reported an actual deficit of **£8.872m** after adjustments for donated assets and gain & losses of asset disposal. This is an adverse variance of £2.278m from its year-to-date target. As of August 23, the Trust is forecasting achievement of its planned deficit totalling **£12.588m.** The Trust's proposed 2023-2024 capital programme totals **£29.792m.** As of August 2023, the Trust has reported actual capital spend totalling **£3.570m**, and a reported under-spend of **£4.570m** from its year-to-date target.			
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper.*	The recommendation to Board is to receive the report, discuss the potential implications and record partial assurance for the achievement of the forecast 2023-2024 planned deficit as a direct consequence of the reported year to date position and financial risks.			

	To note the summary of performance as of August 2023 (Month 5) for the Group (inclusive of Trust and QE Facilities, excluding Charitable Funds).				
Trust Strategic Aims that the report relates to:	**Aim 1** ☒	We will continuously improve the quality and safety of our services for our patients			
	Aim 2 ☐	We will be a great organisation with a highly engaged workforce			
	Aim 3 ☒	We will enhance our productivity and efficiency to make the best use of resources			
	Aim 4 ☐	We will be an effective partner and be ambitious in our commitment to improving health outcomes			
	Aim 5 ☐	We will develop and expand our services within and beyond Gateshead			
Trust corporate objectives that the report relates to:	Achieving financial sustainability				
Links to CQC KLOE	Caring ☐	Responsive ☐	Well-led ☒	Effective ☐	Safe ☐
Risks / implications from this report (positive or negative):					
Links to risks (identify significant risks and DATIX reference)	3127 Overall risk of not meeting financial plan, with contributing risks relating to activity (3102), efficiency (3103) and cost of delivery of New Operating Model (3128).				
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒		

1. Introduction

1.1 The purpose of this report is to provide a summary of financial performance as of 31st August 2023 (month 5) for the Group (inclusive of the Trust and QE Facilities, excluding Charitable Funds).

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

2 Income and Expenditure

2.1 The Trust has reported a deficit of £8.995m for the period April 23 to August 23 and £8.872m after the adjustment for donated assets, gains / loss on disposal of assets.

2.2 This is an adverse variance of £2.278m against the Trusts financial plan as detailed on the Trust Statement of Comprehensive Income (SOCI) as presented in Table 1.

2.3 For the month of August 23 the Trust has reported actual income of £29.730m and total year to date income of £152.924m. This is an adverse variance of £3.780m against the Trusts financial plan. The year-to-date variance comprises of less income than planned for ERF totalling £2.412m, pathology pillar 1 covid testing £1.629m, the impact of unachieved CRP £0.513m, offset by additional income in relation to medical & dental pay award of £0.766m.

2.4 For the month of August 23 the Trust has reported actual operating expenditure of £33.087m and total year to date operating expenditure of £160.595m. This is an adverse variance of £3.652m against the Trusts internal financial plan. The year-to-date variance comprises of the impact of an overspend on pay budgets totalling £3.604m and non-pay budgets of £0.434m, offset by overachievement of CRP totalling £0.386m

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

STATEMENT OF COMPREHENSIVE INCOME

August 23-24	NHSE APRIL - MARCH 24 FINAL PLAN					VARIANCE		
	Annual Plan	Plan In Month	Actual In Month	Plan to Date	Actual to Date	Variance (Actual - Plan)	Month Variance	Movement in Month
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Operating								
Operating Income from Patient Care activities								
Income From NHS Care Contracts	(335,125)	(28,508)	(27,036)	(140,449)	(139,213)	1,236	(235)	1,471
Income From Local Authority Care Contracts	(174)	(39)	(62)	(113)	(137)	(24)	(2)	(22)
Private Patient Revenue	(735)	(61)	(52)	(306)	(314)	(8)	(16)	9
Injury Cost Recovery	(500)	(42)	(55)	(208)	(145)	64	77	(14)
Other non-NHS clinical revenue	(153)	(13)	(11)	(64)	(63)	1	(0)	2
Total Operating Income From Patient Care activities	**(336,688)**	**(28,663)**	**(27,217)**	**(141,140)**	**(139,871)**	**1,270**	**(176)**	**1,446**
Other Operating Income								
Education and Training Income	(10,315)	(863)	(914)	(4,310)	(4,208)	103	154	**(51)**
R&D Income	(797)	(87)	(87)	(430)	(435)	(5)	(6)	**0**
Funding outside of System Envelope	(3,910)	(326)	0	(1,629)	0	1,629	1,303	**326**
Other Income	(18,989)	(1,537)	(1,462)	(8,586)	(8,360)	225	151	**74**
Donations & Grants Received	(229)	(19)	(50)	(96)	(50)	46	76	**(31)**
Cost Improvement Programme - Income	(2,211)	(166)		(513)	0	513	347	**166**
Total Other Operating Income	**(36,451)**	**(2,997)**	**(2,513)**	**(15,563)**	**(13,053)**	**2,510**	**2,026**	**484**
Total Operating Income	**(373,139)**	**(31,660)**	**(29,730)**	**(156,704)**	**(152,924)**	**3,780**	**1,849**	**1,930**
Operating Expenses								
Employee Expenses - Substantive	253,615	19,386	20,402	101,636	100,392	(1,244)	(2,260)	**1,016**
Employee Expenses - Bank	338	70	845	191	3,384	3,194	2,418	**775**
Employee Expenses - Agency	1,606	112	546	825	2,328	1,503	1,069	**434**
Employee Expenses - Other	1,149	95	120	484	634	151	126	**25**
Cost Improvement Programme - Pay	(3,309)	1,445		1,505	0	(1,505)	(59)	**(1,445)**
Total Employee Expenses	**253,399**	**21,108**	**21,913**	**104,640**	**106,739**	**2,099**	**1,294**	**805**
Purchase of Healthcare - NHS bodies	8,037	670	670	3,349	3,227	(121)	(122)	**0**
Purchase of Healthcare - Non NHS bodies	3,742	418	330	1,699	1,784	85	173	**(88)**
Purchase of Social Care	0	0	0	0	0	0	0	**-**
NED's	187	16	17	78	71	(7)	(9)	**2**
Supplies & Services - Clinical	35,154	2,925	3,336	14,731	15,858	1,127	716	**411**
Supplies & Services - General	3,158	252	216	1,266	1,007	(258)	(223)	**(36)**
Drugs	22,516	1,882	2,011	9,415	9,558	143	15	**129**
Research & Development expenses	11	8	2	11	27	16	22	**(5)**
Education & Training expenses	1,624	132	168	668	720	52	15	**37**
Consultancy costs	324	60	56	166	193	27	31	**(4)**
Establishment expenses	3,739	354	409	1,581	1,661	81	26	**55**
Premises	19,193	1,689	1,684	8,063	8,126	63	68	**(5)**
Transport	1,847	155	160	771	678	(93)	(98)	**5**
Clinical Negligence	8,098	696	696	3,225	3,225	0	0	**0**
Operating Leases	165	0	103	61	361	300	197	**103**
Other Operating expenses	12,831	471	545	2,693	2,936	243	169	**73**
Cost Improvement Programme - Non Pay	(5,294)	(90)	0	(1,119)	0	1,119	1,029	**90**
Reserves	0	(0)	0	(0)	0	0	0	**0**
Operating Expenses included in EBITDA	**368,731**	**30,746**	**32,318**	**151,297**	**156,171**	**4,874**	**3,301**	**1,573**
Depreciation & Amortisation - Purchased / Constructed	7,557	660	598	3,351	3,343	(8)	54	**(62)**
Depreciation & Amortisation - Donated / Granted	290	8	(20)	123	123	0	28	**(28)**
Depreciation & Amortisation - Finance Leases	5,112	426	265	2,130	1,325	(805)	(644)	**(161)**
Impairment & Revaluation	100	8	(75)	42	(368)	(409)	(326)	**(83)**
Operating Expenses excluded from EBITDA	**13,059**	**1,103**	**768**	**5,646**	**4,424**	**(1,222)**	**(888)**	**(335)**
Total Operating Expenses	**381,783**	**31,849**	**33,087**	**156,943**	**160,595**	**3,652**	**2,414**	**1,238**
(Profit)/Loss from Operations	**8,644**	**188**	**3,357**	**239**	**7,671**	**7,432**	**4,263**	**3,168**
Non Operating								
Non-Operating Income								
Finance Income	(1,224)	(73)	(259)	(714)	(991)	(276)	(90)	**(186)**
Total Non-Operating Income	**(1,224)**	**(73)**	**(259)**	**(714)**	**(991)**	**(276)**	**(90)**	**(186)**
Non-Operating Expenses								
Finance Costs	483	40	92	201	238	37	(15)	**52**
Gains / (Losses) on Disposal of Assets	0	0	0	0	0	0	0	**0**
PDC dividend expense	3,885	324	324	1,619	1,619	0	0	**0**
Total Finance Costs (for non-financial activities)	**4,368**	**364**	**416**	**1,820**	**1,857**	**37**	**(15)**	**52**
Other Non-Operating Expenses								
Misc. Other Non-Operating expenses	0	0	0	0	0	0	0	
Total Non-Operating Expenses	**4,368**	**364**	**416**	**1,820**	**1,857**	**37**	**(15)**	**52**
(Surplus) / Deficit Before Tax	**11,788**	**480**	**3,514**	**1,345**	**8,537**	**7,192**	**4,158**	**3,034**
Corporation Tax	914	83	92	230	458	228	220	**8**
(Surplus) / Deficit After Tax	**12,702**	**563**	**3,605**	**1,575**	**8,995**	**7,420**	**4,378**	**3,042**
Balancing Adjustment to NHSE Plan		**689**		5,069		(5,069)	(4,380)	(689)
(Surplus) / Deficit After Tax from Continuing Operations	**12,702**	**1,252**	**3,605**	**6,644**	**8,995**	**2,351**	**(2)**	**2,353**
Remove capital donations / grants I&E impact	(114)	(10)	20	(50)	(123)	(73)	(103)	30
Adjusted Financial Performance (Surplus) / Deficit	**12,588**	**1,242**	**3,625**	**6,594**	**8,872**	**2,278**	**(105)**	**2,383**

Table 1: Trust Statement of Comprehensive Income

3 Cost Reduction Programme (CRP)

3.1 Included in the Trusts 2023-24 financial plans is an annual CRP requirement of £15.900m of which the Trust achieved £4.353 as of August 23 and £5.086m for the financial year. This equates to 32.0% of the annual target.

Business Unit	23-24 Annual Target £000	23-24 YTD Target £000	23-24 YTD Achieved £000	23-24 YTD Variance £000	23-24 Annual Achieved	23-24 Annual Variance	23-24 Annual Achieved
Chief Executive	(0.012)	(0.003)	0.000	(0.003)	0.000	(0.012)	0.0%
Chief Operating Officer	(0.111)	(0.027)	(0.010)	(0.018)	(0.010)	(0.102)	8.6%
Clinical Support & Screening	(3.479)	(0.870)	(1.330)	0.460	(1.497)	(1.982)	43.0%
Community	(1.211)	(0.303)	(0.042)	(0.261)	(0.101)	(1.110)	8.4%
Director Of Nursing	(0.186)	(0.047)	(0.052)	0.005	(0.059)	(0.128)	31.4%
Estates & Facilities	(0.195)	(0.049)	0.000	(0.049)	0.000	(0.195)	0.0%
Finance & Information	(0.566)	(0.141)	(0.307)	0.166	(0.429)	(0.137)	75.9%
Medical Director	(0.025)	(0.006)	(0.020)	0.013	(0.020)	(0.005)	78.4%
Medicine & Elderly	(3.129)	(0.782)	0.000	(0.782)	0.000	(3.129)	0.0%
People & Organisational Development	(0.202)	(0.050)	(0.060)	0.010	(0.060)	(0.142)	29.7%
Surgical Services	(3.284)	(0.821)	(1.028)	0.207	(1.100)	(2.184)	33.5%
Corporate Cost Reduction	(3.500)	(1.380)	(1.504)	0.124	(1.811)	(1.689)	51.7%
Total	**(15.900)**	**(4.480)**	**(4.353)**	**(0.127)**	**(5.086)**	**(10.814)**	**32.0%**

4 Cash and Working Balances

4.1 Group cash as of 1st April 23 totalled £49.335m. The cash position of £44.853 as of 31st August is equivalent to an estimated 44 days operating costs and is a £0.454m reduction since July.

4.2 The liquidity metric has deteriorated by 3.60 days against July to -0.05 days, this is 8.64 days below plan (+8.59 days). This is due to a £5.910m decrease in working capital balance against estimate.

4.3 The balance sheet is presented in Table 2.

Statement of Position - August 2023

	2023/2024 July 2023 Group £000's	2023/2024 August 2023 Group £000's	Movement from Prior Month £000's	2023/2024 August 2023 QEF £000's	2023/2024 August 2023 FT £000's
Assets					
Non-Current Assets					
Investments	80	80	0	80	16,824
Property, Plant and Equipment, Net	143,105	143,327	222	1,219	142,108
Right of Use Assets	10,206	9,934	(272)	0	9,934
Trade and Other Receivables, Net	1,942	1,924	(18)	814	1,110
Finance Lease - Intragroup				41,326	0
Trade and Other Receivables - Intragroup Loan	0	0	0		7,403
Total Non Current Assets	155,334	155,266	(68)	43,439	177,380
Current Assets					
Inventories	4,969	4,912	(58)	2,710	2,202
Trade and Other Receivables - NHS	7,478	8,967	1,489	830	8,138
Trade and Other Receivables - Non NHS	6,871	6,383	(487)	1,216	5,168
Trade and Other Receivables - Other	0	0	0		0
Prepayments	6,406	6,021	(385)	626	5,394
Cash and Cash Equivalents	45,307	44,853	(454)	7,480	37,373
Other Financial Assets - PDC Dividend	6	6	0		6
Accrued Income	1,829	1,677	(152)	1,020	657
Finance Lease - Intragroup				424	0
Trade and Other Receivables - Intragroup Loan					2,506
Total Current Assets	72,866	72,819	(47)	14,306	61,443
Liabilities					
Current Liabilites					
Deferred Income	12,204	11,298	(906)	123	11,175
Provisions	3,396	3,254	(142)	579	2,675
Current Tax Payables	4,751	4,984	233	441	4,543
Trade and Other Payables - NHS	1,434	2,229	795	678	1,551
Trade and Other Payables - Other	10,630	8,047	(2,583)	2,409	5,637
Lease Liabilities	2,608	2,359	(249)	0	2,359
Trade and Other Payables - Capital	101	0	(101)	0.000	0
Other Financial Liabilities - Accruals	29,496	35,615	6,120	8,496.898	27,118
Other Financial Liabilities - Borrowings FTFF	999	999	0	0.000	999
Other Financial Liabilities - PDC Dividend	1,295	1,619	324	0.000	1,619
Other Financial Liabilities - Intragroup Borrowings	0	0		2,505.972	0
Finance Lease - Intragroup	0	0		0.000	424
Total Current Liabilities	66,913	70,403	3,491	15,233	58,099
NET CURRENT ASSETS (LIABILITIES)	5,953	2,415	(3,537)	(928)	3,343
Non-Current Liabilities					
Deferred Income	2,023	2,023	0	1,719	304
Provisions	2,280	2,280	0	0	2,280
Trade and Other Payables - Other	-	0	0	0	0
Lease Liabilities	7,959	7,959	0	0	7,959
Other Financial Liabilities - Accruals	0	0	0	0	0
Other Financial Liabilities - Intragroup Borrowings	0	0	0	7,403	0
Other Financial Liabilities - Borrowings FTFF	12,012	12,012	0	0	12,012
Finance Lease - Intragroup				0	41,326
Total Non-Current Liabilities	24,273	24,273	0	9,122	63,880
TOTAL ASSETS EMPLOYED	**137,013**	**133,408**	**(3,605)**	**33,389**	**116,843**
Tax Payers' and Others' Equity					
PDC	149,767	149,767	0	0	149,767
Taxpayers Equity	0	0	0	0	0
Share Capital	0	0	0	16,824	0
Retained Earnings (Accumulated Losses)	(22,648)	(26,254)	(3,605)	24,427	(50,681)
Other Reserves	0	0	0	0	0
Revaluation Reserve	9,795	9,795	0	0	9,795
Misc Reserve	99	99	0	0	99
TOTAL TAXPAYERS EQUITY	137,013	133,408	(3,605)	41,251	108,981
TOTAL ASSETS EMPLOYED	**137,013**	**133,408**	**(3,605)**	**41,251**	**108,981**

Table 2 – Statement of Position

5 Capital

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

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

* After Principal Loan Repayments

5.2 The Trust's approved capital programme for 2023-2024 totals £29.792m; an oversubscription of £1.818m.

5.3 Capital spend to 31st August totalled £3.570m; £4.570m less than the year-to-date plan. Expenditure in the year was in respect of the new operating model, community diagnostic centre, building maintenance and schemes carried forward from the 2022-2023 programme.

Kris Mackenzie, Group Director of Finance & Digital
September 2023

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 15

Report Title:	Integrated Oversight Report			
Name of Meeting:	Board of Directors			
Date of Meeting:	27th September			
Author:	Deborah Renwick & Jon Gaines and IOR Reporting Leads			
Executive Sponsor:	Kris Makenzie, Group Director of Finance & Digital			
Report presented by:	Kris Makenzie, Group Director of Finance & Digital			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☒	**Assurance:** ☒	**Information:** ☐
	To summarise performance in relation to strategic aims, key NHS standards, requirements and KLOE's to outline the risks and recovery plans associated with COVID -19. This report covers the reporting period July and August 23.			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☒ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*				
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*	**Points of note:** Overall elective activity was 108.8% of planned for levels in August, Diagnostic activity was 102.3%, new outpatient 102.8%. Elective overnight activity continues to underperform however archived the highest of any month, achieving 88.6% of planned levels in August (77.0% year to date). Key elective performance headlines are: • RTT <18 weeks waiters' performance is at 68.9% (92% target) • RTT waiting-list list decreased by 40 patients (0.3%) to 13,487 (below planned for levels). • Diagnostic performance was 90.7% (95% target). Audiology continues to be the biggest long-term risk. Some challenge now in Barium Enema. • 28 day and 31 day cancer standards are achieving their target levels for the latest validated month. • Patients waiting over 62 days on a 2ww pathway fell to 43 (below planned level of 67).			

	The average number of G&A beds open remained fell slightly to 433 in August, just below with operational planned levels of 434. The number of long stay patients increased, and as a result the average length of stay increased very slightly to 4.56 days, from 4.5 the previous month. Attendances at A&E remain relatively high but fell by 436 from July, of which 338 were paediatric attendances. Ambulance conveyance remain high, with circa 20% of all A&E attendances via Ambulance in each of the past 2 months. UEC performance measures in August: • 4-hour A&E waiting times decreased to 71.3% • There Zero 12-hour trolley breaches. • 48.3% of Ambulance handovers were within 15 mins of arrival, 95.3% within 30-60 mins. Workforce metrics had maintained improvements across the suite of indicators, however the latest month has seen a worsening picture in relation to sickness rate and appraisal compliance. Total agency spend, as a percentage of the pay bill has increased steadily each month, and again in August to more than 2%, with increases in spend noted in the nursing and medical workforce. Transacted CRP in August is £1,119m above planned levels for the month, this is the third month in row above plan, as a result year to date variance has improved to -£133k below plan. Pay-spend was £1,320m above plan in month, resulting in a £3,414m year to date overspend. Non-pay spend was £1,656m over plan in August, resulting in a £2,019m year to date overspend on this measure.	
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	This report seeks to provide assurance in respect of the strategic aims 1,2,3 and 4. The recommendations to the Board are to receive this report, discuss the potential implications and note the improvements in some areas, and ongoing challenges in others.	
Trust Strategic Aims that the report relates to:	**Aim 1** ☒	We will continuously improve the quality and safety of our services for our patients
	Aim 2 ☒	We will be a great organisation with a highly engaged workforce
	Aim 3 ☒	We will enhance our productivity and efficiency to make the best use of resources
	Aim 4 ☒	We will be an effective partner and be ambitious in our commitment to improving health outcomes
	Aim 5 ☐	We will develop and expand our services within and beyond Gateshead
Trust corporate objectives that the report relates to:	3) We will enhance our productivity and efficiency to make the best use of our resources. SA3.1 Improve the productivity and efficiency of our operational services through the delivery of the New Operating Model and associated transformation plans.	

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

INTEGRATED OVERSIGHT REPORT – September Committees

1. Introduction

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

2. Key issues & findings

2.1 Under the Safe, Effective and Caring domains the majority of indicators are performing well and/or not triggering concern or displaying Special Cause Variation (88% of metrics for Safe, 100% of metrics for Effective and 100% for Caring).

2.2 The responsive domain (waiting lists and constitutional standards) and Well-Led domains (financial KPI's) continue to demonstrate pressures.

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

3.0 Caring Domain

3.1 **Patient Friends & Family Tests (FFT):** Inpatient / day case services. Common cause variation is observed. August saw a slight increase in the percentage of patients reporting a positive experience to 96.6% from 95.6% in the previous month (96.4% average last 3 months). National Benchmarking data (for the latest month published July 2023) shows we remain above the national average of 94.7%, with GH 95.6%. Response rates have fluctuated in 2023 ranging from a low of 5.8% in January to a high of 9.2% in April; 7.7% observed in August.

3.2 A&E services. Common cause variation observed. The proportion of patients rating their experience as positive increased to 87.4% from 84.8% (86.8% average last 3 months). Benchmarking data (for the latest month published July 2023) shows that we remain above the national average of 81.5% with performance at 84.8%. Response rates fluctuate around 5.5%.

3.3 Themes identified from patients who rated their experience as 'poor or very poor' include poor care and treatment received, long wait times, poor communication and staff attitude.

3.4 Although increasing in May and now June, the number of formal complaints reduced in July and August and continues to demonstrate common cause variation, and within expected levels based on past trends. Clinical treatment, poor verbal communication, and appointment waits / delays making up the majority of complaints received. Distribution of complaints continues to be spread across a range of all clinical areas proportionately.

3.5 The number of overdue complaints at the end of August continues to demonstrate significant improvement from previous months. However, increased to 17, the first time in 9 months the numbers have increased. 13 sat with the Medicine Business Unit, 2 Surgical Business Unit and 2 Clinical Support and Screening.

4.0 Safe Domain

4.1 Two Serious Incidents (SI's) were reported to StEIS in August, one categorised as resulting in severe harm with one moderate harm. The severe harm incident related to a fall, and the moderate harm was related to a delay/failure in a diagnosis. The number of reported SIs in the first 5 months of this year to August continue to be lower than the same period last year, reporting 23 this year compared to 30 last year.

4.2 There were 505 patient safety incidents reported in August, slightly down from 525 in July. 2.6% (13) were recorded as resulting in moderate, severe, or major harm. Over the past 12 months the average is 1.9% of incidents recorded as moderate, severe, or major so August as was July were slightly higher than the period average. Patient falls are consistently the top reason for incidents of this nature. Reducing harm from falls has been identified as a Trust Leading Indicator.

4.3 The HCAI 2023/24 national objective for Chloridoids difficle infection (C.Diff) is no more than 23 cases attributed to the Trust. The Trust has recorded 9 year to date. In August we reported 2 Hospital Onset (HOHA), with two were Community Onset (COCA). The trust is therefore reporting 9 cases against the annual allowance and continues to be below trajectory for this point in the year. This measure has been identified as a Trust Leading Indicator.

4.4 The Trust reported two COVID outbreak in August month, down from 3 in July however the incidence nosocomial cases increased from 9 to 17, which is viewed as in line with local and national prevalence. The number of definite health care associated incident was stable at 2 each month.

4.5 There have been no MRSA cases reported in the financial year, however in August there were 4 Healthcare Associated E.coli infections and 12 Community associated. Both figures lower than the previous month.

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

5 Effective Domain

5.1 HSMR continues to show deaths within expected ranges, with the SHMI is showing lower than expected deaths. The Mortality review data for the last 12 months demonstrates that 99.1% of deaths reviewed were 'Definitely not preventable' with 96.2% of cases reviewed identified as 'Good practice'. 86 cases in the period required a review by the Mortality Council and/or the ward-based team.

5.2 General and Acute beds open in July averaged 433 for the month, just below the planned operating bed levels of 434, and lower than July at 436. Bed occupancy remains consistently well above 92% threshold and the ICB average, however occupancy levels remained relatively stable at 94.6% in August compared to 94.8% in July. Daily levels peaked at 98.9% on the 29th August continuing to demonstrate the challenges around high bed occupancy.

5.3 There were on average 46 patients who no longer met the criteria to reside in a hospital bed each day in August, representing an in-month decrease from 51 in July. Our local ambition is to reduce to no more than 18 patients per day. There was also an increase in the days accrued between the patient becoming medically optimised (MO) to discharge from 2,236 to 2,467.

5.4 Average length of stay increased very slightly from 4.5 days in July to 4.56 in August, driven by an increase in length of stay in our elective pathways and more patients with longer lengths of stay (greater than 21 days)

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

6 Responsive Domain

6.1 **ED and Ambulance attendances** – In August attendance levels in A&E were at 9283; average daily attendances were 9 per day more than August last year (representing an increase of 3.1%). However, August's attendances were 438 lower than July, of which 336 related to fewer paediatric attendances. April to August is seeing consistently high levels of Ambulance conveyances, averaging 1866 per month. In August circa 20% or 1875 patients arrived in A&E by ambulance, the same proportion as July.

6.2 **Ambulance handovers** times improved to 48.3% of handovers within 15 mins of arrival, but was slightly lower with 95.3% within 30-60 mins. 77 patients waited between 30-60 minutes for handover (an increase from 59 last month) and 16 patients waited longer than 60 mins (a significant fall from 62 month). The Trust continues to benchmark fairly well across the ICS, ranking top for 30–60-minute handovers. Benchmarking data for August shows the Trust had the fewest, so was top performing Trust in the (ICS) region for 30-60m Ambulance hand-over times, and remained 3rd best for 60+ minute handovers.

6.3 **Total waits in ED** – the proportion of patients waiting more than 12 hours in ED Increased to 4.35% from 3.91% in July, however the Trust reported Zero 12-hour DTA breaches in the month. Slightly more patients waited more than 4 four hours to be seen and treated, with performance at 71.3% in August, placing the Trust 50th out of 137 of Trusts, compared with 55th in July.

6.4 **Rapid response** - validated performance in July was above the 70% target again standing at 72.6%, cumulative performance since April stands at 72.0%. Activity levels also continue to increase with 702 contacts recorded in the month.

6.5 **Diagnostic performance** fell slightly in August to 90.7% of patients waiting less than 6 weeks. The latest benchmarking continues to place us better than the latest national average and ICS averages (74% and 83% respectively). Audiology continues to be the single largest risk area in achieving the 95% standard for the Trust. Audiology performance fell again in August to 55.5% from 56.7% in July, with the number of long waiters standing at 288. The service have identified a number of challenges impacting on and have developed a recovery plan, recovery trajectories have been developed based on different scenarios indicating recovery is not likely to be before February 24. Pressures have also now emerged Barium Enema, which has the second lowest percentage performance of any test in August, having seen waiters increase from 70 to 106 between June and August and >6 week patients increasing from 1 to 42. The service have identified a number of challenges impacting and also developed a recovery plan, indicating recovery is planned to be achieved around November.

6.6 **Cancer Waiting Times**: In August 2ww performance continues to be below standard at 78.5%, but was above the latest NENC and England average for the first time. The 28 Day Faster Diagnosis target for all pathways was above standard at 77.0% in July and 79.3% in August (indicative). The Trust met all three 31 day standards. The 62 day standards (2ww, screening and upgrade) continues to be below standard, but improved to 70.4%. The number of long waiters at the end of August was 43, below the plan of 67 and 16 fewer than July. Pressures remain across most Tumour sites and standards, with particular challenges in Gynaecology, Urology and Upper and Lower GI.

6.7 **Referral to Treatment - 18 weeks**: Challenges remain in achieving planned for activity levels and continues to place pressures on the Trust's waiting lists. In August the number of patients on the waiting list decreased by 40 (or 0.3%) to 13487, which is below planned for levels at this point in the year. The proportion waiting less than 18 weeks for Treatment however also fell to 68.9%, the lowest of the year so far, better than the national average, but worse than the NENC.

6.8 **Referral to Treatment – Long Waiters:** The number of patients on the RTT waiting list waiting more than 78 weeks remained at zero, however the number of patients waiting more than 65 weeks increased to 45 (now above plan, the majority of which sit in the Paediatric long waiters cohort). Those waiting more than 52 weeks, as projected, continued to increase to 237 at the end of August (177 above the planned level of 60). Paediatrics, Pain and Trauma and Orthopaedic patients remain the biggest risk to our over 52-week waiters at present. In pain services locum capacity has been sought in the short term to reduce long waits, longer term plans include recruiting an additional consultant to start in October, providing additional capacity to address the backlog. Paediatric draft plans, to mitigate long waiters include options for WLI's, reviewing the current model of care and reviewing methods of data capture where ongoing support and care is provided whilst children remain on the waiting list for a diagnosis. The specialty remains a significant risk. In T&O various options are being worked up to increase lower limb capacity; current plans place this specialty at risk with significant pressures in patients forecasted to wait longer than 52 weeks by the year end.

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

7. Well Led Domain

7.1 The number of staff in contracted posts again increased slightly in August, and the gap between planned and contracted staffing levels narrowed slightly. As a result the Trust vacancy rate fell to 3.0% in August (a 0.8%/34.5 WTE decrease from July). The trust vacancy rate has decreased due to an increase in contracted Trainee Grades and Registered Nurses.

7.2 Sickness absence rates increased in August to 5.8% across the Group. Both Trust and QEF are now above the 5% target and on an upward Trajectory. Core training continues to improve with Group compliance at 88% in August against the 85% target. In relation to appraisals, while there has been a sustained improvement since May 2022, the Group remains below the 85% target, and in July and now August the figure has declined, to 80.2% in the latest month. This is the second consecutive drop in compliance. QEF has seen decreases in compliance this month to 84.8 with the Trust dropping slightly to 79.4%.

7.3 The month of August saw a further increase in agency requests, however, fill rates for agency staff reduced significantly. Total agency spend, as a percentage of the pay bill has increased steadily each month, since May, and again in August to more than 2%. Total Agency spend has increased during the month of August, with increases in the nursing and medical workforce.

We will achieve financial sustainability

7.4 **Finance -** Transacted CRP in August is £1,119m above planned levels for the month, this is the third month in row above plan, as a result year to date variance has improved to -£133k below plan. Pay spend was £1,320m above plan in month, resulting in a £3,414m year to date overspend. Non-pay spend was £1,656m over plan in August, resulting in a £2,019m year to date overspend on this measure.

NHS
Gateshead Health
NHS Foundation Trust

Integrated Oversight Report

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

SEPTEMBER 23 COMMITTEES

THIS PACK IS BEST VIEWED ON SCREEN IN SLIDESHOW MODE

Contents	Pages	Reporting Period	Data Quality Signoff
Summary of KLOE	3		
Safe			
Serious Incidents reported to StEIS	4	Aug 23	***
Datix - Patient Safety Incidents	5	Aug 23	***
Infection Prevention & Control	6 – 7	Aug 23	***
Effective			
Hospital Standardised Mortality Ratio and Summary Hospital Level Mortality Indicator	8	Feb 21 to Jun 23 / Dec 20 to Apr 23	***
Discharge & Delays	9	Jan 22 to July 23	*
Long Length of stay patients	10	Aug 23 CDS	***
Efficiency and Productivity – Theatres	11	Aug 23	***
Responsive			
Urgent & Emergency Care	12	Aug 23	***
Ambulance handovers	13	Aug 23	***
Community Waiting List and 2hr Rapid Response	14	WList Aug 23 / RR July final	*** / ***
Elective Recovery	15	Aug 23	***
Diagnostics Activity and 6w Performance	16 – 17	Aug 23	***
RTT	18	Aug 23	***
Cancer	19 – 22	July / Aug (indicative)	**
Duty of Candour Verbal Compliance	23	Aug 23	***
Complaints	24 - 25	Aug 23	***
Well Led			
Sickness	26	Aug 23	***
Core Training	27	Aug 23	***
Appraisals	28	Aug 23	***
SIP and Vacancies	29	Aug 23	***
Agency and Bank Spend	30	Aug 23	***

NHS Gateshead Health NHS Foundation Trust

Key to Data Quality Signoff:

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

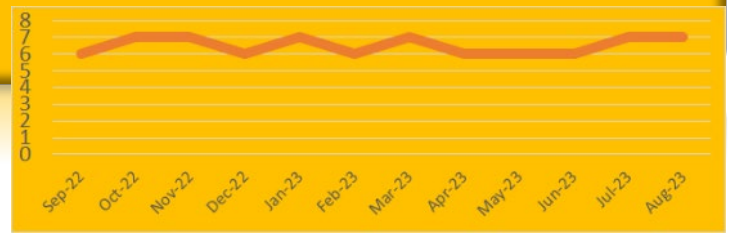
KLOE Summary: Indicators performing against target

Gateshead Health NHS Foundation Trust

Safe

7 of 8 (88%)

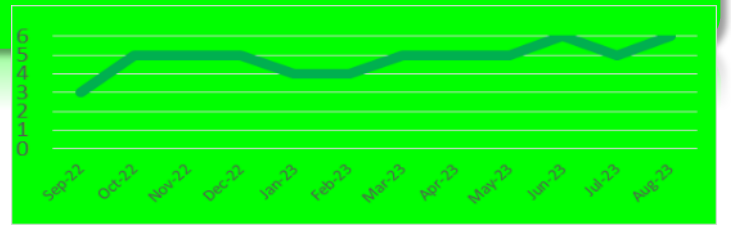
applicable indicators are performing well and/or not triggering SPC or are achieving against targets



Effective

6 of 6 (100%)

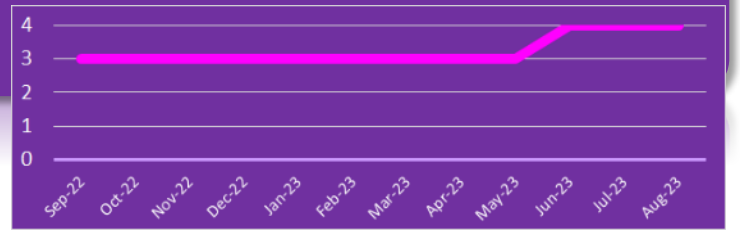
applicable indicators are performing well and/or not triggering SPC or are achieving against targets



Caring

4 of 4 (100%)

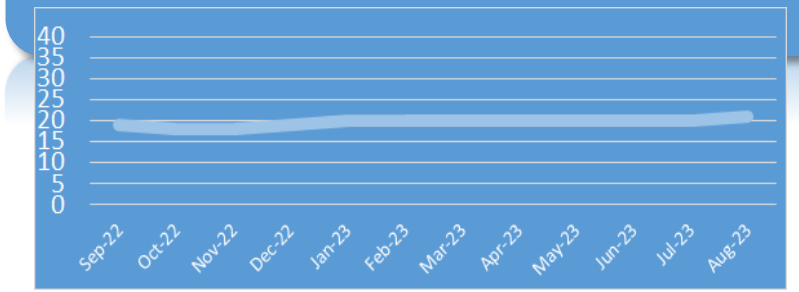
applicable indicators are performing well and/or not triggering SPC or are achieving against targets



Responsive

20 of 41 (49%)

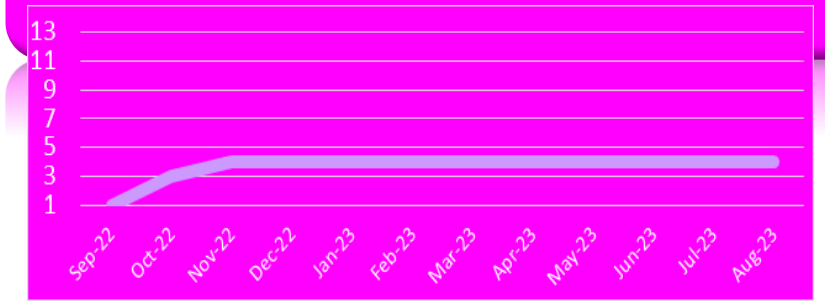
applicable indicators are performing well and/or not triggering SPC or are achieving against targets



Well Led

4 of 13 (31%)

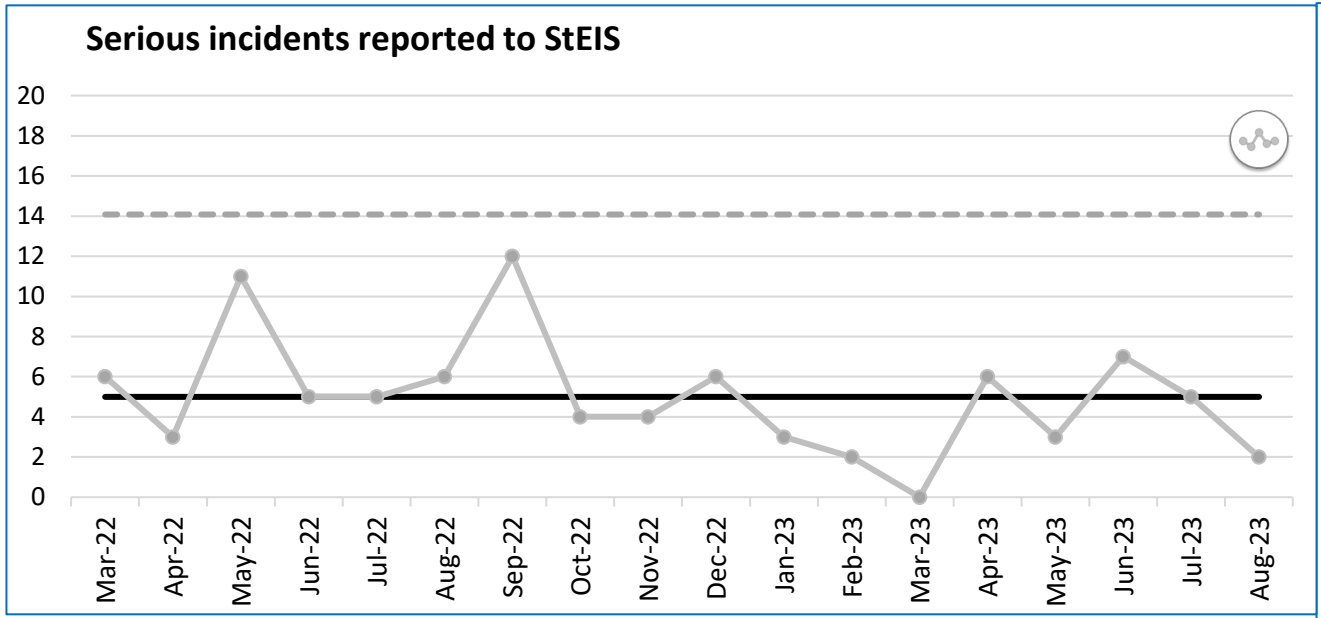
applicable indicators are performing well and/or not triggering SPC or are achieving against targets

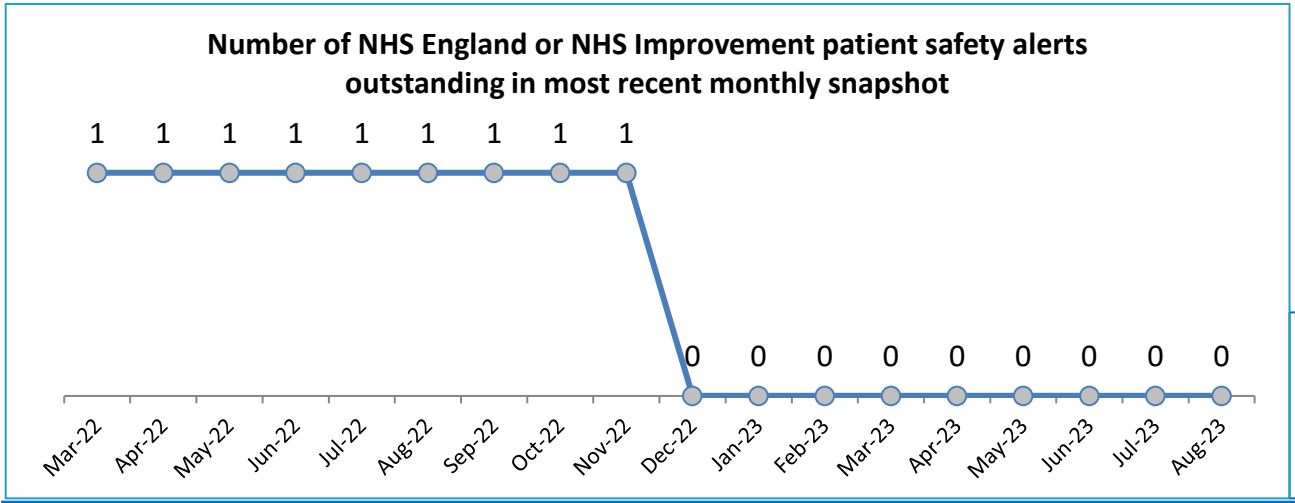


Serious Incidents reported to StEIS

Safe

Gateshead Health NHS Foundation Trust





Serious Incidents reported to StEIS

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

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

Health care are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is justified. Serious Incidents include acts or omissions in care that result in; unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm - including those where the injury required treatment to prevent death or serious harm, abuse.

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

There were 2 SI's declared in August 2023

Severe Harm
1 x Fall from height - chair

Moderate Harm
1 x Diagnosis - delay / failure

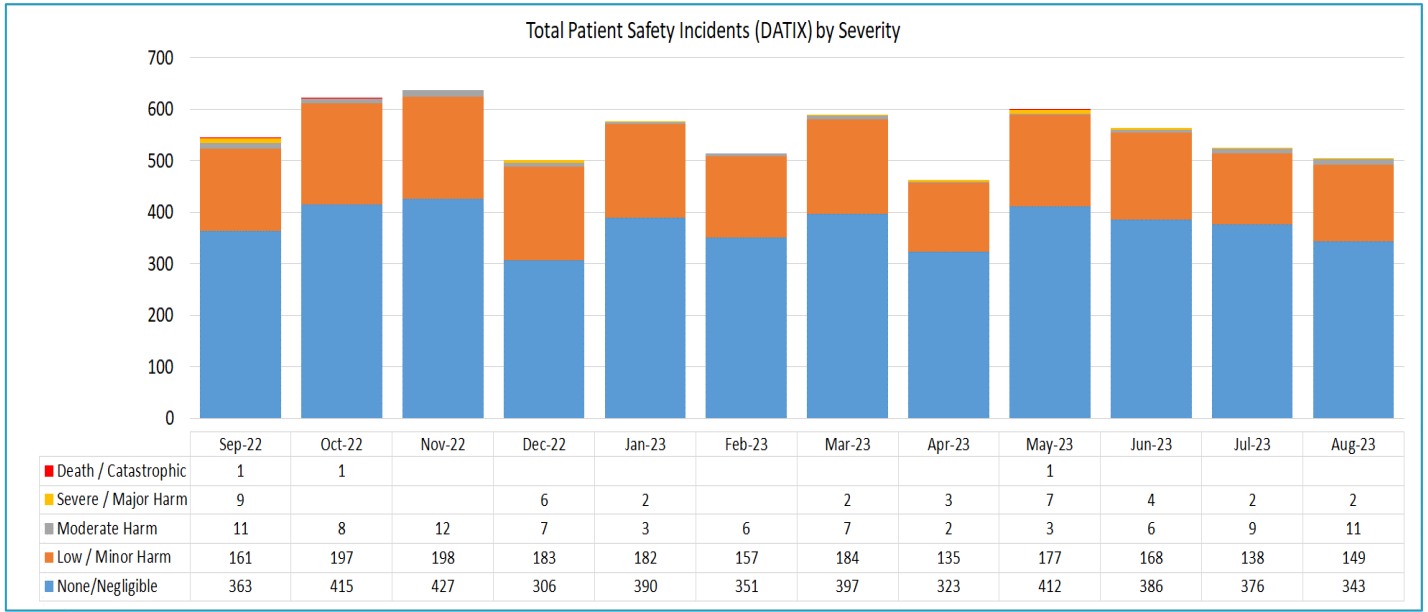
National Patient Safety Alerts

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

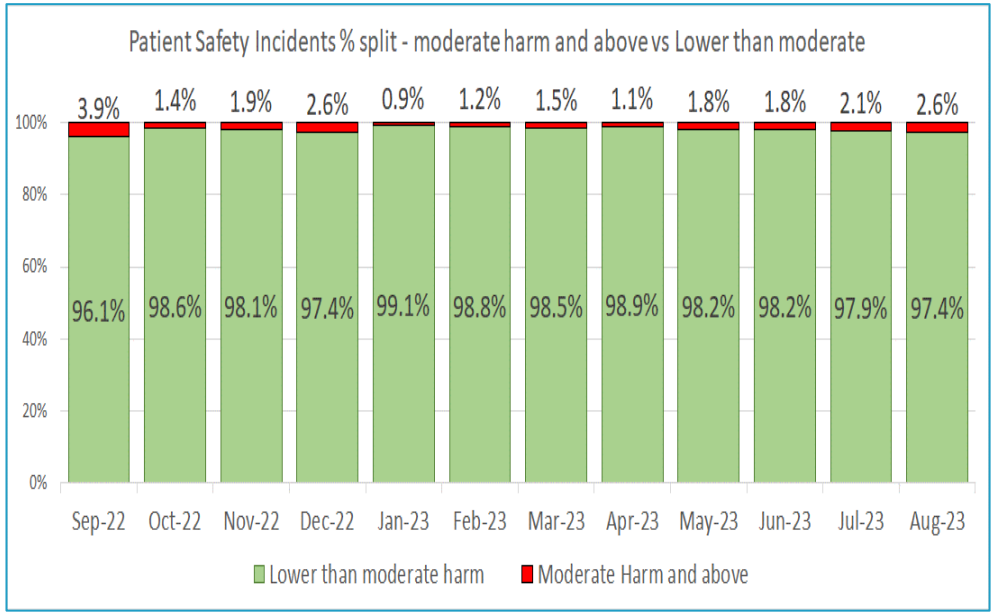
Datix - Patient Safety Incidents - included to provide high level information from Datix incidents

Safe

NHS Gateshead Health NHS Foundation Trust



	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
Death / Catastrophic	1	1							1			
Severe / Major Harm	9			6	2		2	3	7	4	2	2
Moderate Harm	11	8	12	7	3	6	7	2	3	6	9	11
Low / Minor Harm	161	197	198	183	182	157	184	135	177	168	138	149
None/Negligible	363	415	427	306	390	351	397	323	412	386	376	343



Top 10 Datix incidents Sep-22 to Aug-23

1. Patient falls (1524)
2. Medication (932)
3. Pressure damage (653)
4. Delay / failure to treat / monitor (570)
5. Discharge or transfer issue (531)
6. Communication failure (486)
7. Maternity / foetal / neonatal (347)
8. Violence, abuse and harassment (473)
9. Infection prevention & control (213)
10. Pathology sample issues (188)

Top 10 Incidents August-23

1. Patient falls (109)
2. Medication (63)
3. Delay / failure to treat / monitor (56)
4. Pressure damage (50)
5. Violence, abuse and harassment (48)
6. Communication failure (37)
7. Discharge or transfer issue (32)
8. Maternity / foetal / neonatal (30)
9. Pathology sample issues (24)
10. Equipment (21)

- The volumes of Patient safety incidents (DATIX) are provided for the rolling 12 months, by level of harm (top left).
- Over the past 12 months an average of 554 incidents have been logged each month, with monthly figures varying between 463 and 637.
- The chart shows severity continues to be consistently and predominantly recorded as 'No harm and Low harm'.
- Patient falls, Medication, and Pressure damage continue to be the top 3 incident types by volume over the past 12 months, as they have been since this reporting began (bottom left). In the latest month of August *Delay / failure to treat / monitor* was the third largest reason.
- On average 1.9% of incidents each month have been recorded as moderate harm or above (top right), but months ranged from 0.9% to 3.9%. Monthly average of 10 incidents in actual numbers.
- Patient falls, Delay / failure to treat / monitor are typically the top two incident types in the moderate and above groups with Results / investigations issues, medication and discharge typically next.

IPC – Healthcare Associated Infections

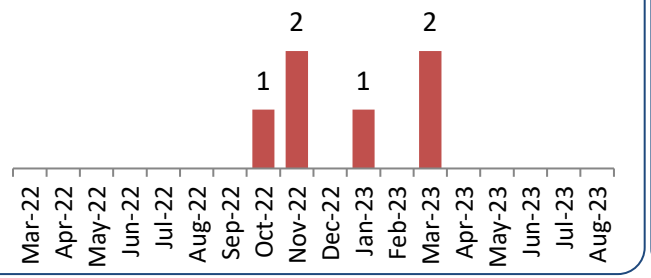
Safe

NHS Gateshead Health NHS Foundation Trust

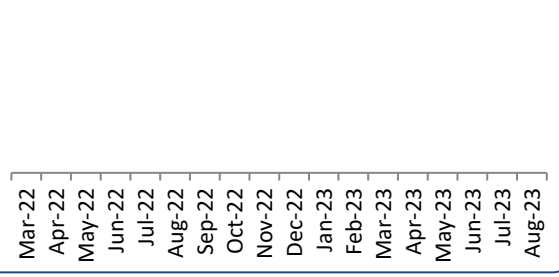
MRSA

The Trust adopts the national aspiration of a zero MRSA blood stream infections (BSI).
The trust has had zero incidence of Healthcare Associated MRSA BSI in the preceding 12 months and zero community healthcare associated MRSA BSI's from April 2023.

MRSA -Community Associated



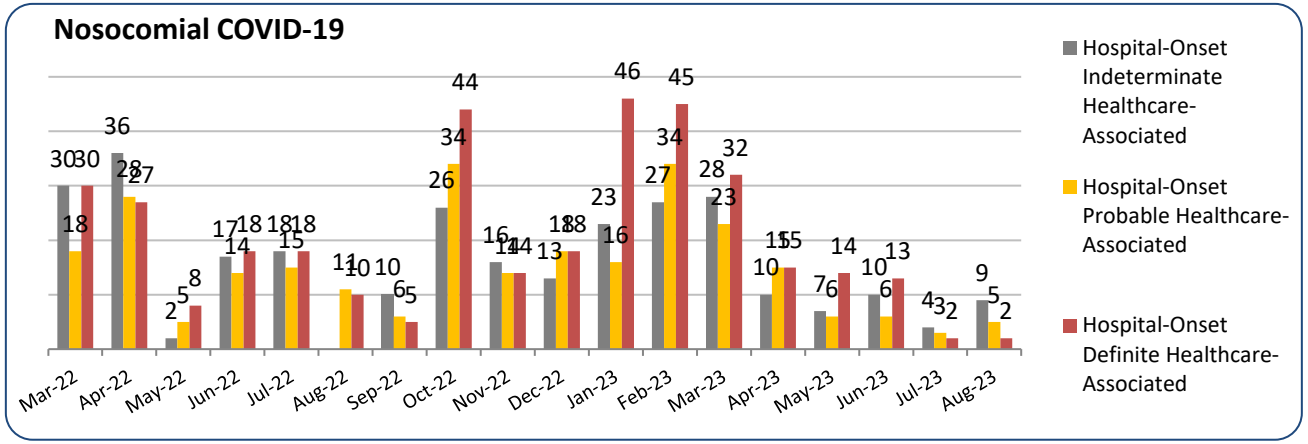
MRSA- Healthcare Associated



Nosocomial COVID 19 cases

All Healthcare associated COVID cases are reported and investigated through the DATIX system.
2 Outbreaks related to COVID were declared within the organisation in August, down from 3 in July. The incidence of nosocomial cases in July continues to fall in line with local and national prevalence. The trust continue to operate a hybrid model to place patients if unable to isolate on their base ward in side rooms.

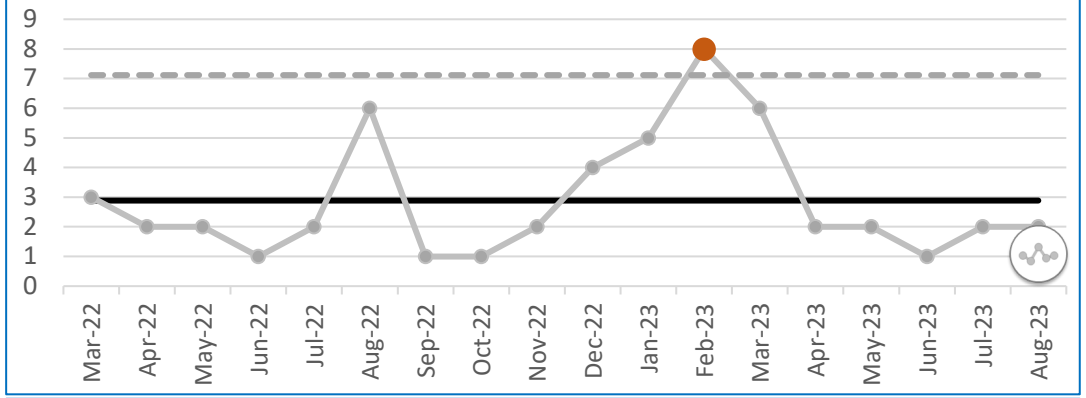
Nosocomial COVID-19



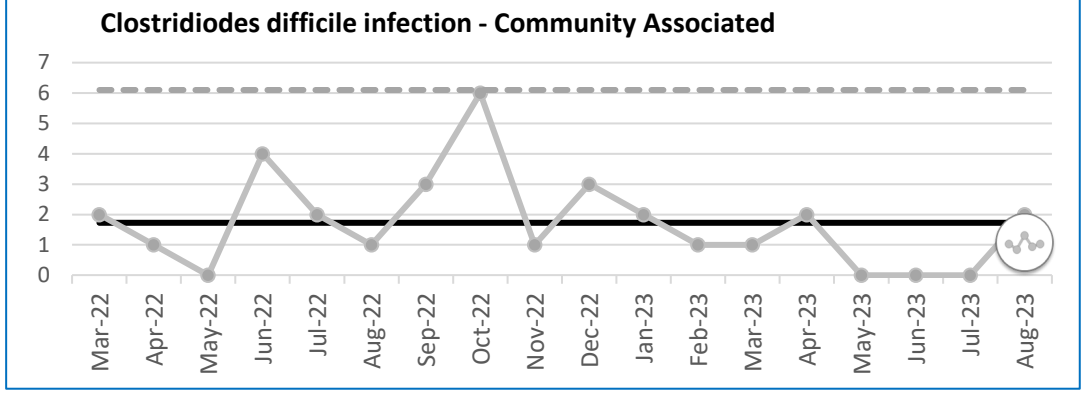
Clostridiodes Difficile Infection

- In August, the Trust reported x2 Hospital Onset Healthcare associated (HOHA) CDI's.
- Gateshead Health has been given a threshold of 23 for CDI in 23/24, we have currently had x 9 Healthcare Associated CDI's from April 2023.
- All Healthcare Associated Infections are investigated, and any learning shared with the relevant business units.

Clostridiodes difficile infection - Healthcare Associated



Clostridiodes difficile infection - Community Associated



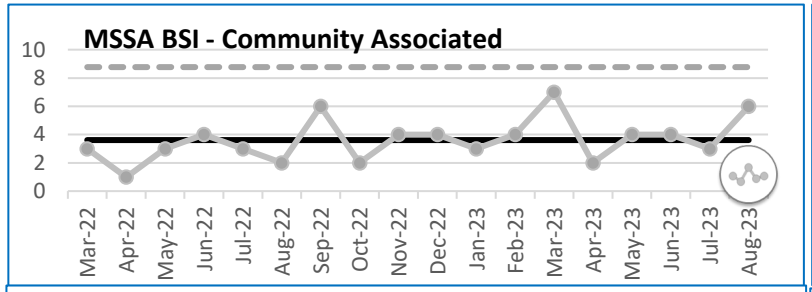
IPC – Healthcare Associated Infections

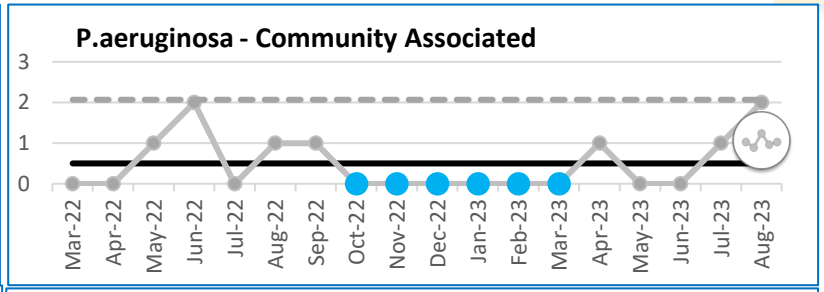
Safe

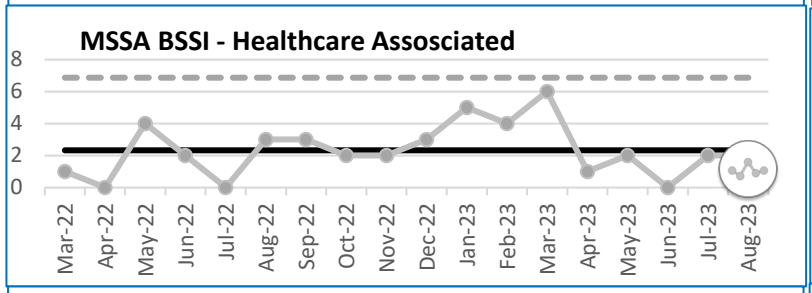
NHS Gateshead Health NHS Foundation Trust

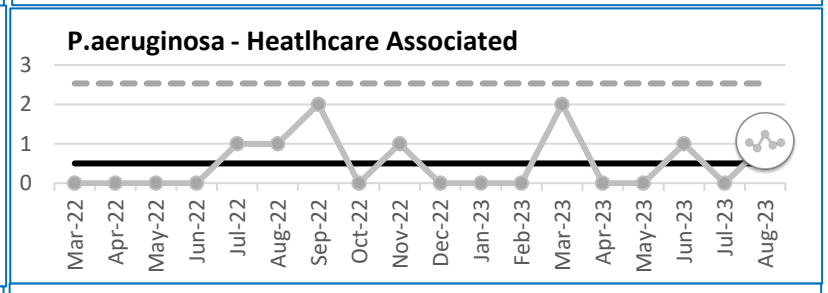
MSSA & E Coli

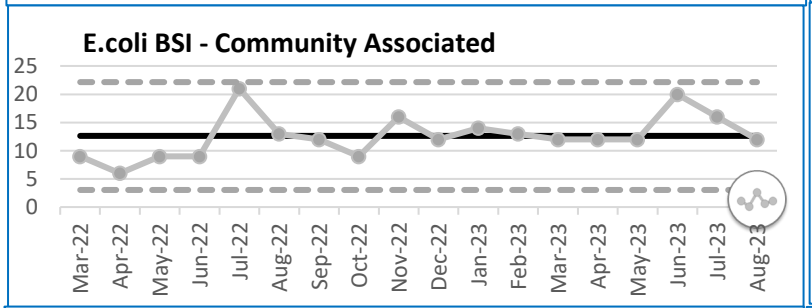
- NHS England has not set a Healthcare Associated MSSA BSI threshold for 2023/24.
- The Trust has reported x2 Healthcare Associated and x6 Community Associated MSSA BSI's in August.
- The Trust has reported x4 Healthcare Associated *E. coli* during August x3 HOHA's and x1 COHA.
- 12 Community associated (COCA's) were reported.
- It should be noted that the majority of the COCA's were samples taken on admission or for assessment in A&E.

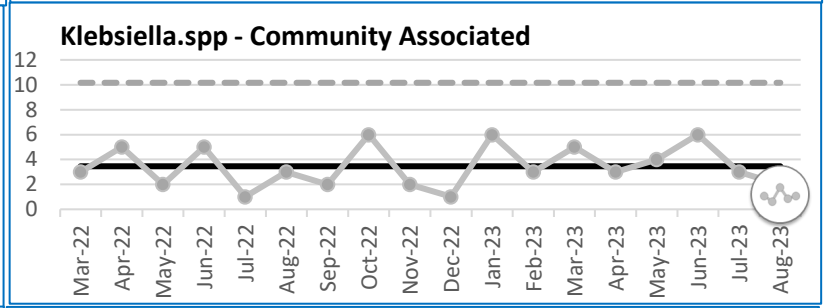


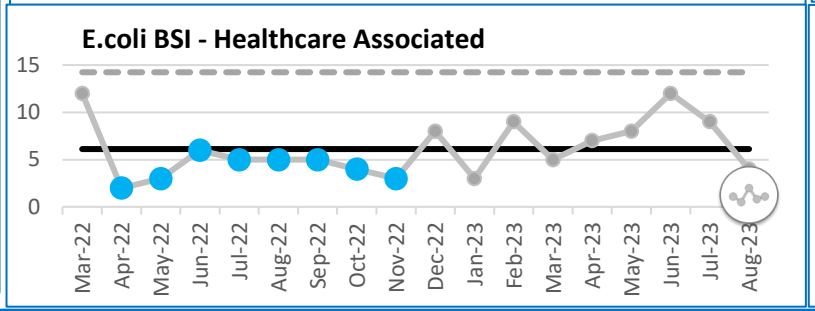


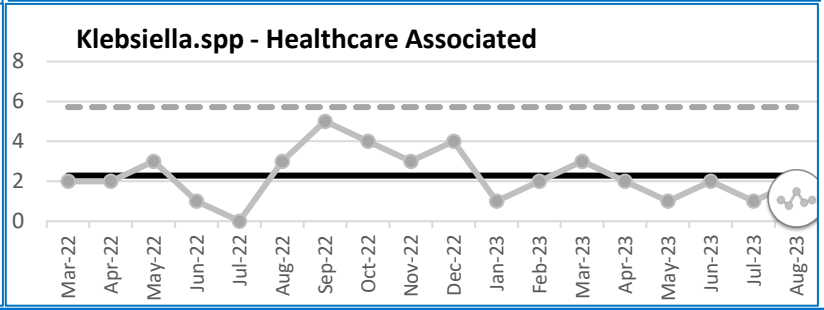












P. aeruginosa & Klebsiella spp

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

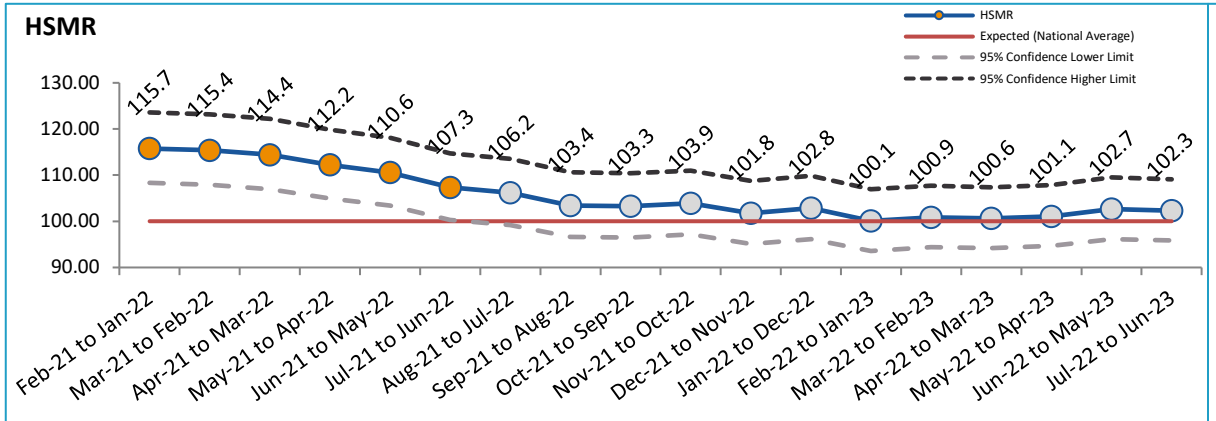
The Trust has reported in August:

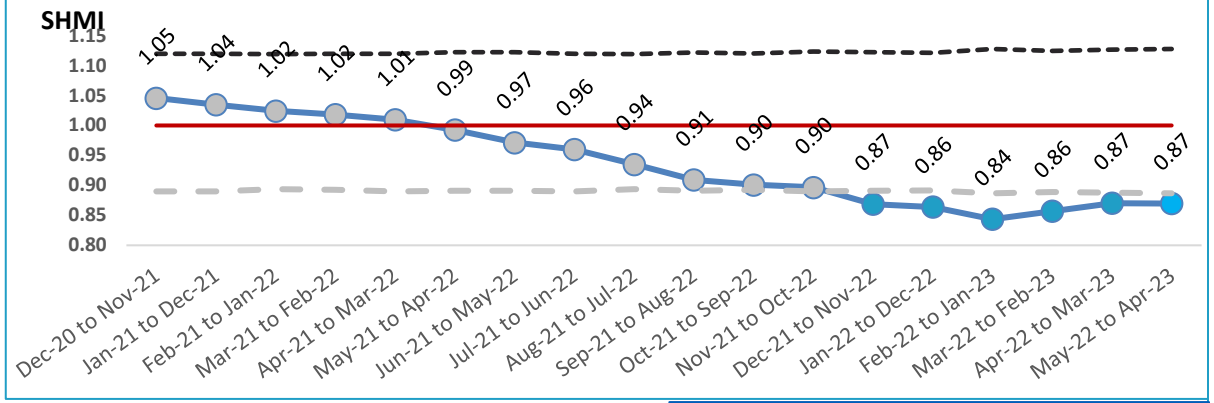
- *P. aeruginosa* x1 Healthcare associated BSI and x2 Community Associated BSI's.
- *Klebsiella spp* x2 Healthcare Associated and x 2 Community associated BSI's

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

Effective

Gateshead Health NHS Foundation Trust





Mortality Review Data Extracted
Deaths 01/08/2022 to 31/07/2023

Deaths in period	Deaths reviewed by Medical Examiner	Hogan 1 - Definitely Not Preventable	NCEPOD Score 1 Good Practice
1240	1240	99.1%	96.2%
	100.0%		

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

Assessment

- The HSMR is showing deaths 'As Expected' with a score of 102.3 against the national average figure of 100.
- The SHMI remains lower than expected deaths with the latest figure of 0.87, below the national average. A likely explanation for the reduction in the SHMI score is the inclusion of SDEC activity within the inpatient dataset from Sep-21. Observed deaths will remain the same, however the increased volume of activity will result in higher expected deaths being calculated by the model. Once SDEC activity moves to Type 5 S&E activity then the SHMI score is likely to increase at that point.
- Mortality review data for the last 12 months demonstrates that 99.1% of deaths reviewed were 'Definitely not preventable' with 96.2% of cases reviewed identified as 'Good practice'.
- 86 cases in the period require a review by the Mortality Council and/or the ward-based team.

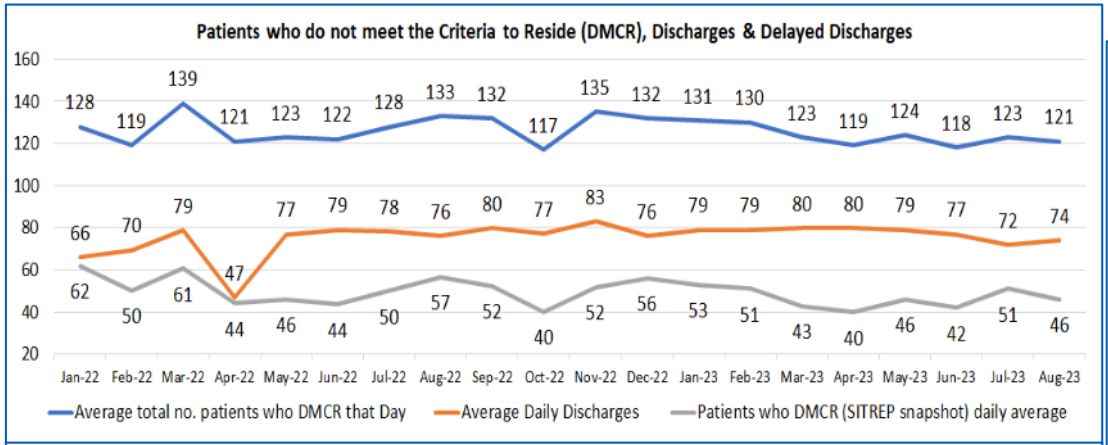
Since the inception of the Medical Examiner Service in September 2020, all deaths are reviewed and cases may be escalated for additional investigations i.e. Mortality Council, patient safety investigation.

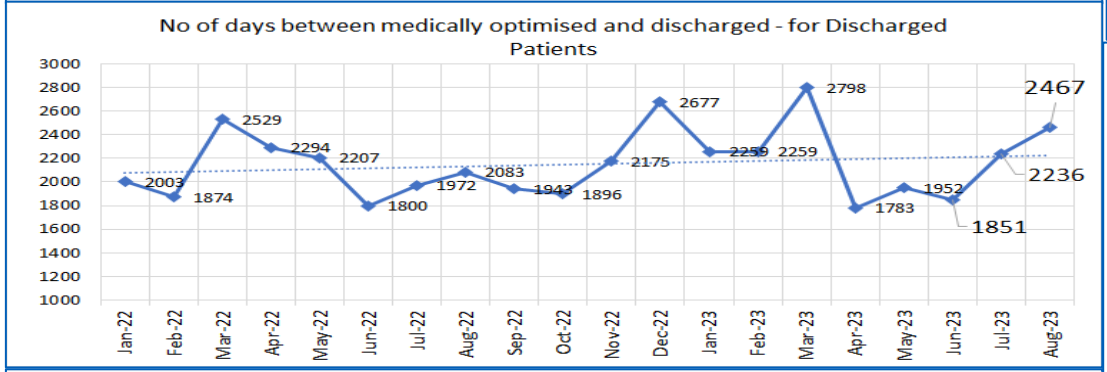
Actions

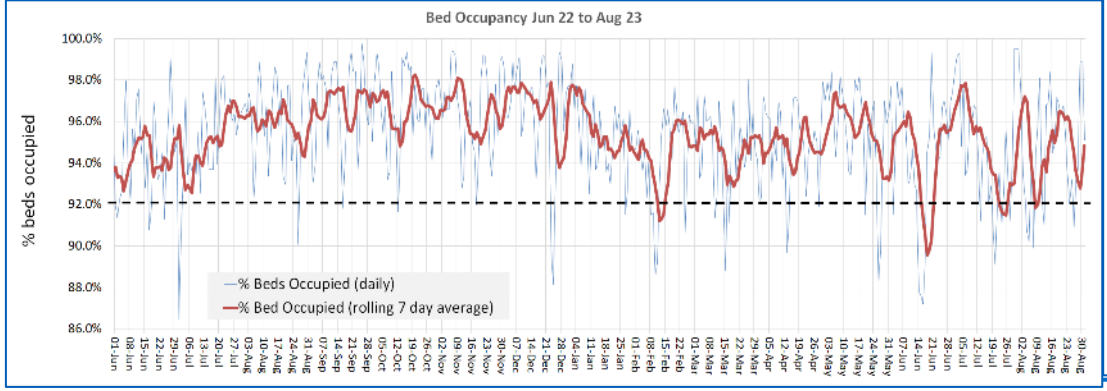
- The process for reviewing deaths were patients had a serious mental illness diagnosis.
  - The process is embedded for those over 65, however the process to review under 65s relies on input from CNTW. The process has now been agreed with CNTW, they will review the backlog of cases and present at the Mortality Council in the next couple of months and do these when they arise going forward. To address the backlog of cases requiring Mortality Council review – 2 additional extended Mortality Councils took place in early July, 34 cases were reviewed in total.
  - Further Mortality Councils have been extended to attempt to resolve the backlog of cases with the first of these scheduled for 21st September. However, due to industrial action, this meeting has been stood down.
  - Some of the backlog are cases that rely on other processes such serious incident and complaints investigations – these cases will be scheduled on completion of these investigations.
- Outstanding surgical ward level reviews have been escalated to the SafeCare Lead and those requiring review in the Medical Business Unit are to be discussed with the Clinical Lead to agree a way forward.
- An advert to promote attendance by medical staff at the Mortality Council featured in the staff newsletter week commencing 17th July and also the MD bulletin, in an attempt to decrease the occasions when the meeting cannot go ahead due to lack of representation.

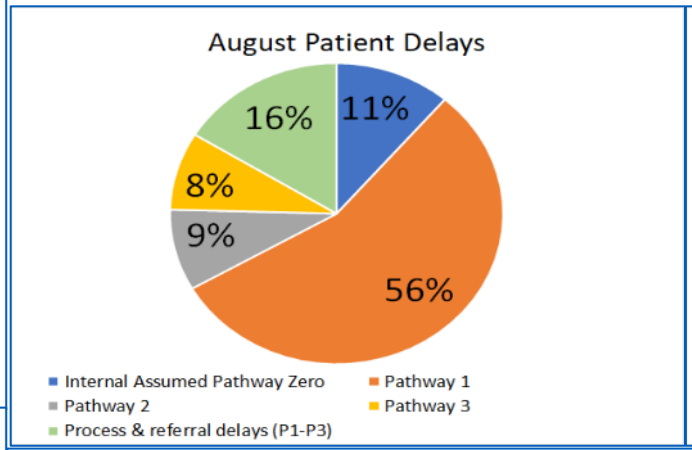
Recommendation - Continue to inform & note actions undertaken at Mortality and Morbidity steering group and Quality Governance Committee via the Integrated Oversight Report and Mortality Paper.

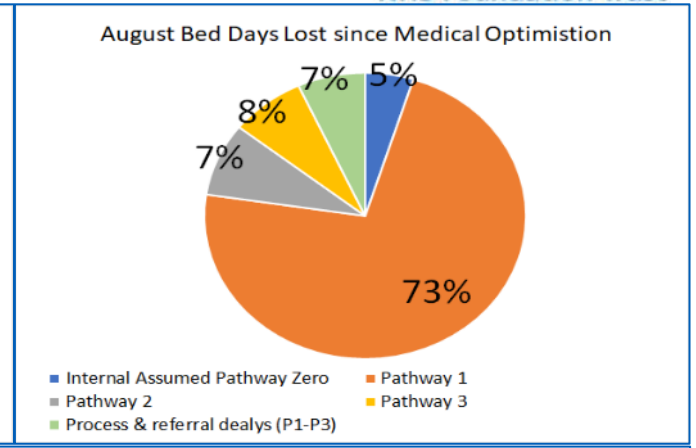
Discharge & Delays











Discharge and Delays – Discharges Jan 23 to present

During the day (on average) 124 patients don't meet the criteria to reside. We discharge on average 78 of these patients per day (63%):

- 57% of the discharges occur before 5pm (circa 44 patients) (12% of these discharges occur before 12 noon (4 of the 45 patients)
- 43% of the discharges occur after 5pm (34 patients)
- The total number of bed days accrued since medical optimisation **for discharged patients**, shown in the chart (left). Having reduced significantly in April, the figure has increased in each of the past 2 months from 1851 in June to 2467 in August. In the current financial year, on average 2058 bed days have been lost each month.

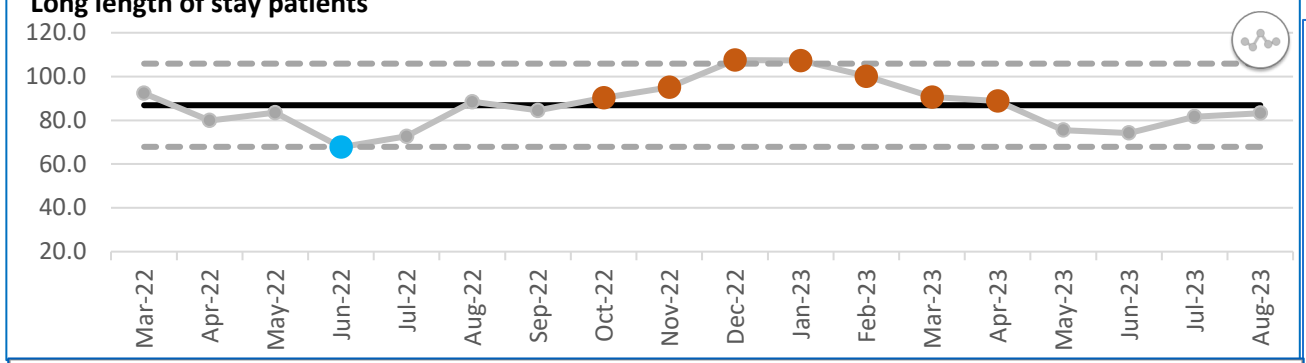
August Update:

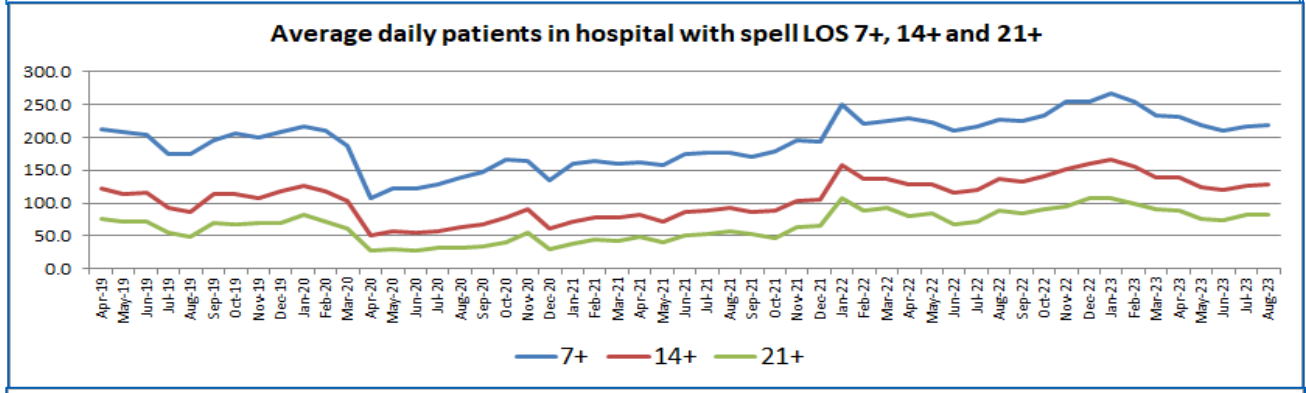
- Av. daily admissions: 87 per day (89 July) (range 52–117) / Average daily discharges: 85 per day (range 35-115) (86 July)
- CTR average daily patients – 121 per day, a slight fall from 123 in July.
- CTR average discharges - 74 per day, an increase from 72 in July
- 58% of discharges occur before 5pm, slight fall from 60% July
- Pathways 1-3 accounted for 73% of the patients and 88% bed day delays, Internal assumed pathways zero and process and referral delays account for 27% of the patients and 12% of the bed days delayed
- The average daily number of patients who no longer meet the criteria to reside fell in August to 46, from 51 in July, and which remains below the December high of 56. Out of area patients continue to account for variable but signficant proportions of our Hub discharges (Sunderland and Durham).
- Trust has the highest bed occupancy levels in ICS since June 22. August's bed occupancy averaged 94.6%, a very slight fall from 94.8% in July (ICS average 88.5% August). Bed occupancy remains consistently well above 92% threshold, using 7 day rolling average basis, however with some significant fluctuations below towards the target in these latter more recent months.

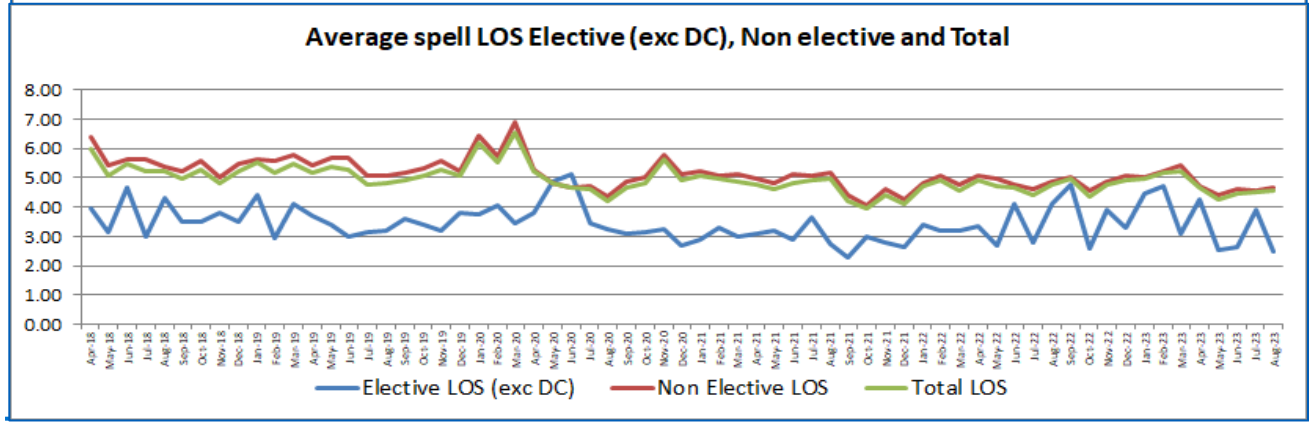
Report by exception: Long Length of Stay Patients

Effective

Gateshead Health NHS Foundation Trust





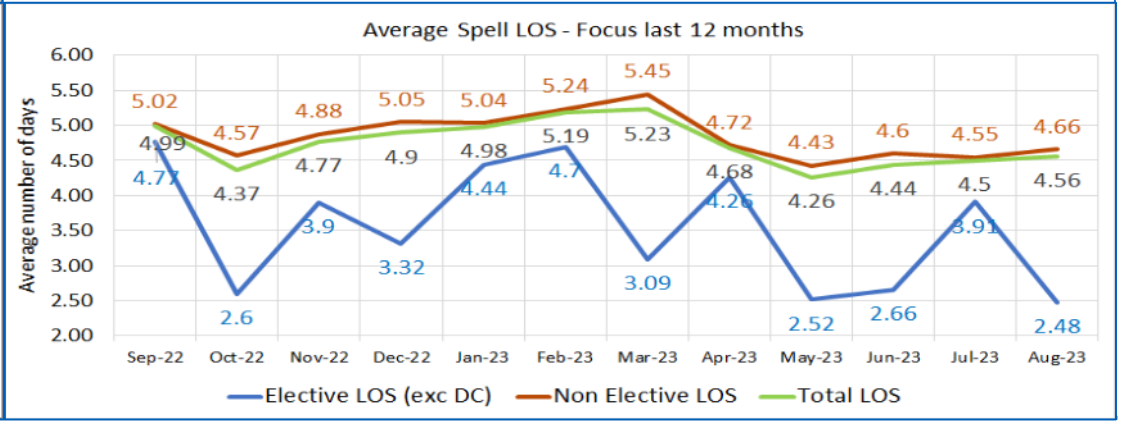


Situation

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

Background

- An expectation that the daily average number of patients staying 21+ days would not exceed 59. The ECIST existing target of 59 is subject to either pass or fail based on common cause variation.
- The number of LLOS patients increased in August to 83.3 from 81.7 in July.
- The number of patients in the hospital with spells of more than 7+, 14+ and 21+ days had reduced in calendar year 2023, however increased in all areas in July 23 and August.
- In August there was a daily average 218.6 patients in the hospital with a spell of 7+ days, a 1.7% increase from 216.9 in July
- A daily average of 129.2 patients in the hospital with a spell of 14+ days, a 2.1% increase from 127.1 in July
- A daily average of 83.3 patients in the hospital with a spell of 21+ days, a 1.6% increase from 81.3 in July
- The Trust average length of stay of elective patients (excluding day cases) fluctuates each month, reducing significantly in August to 2.48, from 3.91 in July
- Total LOS remained fairly stable at 4.56 in August, compared with 4.5 in July. Whilst non elective LOS increased slightly from 4.55 to 4.66. Both figures remain well below the highs of March 23.



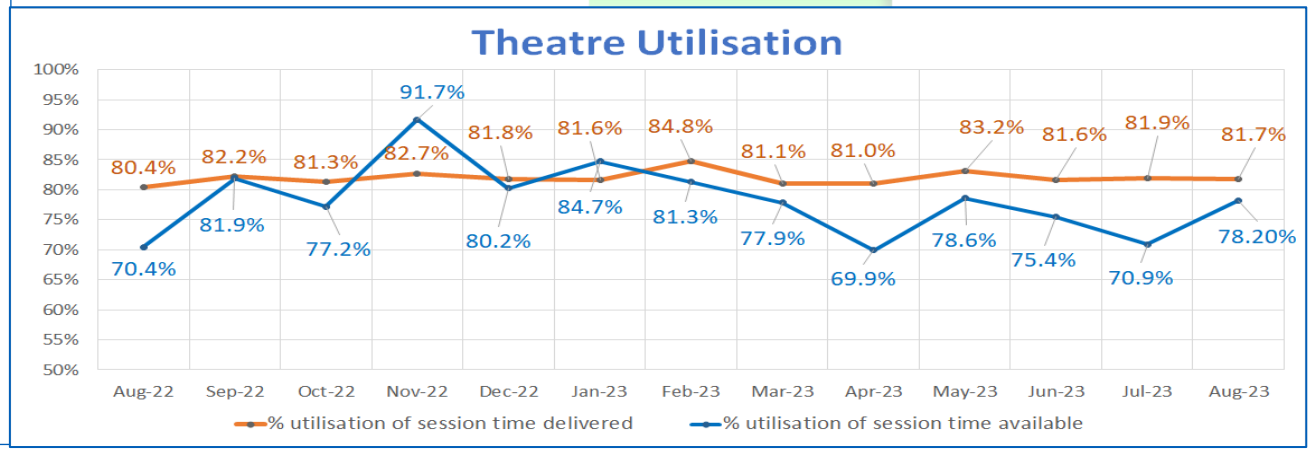
Efficiency and Productivity – Theatres

Effective

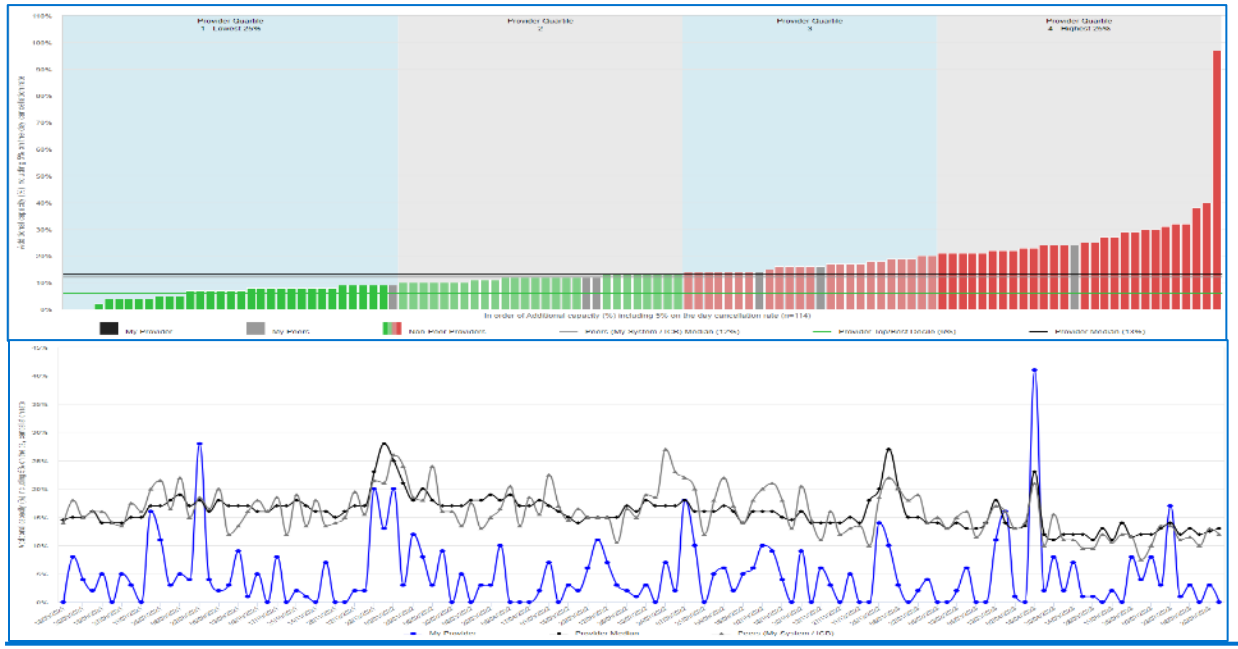
Gateshead Health NHS Foundation Trust

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

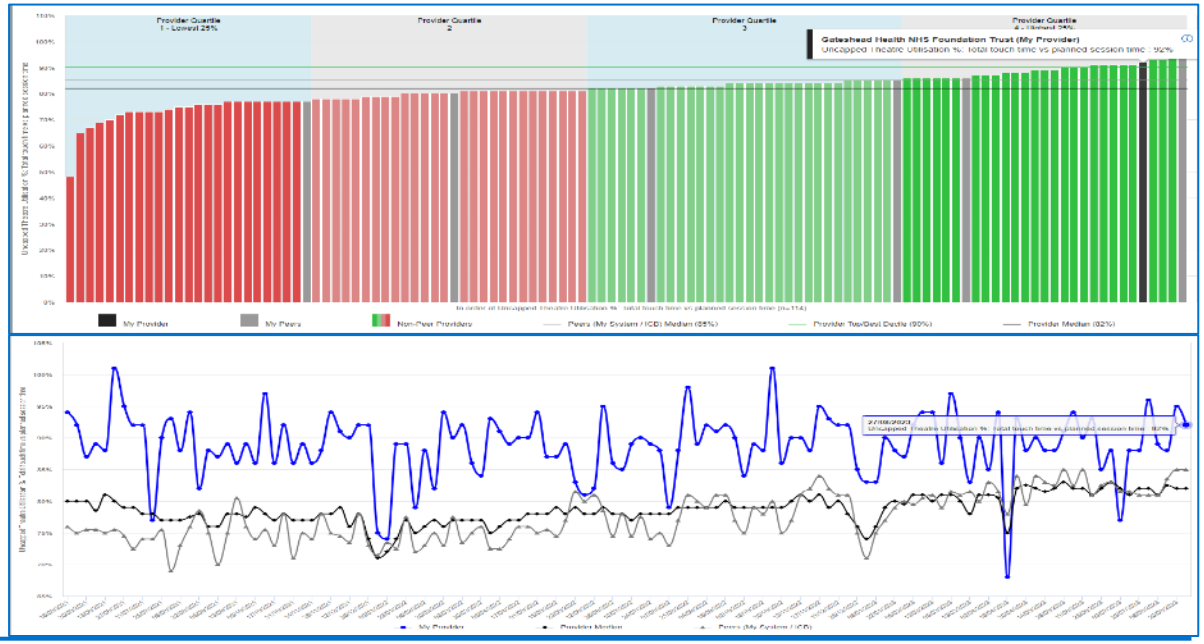
- Maximise our running theatre sessions > =85% with appropriate volumes of cases per list. At the end of August, the Trust continued to be below the threshold at 81.7%, but almost the same as July which was 81.9%
- Maximising the use of the theatre session time available is also an area of improvement. The chart right, now factors in funded capacity. From a high of 91.7% in November the general overall monthly trend has been of lower performance, ranging between 84.7% and 69.9%. In August the figure improved to 78.2% from 70.9% in the previous month.
- Latest published National data shows the Trusts performance on Uncapped theatre utilisation rate of 92% for touch time/planned, which is higher than the latest peer average of 85% and latest national average of 82%. The Trusts Capped theatre utilisation rate of 88.4% for touch time/planned is again higher then latest peer average of 78.5% and national average of 76.9%.
- National data also benchmarks well in relation to additional capacity (%) including 5% on the day cancellation rate which stands at 0%, and continues to be in the best performing quartile, lower than the latest peer average (12%) and national average (13%).



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



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



UEC Measures

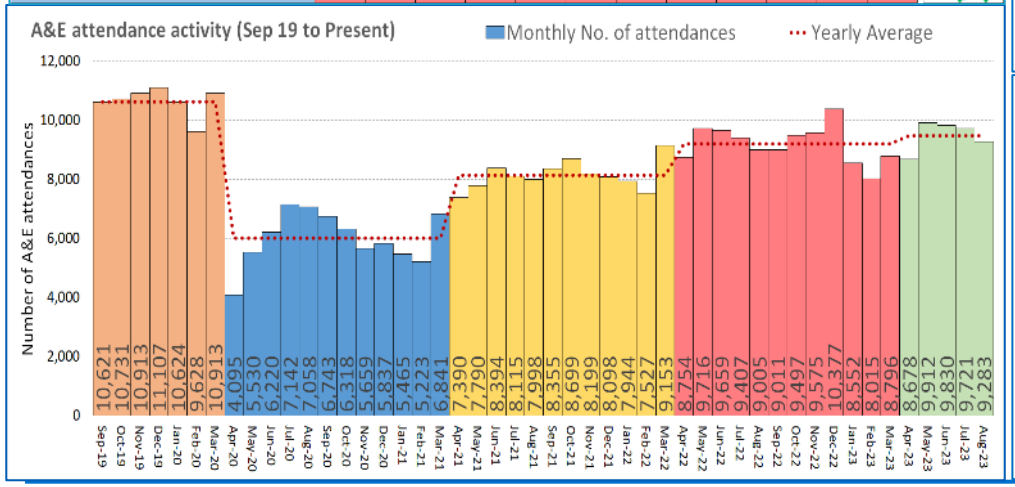
Responsive

Gateshead Health NHS Foundation Trust

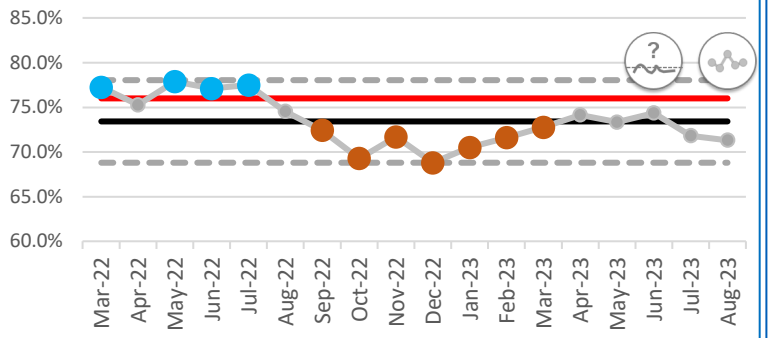
NHSI SOF Operational Performance & National Operational Standards

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

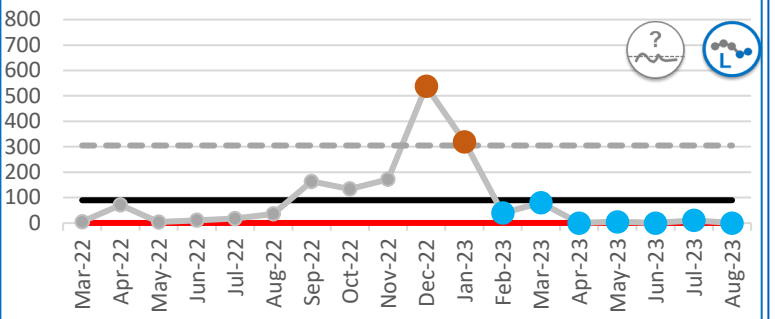
	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Monthly Trend
Attendances: Type 1	5796	6254	6220	7012	5500	5255	5940	5843	6499	6000	6178	5803	
Attendances: Type 3	3215	3243	3355	3365	3052	2760	2856	2835	3413	3830	3543	3480	
Total Attendances	9011	9497	9575	10377	8552	8015	8726	8678	9912	9830	9721	9283	
Total Breaches	2484	2918	2709	3237	2522	2275	2395	2243	2641	2520	2739	2662	
Trust Total - % seen in 4 hours	72.4%	69.3%	71.7%	68.8%	70.5%	71.6%	72.6%	74.2%	73.4%	74.4%	71.8%	71.3%	
National Rank (Accute trusts - Lower is better)	33	38	31	25	50	47	37	43	44	39	55	50	
12 hour trolley waits (DTA breaches)	164	134	172	538	320	40	80	0	5	0	11	0	
Volume in department >12hours	703	731	738	1116	710	325	496	237	355	395	380	404	
A&E >12hour waits (target <2%)	7.80%	7.70%	7.71%	10.75%	8.30%	4.05%	5.68%	2.73%	3.58%	4.02%	3.91%	4.35%	
Peadiatric Type 1 Attendances (number)	886	1070	1388	2030	977	946	1103	1003	1172	1014	1042	706	
Peadiatric Type 1 Attendances (% of all attendances)	9.8%	11.3%	14.5%	19.6%	11.4%	11.8%	12.6%	11.6%	11.8%	10.3%	10.7%	7.6%	
Average bed occupancy	96.8%	96.7%	96.5%	96.6%	95.4%	94.4%	94.6%	94.9%	95.6%	94.4%	94.8%	94.6%	



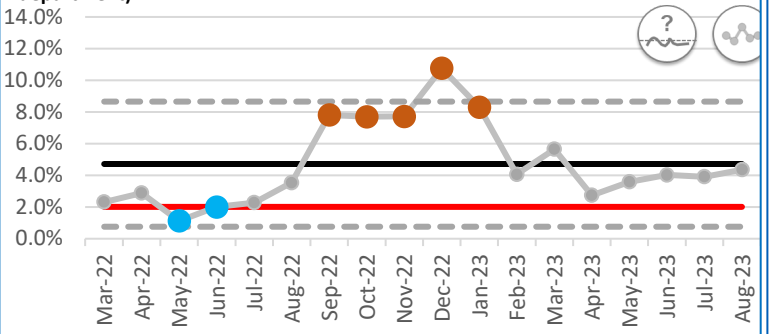
UEC 4 hour



12 hour trolley waits (from DTA to left department)



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



Situation

- Attendances decreased in August to 9,283 from 9,721 in July, daily attendances averaged 9 per day more than August 2022 (representing an increase of 3.1%).
- The Trust ranked 50th nationally in August, compared to 55th in July.
- Overall time in the department for non-admitted patients was 2 hours 50 minutes (+3 mins to July) and admitted patients 8 hours 18 minutes (+11 mins to July). Analysis shows that 4-hour performance differs significantly for admitted and non-admitted patients.
- The target for 12 hr dept times of no more than 2% of all attendances has not been met since June 22, and increased to 4.35% of attendances (404) in August, compared with 3.91% (380) in July.
- There were **zero** 12hr DTAs in August, down from 11 in July, the total year to date in August is 16 since April. The same period last year saw 140 12 hr DTAs.
- Bed occupancy levels remained fairly stable at 94.6% compared to 94.8% the previous month. However, there was a daily peaks of 98.9% on the 29th August.
- General and Acute beds open in August averaged 433 for the month, slightly below the planned level of beds of 434, and lower than July .

Context:

- Urgent and Emergency Care remains under pressure however, with some of the highest monthly attendance numbers since Covid however attendances did reduce in the latest month. Challenges remain however as a result of high bed occupancy, pressures on social care discharges, IPC bed closures other challenges in the managing and placing of patients.
- The Trust was at OPEL 2 throughout the whole of April, with exception of one day. The ratio changed in May with 23 out of 31 days spent at OPEL3 (74%), 16/30 days in June (53%), 15/31 (47%) in July, and 12/31 (39%) in August.

UEC Measures - Ambulance Handovers

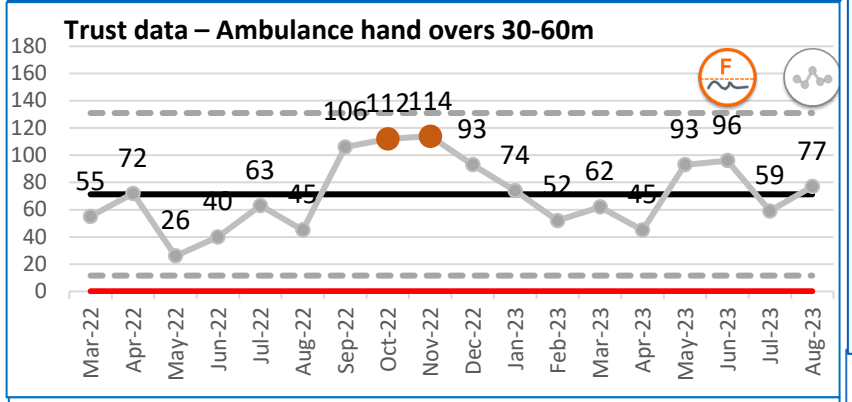
Responsive

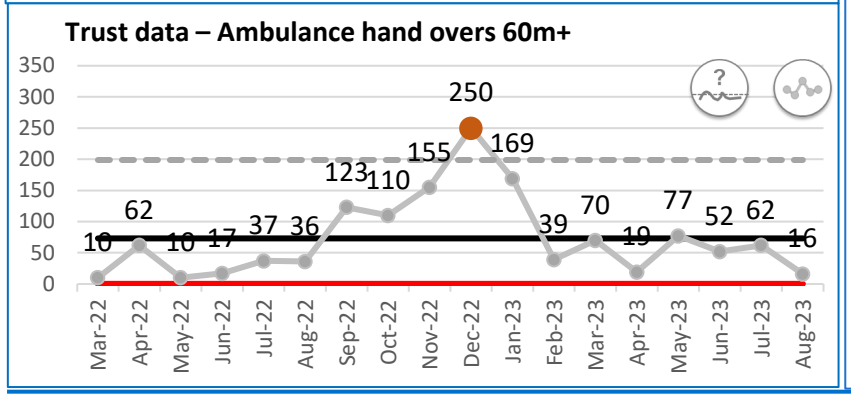
Gateshead Health NHS Foundation Trust

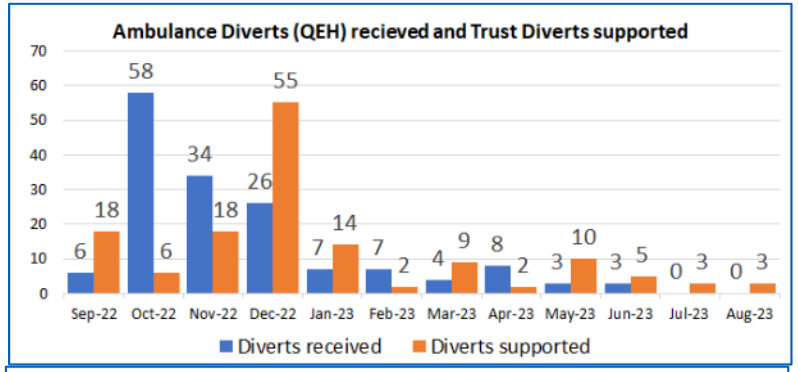
NHSI SOF Operational Performance & National Operational Standards

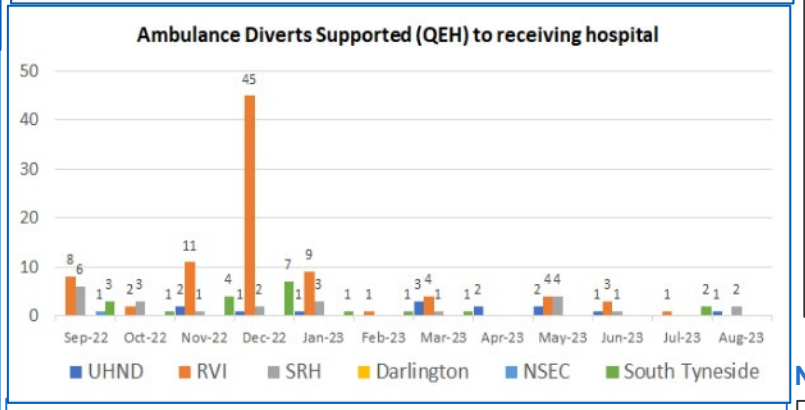
1. No. of ambulance delays
2. No. of ambulance diverts

Ambulance Arrivals and handover delays	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Monthly Trend
No. Patients arriving by Ambulance	1753	1708	1679	1563	1629	1597	1778	1809	1885	1821	1941	1875	
% of handovers <15 Minutes	38.2%	34.7%	33.6%	24.7%	39.5%	48.6%	48.0%	48.0%	40.3%	46.6%	47.7%	48.3%	
% of handovers 30-60 Minutes	93.0%	92.9%	92.2%	93.4%	94.9%	96.3%	95.9%	97.1%	90.5%	94.1%	96.5%	95.3%	









Situation

- April to August has consistently seen some of the highest number of Ambulance arrivals in the past 12 months, averaging 1866 per month YTD, with the highest month in July with 1941 arrivals. In August there were 1875. which remains slightly above the period average.
- In August the Trust received no diverts for the second month in a row. But was supported with 3 diverts, 2 to Sunderland and 1 to UHND.
- 95.3% of patients arriving by ambulance waiting between 30-60 minutes for handover, just above the 95% target but a reduction from 96.5% in July. 48.3% of handovers were within 15 mins, which is an improvement from 47.7% lasty month.
- In August 23, there were 77 30-60 minute delays reported and 16 60+ minutes delays.
- NEAS handover date in August shows the Trust had the fewest, so was top performing Trust in the (ICS) region for 30-60m Ambulance hand-over times, and remained 3rd best for 60+ minute handovers.

NEAS Handover Data – 30-60 minutes (benchmarking)

	2019/20														
Provider	Avge	Min	Max	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
Gateshead Health NHS Foundation Trust	40	5	99	48	117	105	116	101	84	54	77	51	90	100	61	81
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	93	65	109	93	114	137	121	161	139	137	136	146	183	137	166	226
Northumbria Healthcare NHS Foundation Trust	472	283	723	556	557	484	405	426	350	288	355	273	383	441	172	314
South Tees Hospitals NHS Foundation Trust	138	105	184	413	452	339	319	187	383	368	387	429	386	387	445	437
North Tees & Hartlepool NHS Foundation Trust	64	42	116	105	87	152	134	160	139	54	55	112	87	71	124	98
County Durham & Darlington NHS Foundation Trust	313	165	438	367	368	394	373	285	225	170	237	171	151	179	193	165
South Tyneside and Sunderland NHS Foundation Trust	313	208	471	462	422	520	468	459	413	267	375	335	380	348	291	269
North Cumbria University Hospitals NHS Trust	405	265	559	297	303	316	320	381	271	111	216	172	126	135	110	126
NENC	1836	1308	2612	2341	2420	2447	2256	2160	2004	1449	1838	1689	1786	1798	1562	1716

NEAS Handover – 60 minutes + (benchmarking)

	2019/20														
Provider	Avge	Min	Max	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
Gateshead Health NHS Foundation Trust	21	0	81	41	125	132	174	279	170	49	62	20	77	53	76	21
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	2	0	6	3	1	10	8	12	9	7	13	8	10	7	17	16
Northumbria Healthcare NHS Foundation Trust	79	24	206	102	125	171	123	236	90	20	72	27	50	102	7	39
South Tees Hospitals NHS Foundation Trust	47	10	117	200	246	289	278	328	174	202	276	206	174	223	134	162
North Tees & Hartlepool NHS Foundation Trust	6	1	18	30	23	39	40	118	96	4	7	22	10	14	16	6
County Durham & Darlington NHS Foundation Trust	178	32	404	373	425	449	410	526	278	60	83	42	28	36	20	11
South Tyneside and Sunderland NHS Foundation Trust	117	23	268	160	100	270	205	407	281	58	198	111	157	70	46	40
North Cumbria University Hospitals NHS Trust	72	26	117	184	228	209	238	319	165	52	115	33	73	42	33	46
NENC	522	227	1138	1093	1273	1569	1476	2225	1263	452	826	469	579	547	349	341

Community Waiting List and 2hr Rapid Response

Responsive

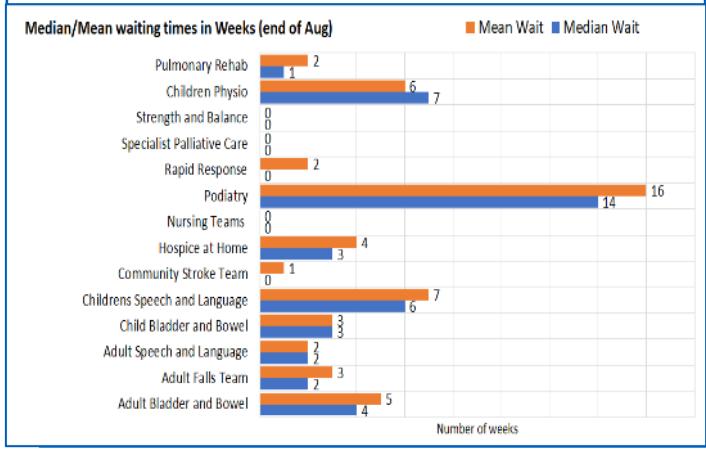
NHS Gateshead Health NHS Foundation Trust

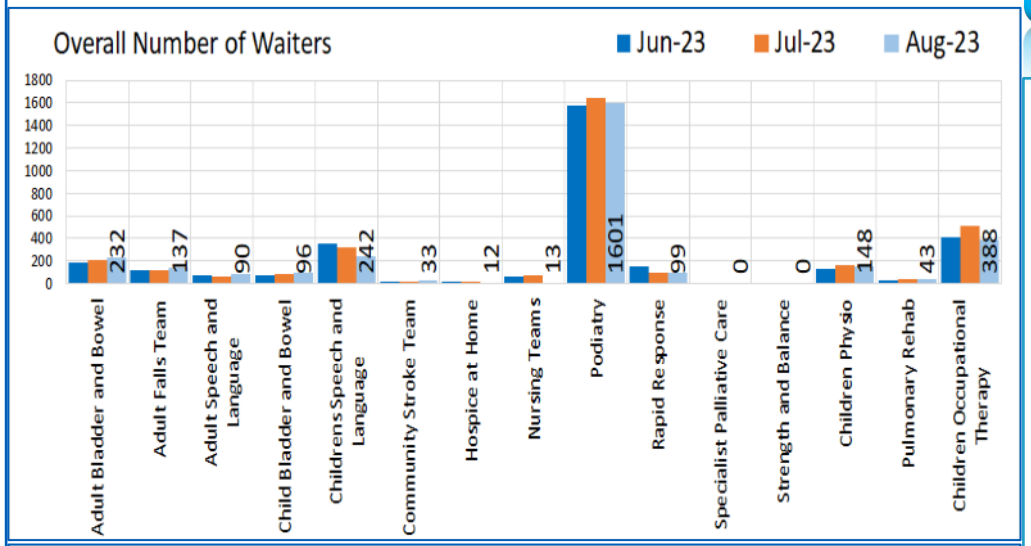
Context
Community waiting list data is now submitted as part of the monthly Community Health Services SITREP. The following data is a summary of the latest submission as the 18 August 23. **Note:** CYP Occupational Therapy service is in the process of transferring data across to the EMIS system, therefore is captured manually with plans for electronic reporting in the upcoming months.

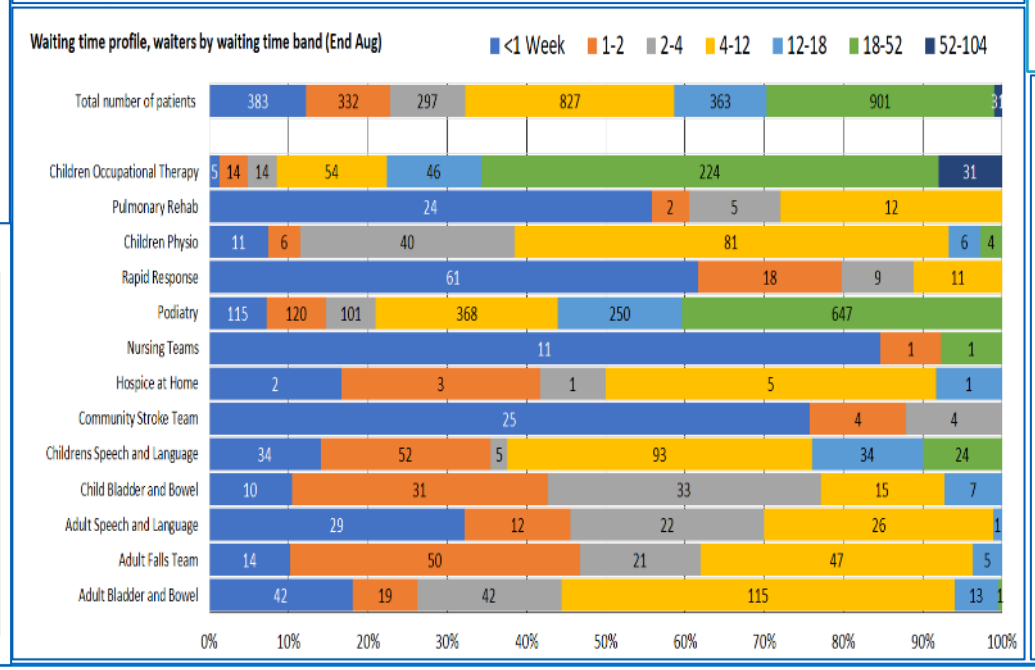
Key points

- As at end of August, there were 3134 patients awaiting assessment, which is an 11% increase since April 23, but a 7.3% from the end of July when the figure stood at 3381.
- At the end of August, 51.1% of patients were on the waiting list for Podiatry, followed by 12.4% for Children's OT and 7.7% for Children's SALT (chart to the right). Each of these cohorts of patients have reduced in the latest month.
- The longest average waits are seen in Podiatry, where average waiting times are between 14 to 16 weeks, this has reduced from last month.
- Of the total waiting lists (chart middle bottom), 70% of patients were waiting less than 18 weeks for assessment, 28% waited between 18-52 weeks, and 1% (31 patients, down from 88 last month) waited between 52-104 weeks; of which, all 31 were waiting within the Children's OT service.

Next Steps:
Routine reporting and monitoring of this data has been mainstreamed into Community performance reporting. Work is ongoing to validate current waiting lists.

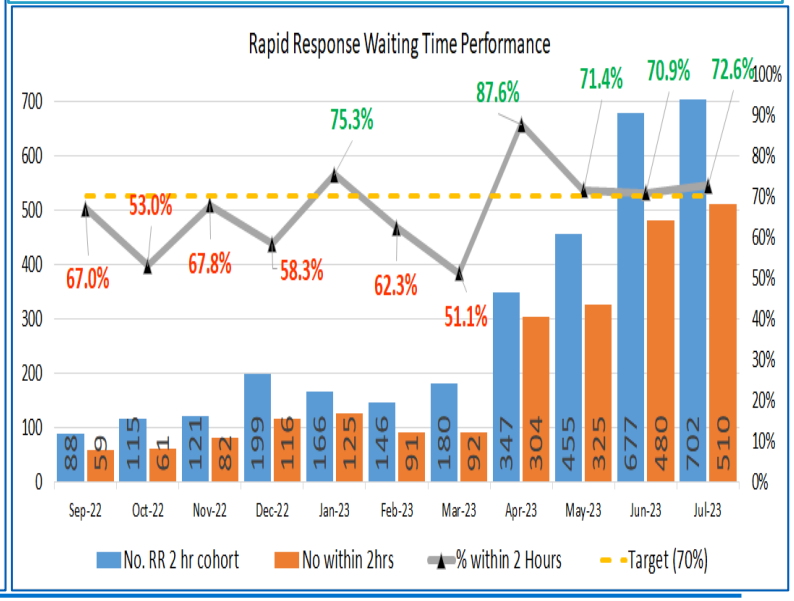






Background
Following a revision to guidance in April 23, work has been undertaken within the Community Business Unit to ensure additional activity which the services undertake, including new activity that now fits the criteria for the performance measure, is being captured appropriately in order to be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

Rapid Response
Latest validated month for July shows the Rapid Response team responded to 702 two-hour Urgent Community Responses (UCRs), of which 510 were seen within 2 hours, exceeding the 70% target at 72.6% for the fourth month in a row. Cumulatively since April, the service stands at 72% validated performance. **August data is not yet validated and will be included in next month's report.**



Elective Care Activity & Recovery

Responsive

Gateshead Health NHS Foundation Trust

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

Elective Activity - % of planned for levels 23/24 achieved	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Year To Date
Total - Comined Elective Activity (>100%)	100.7%	101.4%	117.9%	95.1%	108.8%		104.4%
Daycase (>100%)	85.9%	100.6%	119.9%	92.8%	109.8%		101.3%
Elective Overnights (>100%)	79.1%	75.4%	71.1%	73.1%	88.6%		77.0%
Outpatient - New (>100%)	87.3%	94.4%	100.2%	85.8%	102.8%		93.9%
Outpatient - Followup (Less than <100%)	109.6%	104.9%	127.2%	99.8%	111.4%		110.0%
Total Outpatient	103.0%	101.9%	118.5%	95.7%	108.9%		105.2%

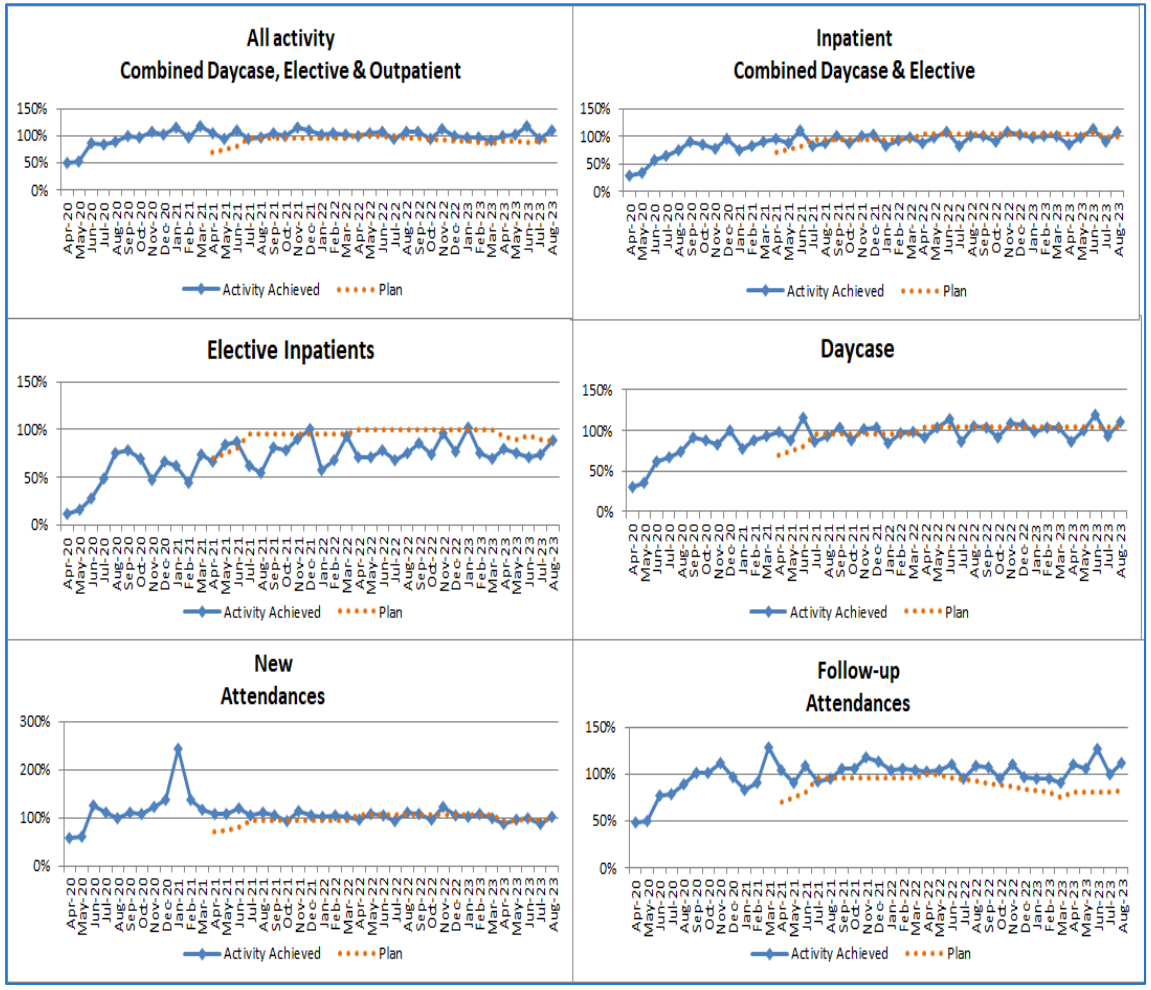
August activity is above planned levels with **Combined elective activity at 108.8%,** and 104.4% year to date:

- **Day case** activity was 109.8% in month, 101.3% year to date
- **Elective inpatients** 88.6% in month, the best month so far this year, and 77.0% year to date
- **New Outpatients** 102.8% in month. 93.9% year to date
- **FU Outpatients** 111.4% in month and 110.0% year to date

A combined rolling cumulative year to date figure is now included in the table above to identify the overall level of activity achieved as the year moves on, as well as individual in month achievement. Overall, Trust Activity this year is above planned levels, this however has largely been driven by above plan levels of day cases, but also follow-up outpatient activity which was planned to reduce, but this has not been the situation so far. Follow-up outpatient volumes have exceeded planned for levels in 4 out of 5 months this year. Elective overnight and new outpatient activity year to date or both below planned for levels overall.

Other key requirements in August:

- The Trust is reporting 24.24% of all outpatient attendances conducted remotely, which is slightly below the 25% expectation but consistent with other months.
- 3.27% of all OP appointments recorded as Patient Initiated Follow-Up, which is slightly below planned levels of 5.0% but continues to benchmark well regionally



Activity & Recovery - Diagnostics

Responsive

NHS Gateshead Health NHS Foundation Trust

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

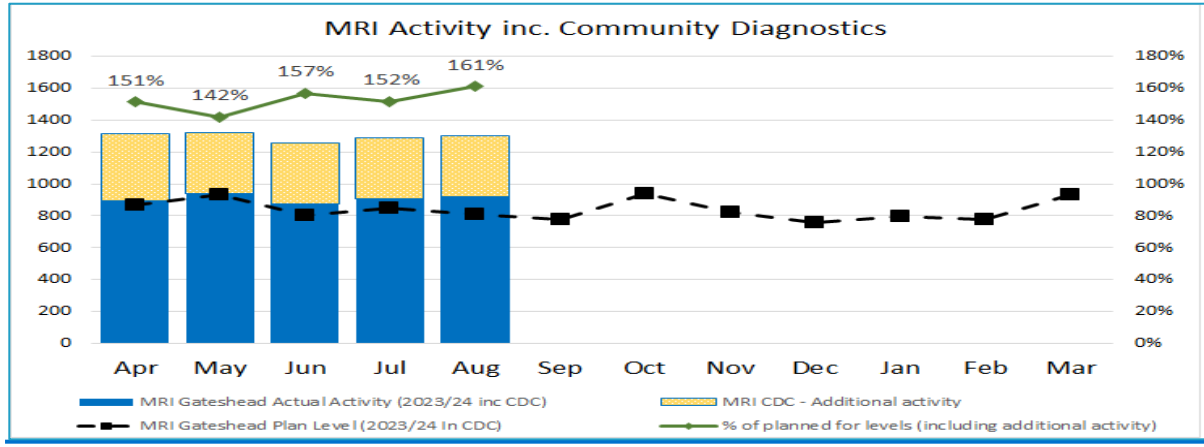
Diagnostic Activity - % of planned for levels 23/24 achieved	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Year to date
Total (>100%)	95.4%	96.1%	105.3%	90.5%	102.3%		97.8%
MRI (>100%)	103.0%	101.4%	109.2%	106.9%	113.9%		106.7%
CT (>100%)	103.5%	101.7%	102.3%	98.3%	102.3%		101.6%
Colonoscopy (>100%)	86.7%	121.0%	128.7%	100.3%	104.1%		108.0%
Non Obs Ultrasound (>100%)	90.2%	86.3%	99.5%	76.8%	93.6%		89.1%
Flexi Sigmoidoscopy (>100%)	65.6%	108.2%	85.2%	79.2%	106.6%		87.6%
Gastroscopy (>100%)	72.7%	104.6%	124.7%	87.5%	136.1%		102.6%
Echo (>100%)	99.4%	96.4%	125.7%	101.9%	113.8%		106.9%
Endoscopy (>100%)	77.1%	111.5%	120.1%	91.8%	118.3%		102.8%

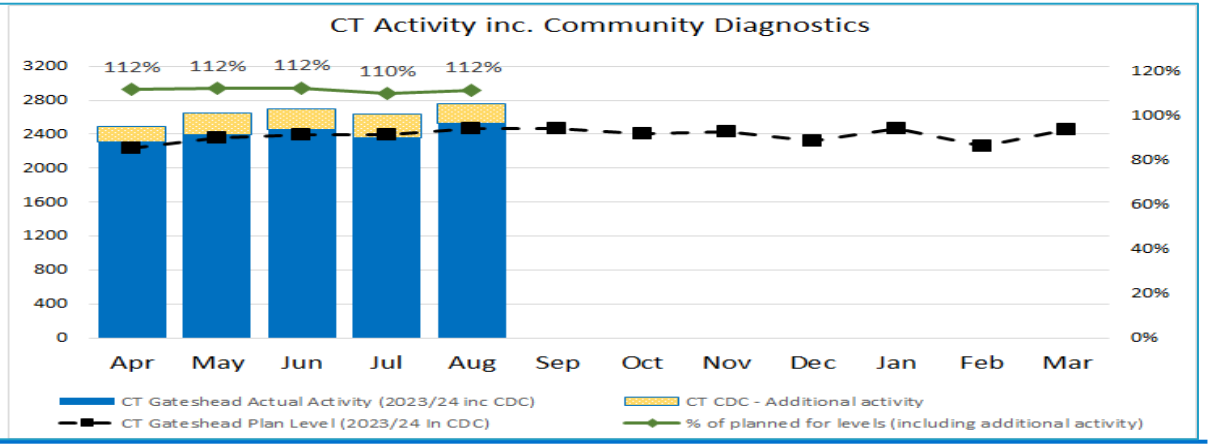
Note: The tests listed on this page are not all diagnostic activity tests undertaken by the Trust, only those that form part of the 23/24 Operational Plan expectations. This page monitors delivered activity against those planned for levels only. Activity in the table right reports on Gateshead only activity,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

In August the overall level of diagnostic activity delivered against plan for levels was above target reporting 102.3% of planned activity, an increase from 90.5% in July. Year to date the figure stands at 97.8% of overall planned activity being achieved.

MRI continues to achieve and exceeded planned levels of activity in all months and overall year to date. MRI, CT, Colonoscopy, Gastro and Echo are all achieving planned for levels year to date. In August when adding on non-Gateshead activity the percentages of activity delivered including CDC were 161% for MRI and 112% for CT.

The combined endoscopy tests achieved 118% of planned levels of activity in August through the use of insourcing, and 102.8% year to date NOUS is the only test consistently below planned for levels of activity, at 93.6% in August and 89.1% year to date.





Maximum 6-week wait for diagnostic procedures

Responsive

Gateshead Health NHS Foundation Trust

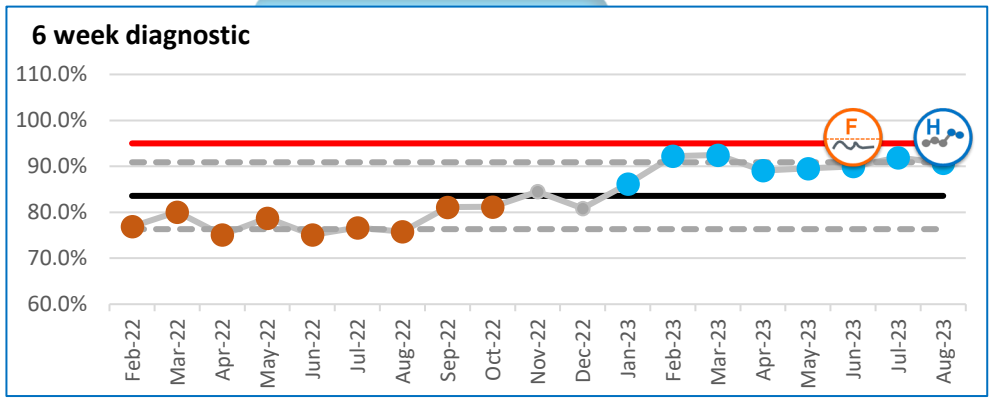
NHSI SOF Operational Performance & National Operational Standard

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

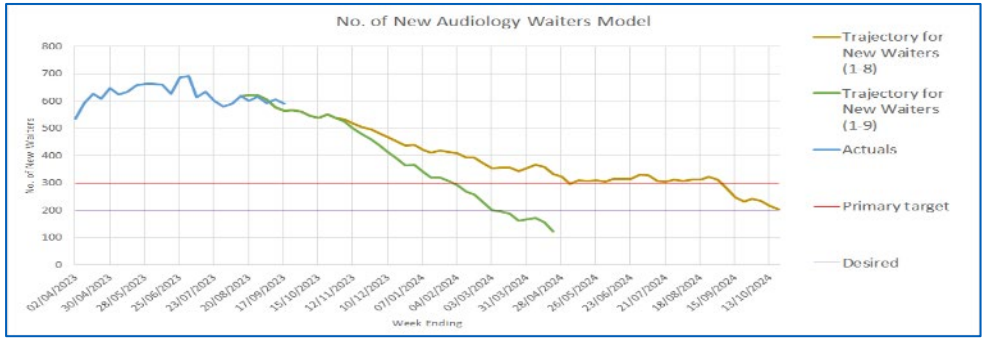
Trust Diagnostic performance:

- Performance 90.7% in August, a slight decrease from 91.9% in July. Overall, Trust performance remains below 95% target.
- August's performance however continues to be above latest NENC average of 83.3% (July 23) and continues to exceed the latest national average of 74.5% (July 23).
- Numbers waiting for a diagnostic test fell from 5576 in July to 5492 in August, with the number of patients waiting >6 weeks however increasing from 451 to 512.
- Currently two particular areas stand out in relation to risks in achieving the Trust wide 95% standard:
- First in Audiology, who account for 288 (56.3%) of the long waiters. Audiology is the single largest risk area in achieving the 95% standard for the Trust. Audiology performance was the lowest of any test in August and fell slightly in August to 55.5% from 56.7% in July. The service have identified a number of challenges impacting on and have developed a recovery plan, which is being monitored as part of the weekly Performance Clinics. Recovery trajectories have been developed based on different scenarios (chart right) which show recovery is not likely to be before February 24 at the earliest.
- Secondly Barium Enema, which has the second lowest percentage performance of any test in August, having seen waiters increase from 70 to 106 between June and August. And the number of patients waiting >6 weeks increase from 1 to 42. The service have identified a number of challenges impacting on and have developed a recovery plan, which is being monitored as part of the weekly Performance Clinics. Recovery trajectories have been developed (chart bottom right) which show recovery is planned to be achieved in November.
- The 4 tests that are part of Endoscopy (Colonoscopy, Flexi Sig, Gastroscopy and Cystoscopy) have noted some improvement in August, which has been supported through the use of insourcing throughout August. As a result, the overall number waiters for these tests have reduced from 891 to 809 (10.1% reduction) and overall long waiters in this cohort reduced from 101 at the end of June, to 82 at the end of August (18.8% reduction). However, with the exception of Cystoscopy which was 94.5% in the latest month, the remaining 3 tests of Colonoscopy, Flexi Sig, Gastroscopy remain below the 95% target.

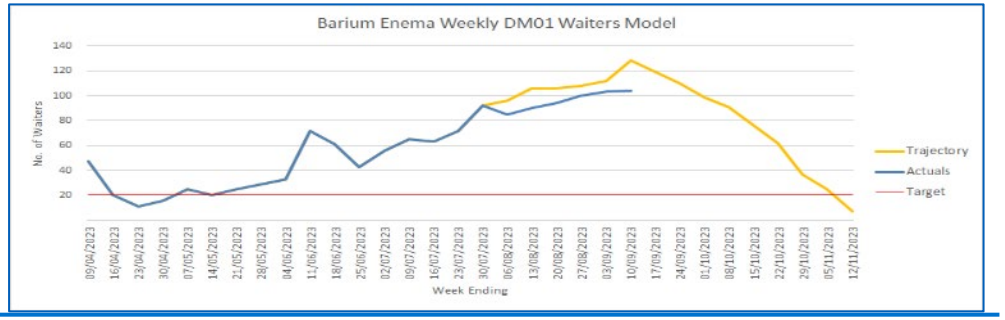
	95 % Standard												
Diagnostic waiters <6 weeks	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Trend
Trust Total (95%)	95.0%	81.2%	84.5%	80.8%	86.2%	92.2%	92.5%	89.1%	89.5%	90.0%	91.9%	90.7%	
Barium Enema (95%)	97.6%	100.0%	100.0%	100.0%	97.8%	100.0%	100.0%	100.0%	100.0%	98.6%	85.7%	60.4%	
CT (95%)	99.8%	99.5%	99.3%	99.0%	99.5%	99.3%	99.2%	99.4%	99.8%	99.1%	98.6%	98.8%	
MRI (95%)	98.9%	99.3%	98.4%	95.4%	97.6%	99.7%	100.0%	99.7%	100.0%	100.0%	98.4%	99.4%	
Non-Obstetrc Ultrasound (95%)	99.3%	99.3%	99.6%	99.6%	99.4%	99.4%	99.5%	99.2%	98.9%	99.5%	98.4%	97.4%	
Audiology (95%)	54.9%	48.9%	52.0%	42.3%	51.1%	65.2%	60.1%	51.4%	52.6%	52.0%	56.7%	55.5%	
Urodynamics (95%)	95.2%	96.0%	97.4%	90.7%	91.2%	100.0%	88.2%	92.6%	100.0%	94.4%	96.9%	95.8%	
Colonoscopy (95%)	96.2%	94.5%	98.2%	93.5%	96.3%	92.1%	86.8%	81.6%	85.5%	89.3%	92.3%	90.4%	
Flexi-Sig (95%)	97.5%	100.0%	98.2%	94.5%	96.4%	93.1%	92.1%	81.2%	89.1%	85.5%	85.7%	79.0%	
Gastroscopy (95%)	98.3%	96.9%	97.5%	95.6%	95.1%	98.7%	95.5%	91.0%	88.6%	92.8%	89.9%	90.9%	
Dexa (95%)	97.7%	98.0%	99.0%	98.5%	99.5%	98.2%	98.7%	97.4%	99.1%	98.4%	98.8%	98.9%	
Echo Cardiology (95%)	39.1%	42.7%	52.1%	42.5%	63.0%	85.3%	93.9%	90.6%	86.4%	87.3%	94.8%	94.9%	
Cystoscopy (95%)	97.8%	100.0%	100.0%	97.0%	93.1%	90.0%	91.3%	87.6%	87.4%	84.5%	89.2%	94.5%	



Audiology Waiters Trajectory from weekly monitoring:



Barium Enema Waiters Trajectory from weekly monitoring:



Referral to Treatment

Responsive

Gateshead Health NHS Foundation Trust

RTT Long Waiters (at month end)

Waiters at month end		Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Trend
Total Waiters	Actual	12430	12837	12715	12593	12753	12864	12880	13389	13381	13725	13527	13487	
52w waiters	Plan	30	20	15	10	5	2	0	100	90	80	70	60	
	Actual	91	89	95	99	84	70	86	98	145	196	236	237	
General Surgery	Actual	17	10	13	16	8	2	8	14	13	21	25	26	
Gynaecology	Actual	2	0	1	0	1	0	4	2	2	2	3	6	
Trauma & Orthopaedics	Actual	31	17	16	16	9	11	8	10	22	25	34	45	
Urology	Actual	1	1	1	1	1	4	2	4	9	10	10	9	
Paediatrics	Actual	17	24	32	30	42	33	45	44	70	82	104	92	
Cardiology	Actual	2	3	1	5	7	7	1	2	0	1	0	1	
Gastroenterology	Actual	4	7	3	5	1	1	1	3	1	6	2	0	
General Medicine	Actual	0	0	0	0	0	0	0	0	0	0	0	0	
Geriatric Medicine	Actual	0	0	0	0	0	0	0	0	0	1	0	0	
Respiratory Medicine	Actual	9	13	14	16	2	2	1	0	0	0	0	0	
Rheumatology	Actual	0	0	0	0	1	0	0	0	0	0	0	0	
Other	Actual	8	14	14	10	12	10	16	19	28	48	58	58	
65 week waiters	Plan								59	52	45	38	31	
	Actual								6	4	14	17	45	
78 week waiters	Plan	0	0	0	0	0	0	0	0	0	0	0	0	
	Actual	5	2	3	2	0	0	0	0	0	0	0	0	

RTT % Within 18 weeks	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Monthly Trend
Trust (92%)	74.3%	73.4%	72.1%	68.7%	70.2%	70.5%	71.0%	69.9%	72.4%	70.7%	70.6%	68.9%	
General Surgery (92%)	79.8%	79.0%	78.6%	73.0%	71.7%	69.7%	68.9%	67.6%	69.6%	68.3%	67.2%	67.4%	
Gynaecology (92%)	81.7%	80.5%	78.8%	77.2%	72.8%	70.4%	72.5%	68.1%	68.4%	66.3%	67.3%	65.9%	
Trauma & Orthopaedics (92%)	63.2%	62.6%	61.7%	57.6%	58.6%	60.4%	59.3%	55.4%	57.4%	57.4%	58.3%	57.1%	
Urology (92%)	77.5%	76.2%	75.2%	69.9%	68.1%	74.5%	75.4%	70.5%	73.7%	69.4%	64.0%	67.6%	
Paediatrics (92%)	68.5%	69.1%	68.1%	67.1%	67.8%	69.0%	67.8%	65.4%	67.6%	65.7%	64.8%	60.4%	
Cardiology (92%)	69.6%	71.2%	71.6%	70.3%	73.8%	75.7%	75.2%	79.1%	82.6%	79.2%	73.7%	70.2%	
Gastroenterology (92%)	80.8%	77.2%	71.5%	67.1%	72.6%	72.1%	77.4%	79.1%	87.0%	83.2%	81.2%	78.2%	
General Medicine (92%)	76.9%	88.9%	88.9%	81.8%	91.8%	95.5%	94.2%	94.3%	90.7%	96.2%	93.1%	83.0%	
Geriatric Medicine (92%)	89.1%	86.8%	83.4%	78.2%	81.9%	84.0%	79.7%	79.5%	78.4%	76.1%	80.5%	81.2%	
Respiratory Medicine (92%)	64.4%	60.9%	66.8%	65.3%	79.4%	79.1%	76.9%	79.4%	88.5%	89.2%	88.5%	83.3%	
Rheumatology (92%)	82.6%	83.2%	78.9%	75.9%	87.4%	93.3%	91.5%	90.8%	94.2%	94.3%	92.6%	93.0%	
Other (92%)	69.2%	69.2%	67.2%	65.4%	66.8%	67.8%	68.4%	68.1%	69.4%	68.1%	71.5%	67.6%	

NHSI SOF Operational Performance & National Operational Standard

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

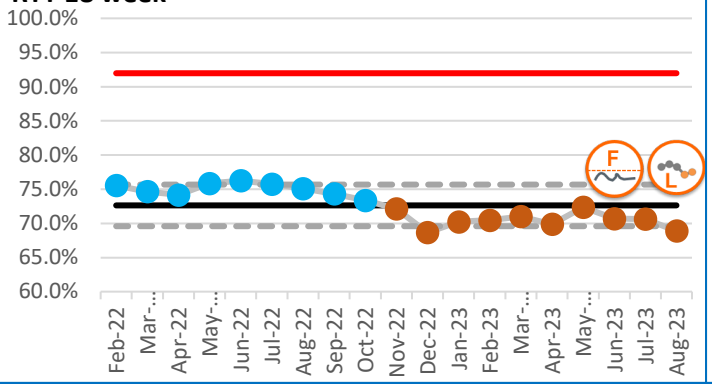
Trust RTT performance

- August Trust performance 68.9% a reduction from 70.6% in July - remaining below the 92% target.
- At 68.9% Trust performance exceeds latest national average 58.6% (July 23), but is below the ICB average of 70.1% (July 23)
- The Trusts total waiting list reduced from 13,527 in July to 13,487 in August (decrease of 40 or 0.3%).
- There continues to be no patients waiting more than 78 weeks in August, however the number waiting more than 65 weeks increased from 14 to 45, which now above planned for levels for the month (which was no more than 31)
- The number patients waiting 52 weeks continues to increase with 237 in August, however that was only 1 more than the end of July figire of 236.
- 237 is 177 above planned levels of 60 for August. The numbers in this cohort are projected to rise again in the coming months. Recovery plans have been developed in the most challenged specialities, which are being overseen as part of weekly Performance Clinics.
- The most challenged specialities for 52w waiters remain Paediatrics, Pain, Trauma and Orthopaedics and emerging pressures in General Surgery

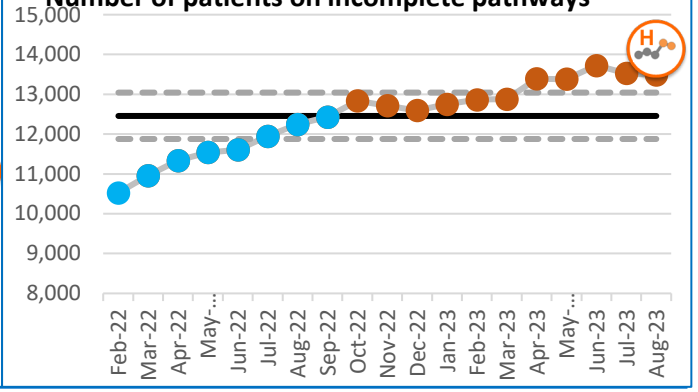
Main Risks – increasing 52w+ waiters

- **Paediatrics** – pressures continue and are increasing in Paediatric long waiters, best case projections based on current cohort indicate by the end of September there will be circa 112 over 52-week waiters. Paediatric long waiters are exclusively children aged 0-4 awaiting an autism assessment. A proposal to revisit the Pathways for these children to align them to guidance is being considered.
- **Pain** –projections based on current cohort indicate by the end of September there will be circa 79 over 52-week waiters. Locum capacity has been sought which commenced in July and will continue in September/October which will support in reducing these numbers, and new staff start in October which will provide further additional capacity to address the backlog. As a result, the service are revisiting the projections of their long waiters with an aim to achieve 0.
- **Trauma and Orthopaedics – P**rojections based on current cohort indicate by the end of September there will be circa 42 over 52-week waiters, maintaining the current position but not improving. A range of proposals are beign considered through SMT to address the challenges in T&O

RTT 18 week



Number of patients on incomplete pathways



Cancer Standards - 2 Week Waits

Responsive

NHS Gateshead Health NHS Foundation Trust

NHSI SOF Operational Performance & National Operational Standard

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

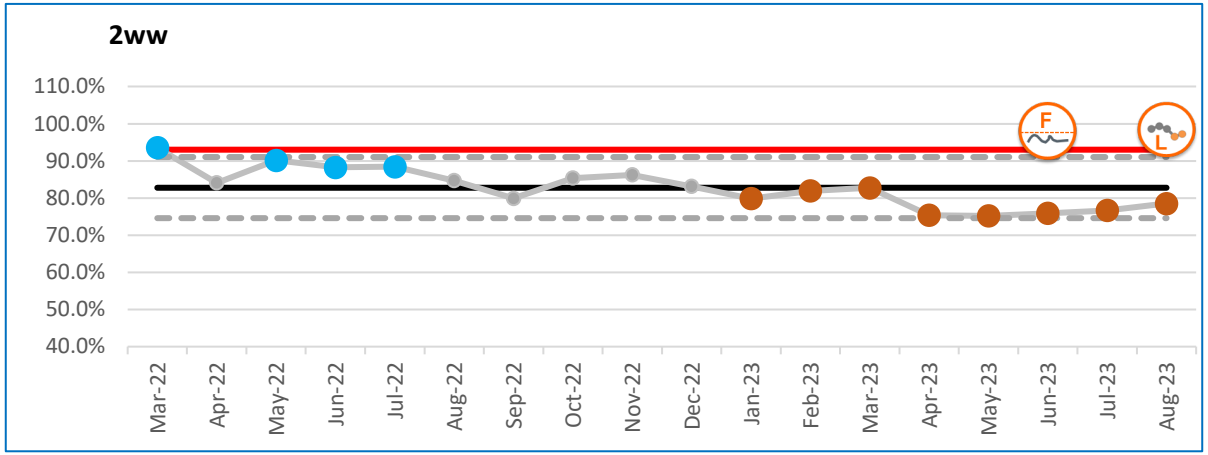
2ww performance	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Monthly Trend
Trust (93%)	79.9%	85.1%	86.6%	83.3%	79.8%	82.3%	82.7%	75.4%	75.3%	75.9%	76.2%	78.5%	
Breast (93%)	93.2%	93.2%	94.8%	88.0%	94.4%	96.7%	94.9%	90.4%	94.8%	96.6%	96.5%	94.7%	
Gynae (93%)	73.6%	85.9%	79.4%	93.7%	90.9%	91.1%	90.7%	70.4%	30.7%	7.2%	8.9%	26.9%	
Lower GI (93%)	36.4%	42.4%	40.2%	44.9%	37.5%	25.5%	35.6%	25.0%	35.3%	33.3%	43.0%	38.7%	
Testicular (93%)	100.0%	100.0%	100.0%	83.3%	100.0%	100.0%	100.0%	75.0%	75.0%	100.0%	100.0%	100.0%	
Urology (93%)	94.2%	93.7%	94.1%	86.5%	69.0%	86.0%	82.5%	79.7%	89.7%	92.5%	87.3%	94.0%	
Haematology (93%)	86.7%	100.0%	100.0%	100.0%	85.7%	91.7%	100.0%	75.0%	85.7%	100.0%	100.0%	100.0%	
Lung (93%)	47.2%	81.8%	88.6%	90.0%	90.8%	91.3%	79.3%	96.8%	94.3%	96.4%	87.0%	91.4%	
Upper GI (93%)	74.6%	76.3%	88.9%	85.5%	45.5%	62.0%	73.1%	44.7%	45.9%	59.9%	74.3%	74.2%	
												Indicative	
Symptomatic Breast (93%)	90.3%	100.0%	89.7%	100.0%	100.0%	100.0%	97.2%	91.2%	100.0%	100.0%	98.0%	100.0%	

Trust 2 week wait Cancer performance

- Trust performance for July 78.5% against the 93% target
- 78.5% is above the latest England average at 77.5% (July 23) and NENC average which is 78.4% (July 23)
- The overall 2 week wait performance has not achieved the expected level in any month of the year so far, but for the time since November 22 is above comparator averages
- Indicative performance for August is slightly increased to 78.5%

Tumour site update:

- In July Breast, Symptomatic Breast, Testicular and Haematology achieved the 93% target. Both Breast and Symptomatic Breast typically achieve the target.
- This pattern has continued in the indicative figures for August
- There was a notable reduction in Gynae overall performance at 8.9% in July, which has some early signs of improvement in August to 26.9% (indicative)
- Both lower GI and Upper GI have improved but remain below target
- Activity volumes for most tumour sites is higher than in 19/20 with the exception of some individual months and tumour sites.



Volumes as a % of 2019/20 Activity	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
Trust (100%)	112%	119%	121%	113%	121%	122%	146%	111%	112%	136%	113%	147%
Breast (100%)	121%	124%	128%	113%	119%	128%	155%	118%	119%	161%	134%	183%
Gynae (100%)	163%	196%	155%	151%	134%	135%	139%	121%	126%	177%	128%	181%
Lower GI (100%)	85%	70%	83%	85%	96%	107%	153%	105%	119%	75%	83%	96%
Testicular (100%)	100%	100%	20%	150%	140%	67%	50%	160%	50%	88%	120%	50%
Urology (100%)	132%	123%	128%	150%	155%	131%	106%	94%	100%	99%	74%	120%
Haematology (100%)	136%	88%	140%	100%	100%	240%	89%	300%	78%	157%	186%	86%
Lung (100%)	89%	153%	175%	113%	224%	157%	208%	144%	140%	185%	166%	147%
Upper GI (100%)	79%	108%	103%	96%	98%	90%	120%	76%	74%	117%	77%	91%
												Indicativ

Cancer Standards – 28 day Faster Diagnosis

Responsive

NHS Gateshead Health NHS Foundation Trust

Trust 28 day Faster Diagnosis performance:

- Trust has achieved 75% target in most months since June 22, with the exception of May
- Julys reporting showed performance at 77.0% and continues to exceed the latest national average 74.1% (July 23), but is slightly below the latest NENC average 80.8% (July 23)
- In February for the first time, both the NENC and national average achieved the 75% target, and has remained so since. However, the England average remains below target.
- Indicative performance for August shows slight improvement to 79.3% in the month

Tumour site update:

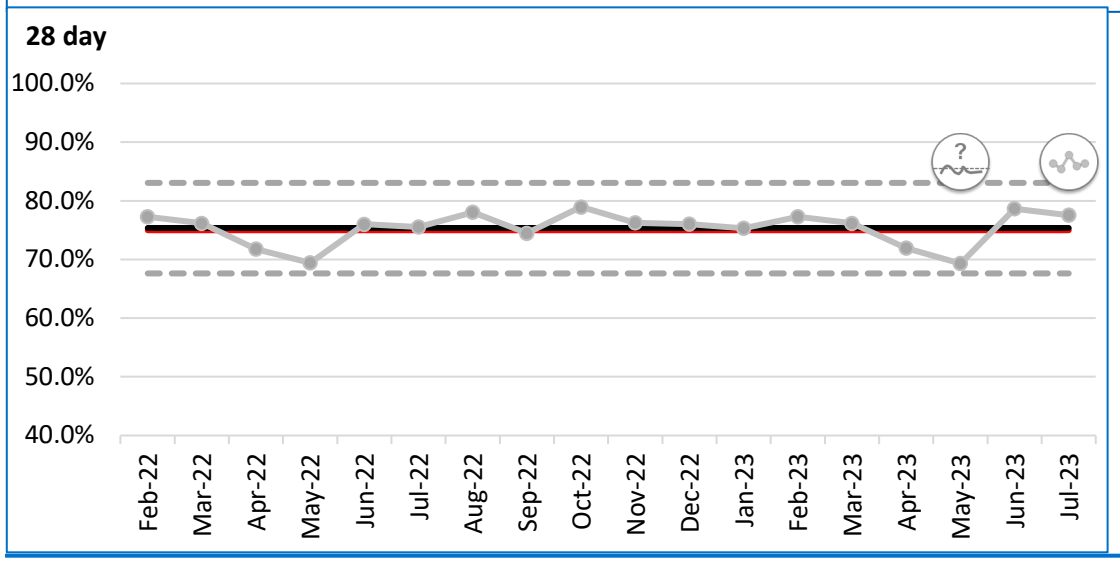
- Breast and Symptomatic Breast sites exceed the 75% target in each of the last 12 months, and largely drives the Trusts overall performance given the volume of patients
- Testicular and Lung have improved and have continued to achieve the target consistently since January to the latest validated month of July
- While Trust wide performance generally achieves the standard, performance risks continue across a number specialties - Particular consistently challenged specialties Gynae (both Gynae and Gynaeonology), Lower GI, Urology, Haematology and Upper GI

Risks

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

NHSI SOF Operational Performance & National Operational Standard

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



Faster Diagnosis Standard	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Monthly Trend
Trust (75%)	74.9%	80.2%	79.1%	78.7%	75.6%	78.0%	77.6%	75.3%	72.0%	78.6%	77.0%	79.3%	
Breast (75%)	96.9%	95.4%	96.6%	98.1%	94.7%	96.6%	97.4%	97.2%	98.6%	98.3%	98.5%	98.1%	
Gynae and GynaeOnc Combined (75%)	68.0%	61.7%	50.8%	44.6%	51.0%	51.2%	66.1%	57.1%	47.2%	56.9%	45.0%	59.7%	
Gynae (75%)	70.1%	65.1%	50.0%	44.8%	50.5%	51.3%	66.7%	59.3%	48.7%	61.1%	48.6%	61.0%	
Gynaeoncology (75%)	45.5%	45.5%	54.5%	42.9%	57.1%	50.0%	60.0%	0.0%	25.0%	25.0%	25.0%	50.0%	
Lower GI (75%)	52.3%	54.6%	51.6%	57.7%	38.1%	47.0%	36.9%	30.1%	33.3%	36.4%	53.3%	46.5%	
Testicular (75%)	66.7%	75.0%	100.0%	100.0%	100.0%	75.0%	83.3%	100.0%	75.0%	100.0%	100.0%	80.0%	
Urology (75%)	65.2%	62.4%	64.5%	66.3%	50.6%	67.6%	57.0%	35.1%	21.6%	36.7%	33.3%	51.1%	
Haematology (75%)	68.8%	28.6%	45.5%	71.4%	20.0%	66.7%	63.6%	70.0%	50.0%	71.4%	54.5%	50.0%	
Lung (75%)	53.8%	75.0%	85.3%	69.2%	80.7%	77.5%	84.5%	78.7%	83.1%	81.8%	89.5%	72.9%	
Upper GI (75%)	41.7%	55.6%	52.0%	56.4%	55.1%	55.2%	51.6%	52.7%	42.0%	64.3%	64.4%	64.2%	
												Indicative	
Sympt. Breast (75%)	100.0%	96.6%	100.0%	95.5%	100.0%	96.0%	97.3%	100.0%	100.0%	100.0%	98.1%	100.0%	

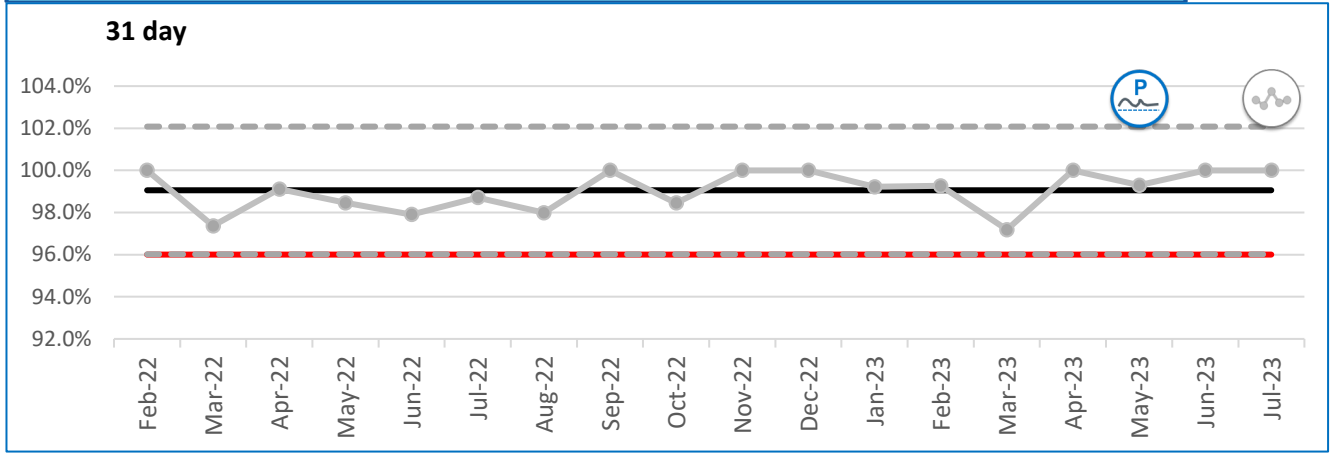
Cancer Standards - 31 Day Waits

Responsive

NHS Gateshead Health NHS Foundation Trust

NHSI SOF Operational Performance & National Operational Standard

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



31 day performance	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Monthly Trend
Trust (96%)	100.0%	98.4%	100.0%	100.0%	99.2%	100.0%	97.2%	100.0%	99.3%	100.0%	99.0%	99.2%	
Breast (96%)	100.0%	100.0%	100.0%	100.0%	98.1%	100.0%	98.4%	100.0%	98.4%	100.0%	100.0%	100.0%	
Gynae and GynaeOnc Combined (96%)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	90.9%	100.0%	100.0%	100.0%	100.0%	100.0%	
Gynae (96%)	100.0%	100.0%	100.0%	NA	100.0%	100.0%	80.0%	NA	100.0%	100.0%	NA	100.0%	
Gynaeoncology (96%)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	92.3%	100.0%	100.0%	100.0%	100.0%	100.0%	
Lower GI (96%)	100.0%	88.2%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Urology (96%)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	87.5%	
Haematology (96%)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Lung (96%)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	85.7%	100.0%	
Upper GI (96%)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
												Indicative	
Susequent Treatments	**Sep-22**	**Oct-22**	**Nov-22**	**Dec-22**	**Jan-23**	**Feb-23**	**Mar-23**	**Apr-23**	**May-23**	**Jun-23**	**Jul-23**	**Jul-23**	
Surgery (96%)	95.5%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Drug (98%)	100.0%	98.6%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	94.7%	
												Indicative	

Trust 31 day cancer performance:

- The Trust continues to exceed the 31-day standard for July,
- Trust performance for July stood at 99.1% with the both the subsequent treatments for Surgery and Drugs at 100%
- The Trust continues to exceed the latest national average of 91.8% (July 23) and the NENC average 91.3% (July 23)
- August's indicative position is 99.2%,so consistent with July's position
- Volumes of 31-day activity is consistently below 19/20 baselines for some tumour sites over the past 4 months, notably Gynae and lower GI

Tumour site update:

- Typically, the majority of tumour sites achieve the standard each month, and in fact exceed the 96% threshold, only Lung failed to achieve the standard in July

Risks

- Capacity / shared pathways, Theatre workforce pressures

Volumes as a % of 2019/20 Activity	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
Trust (100%)	100.8%	87.7%	125.4%	103.3%	95.5%	141.9%	65.2%	77.2%	109.3%	111.3%	75.0%	91.2%
Breast (100%)	89.8%	82.8%	125.9%	101.7%	100.0%	190.6%	76.7%	69.4%	126.0%	126.8%	68.6%	129.2%
Gynae (100%)	91.7%	96.3%	147.4%	133.3%	129.4%	100.0%	92.0%	56.0%	83.3%	79.2%	66.7%	39.3%
Lower GI (100%)	107.1%	94.1%	125.0%	122.2%	45.0%	88.9%	18.2%	114.3%	66.7%	69.2%	42.9%	38.5%
Urology (100%)	160.0%	200.0%	233.3%	216.7%	111.8%	166.7%	75.0%	200.0%	200.0%	191.7%	138.5%	75.0%
Haematology (100%)	71.4%	100.0%	180.0%	166.7%	80.0%	225.0%	38.0%	71.4%	85.7%	83.3%	144.4%	100.0%
Lung (100%)	91.7%	50.0%	92.3%	13.3%	42.9%	70.0%	50.0%	86.7%	140.0%	83.3%	56.3%	107.1%
Upper GI (100%)	300.0%	40.0%	27.3%	116.7%	225.0%	166.7%	42.9%	33.3%	66.7%	100.0%	66.7%	133.3%
												Indicative

Cancer Standards - 62 Day 2ww pathways

Responsive

NHS Gateshead Health NHS Foundation Trust

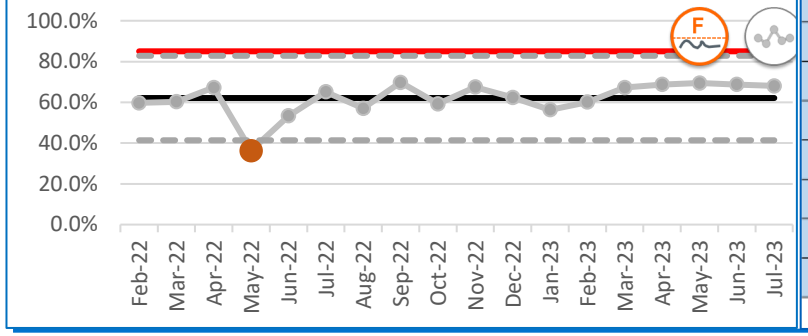
Trust 62-day 2ww cancer performance

- Performance for July stood at 70.4%, above the latest national average 62.8% (July 23) and NENC average 63.1% (July 23).
- **The Trust reported 43 patients waiting over 62 days on a 2ww classic pathway (6.8% of the total waiters on a 62-day 2ww classic pathway) (60 on all pathways (7.6% of total waiters)).**
- Within the operational guidance 'Systems are being asked to plan to reduce >62-day backlogs, the Trust submitted a plan of 67 for August 2023, reporting 43 for the month, the plan **has been** met.
- The number of long waits (>104 days) on a 62 day (2ww) pathway at the end of August had increased to 9 patients (1.4% of total waiters on a 62 day 2ww classic pathway) (13 on all pathways (1.7% of total waiters).
- Indicative performance for August (indicative) stands at 75.2%, remaining above both comparator averages.

Tumour site update:

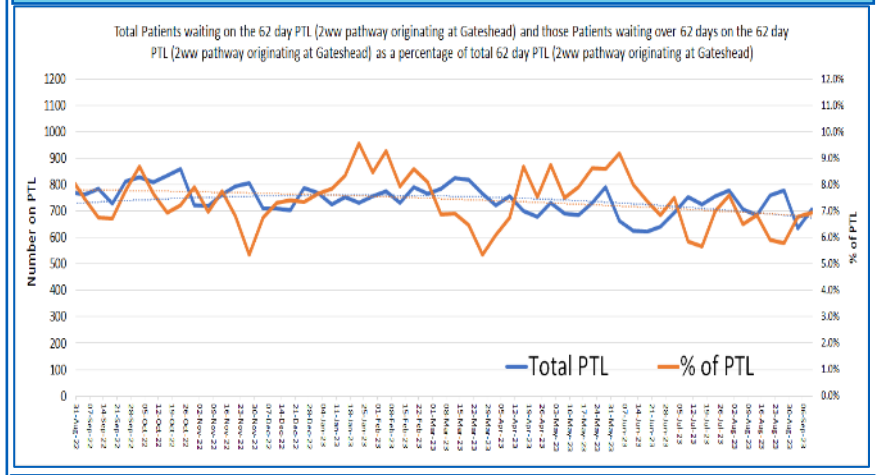
- Breast has consistently exceeded the standard since February, however there are performance risks across the majority of other specialties to achieve 85%
- Monthly positions are variable but consistently challenged specialties continue to be Gynae (specifically Gynae oncology), Lower GI, Urology. With other specialities more variable such as Lung and Upper GI, however mostly these also remain below the targets.

62 day



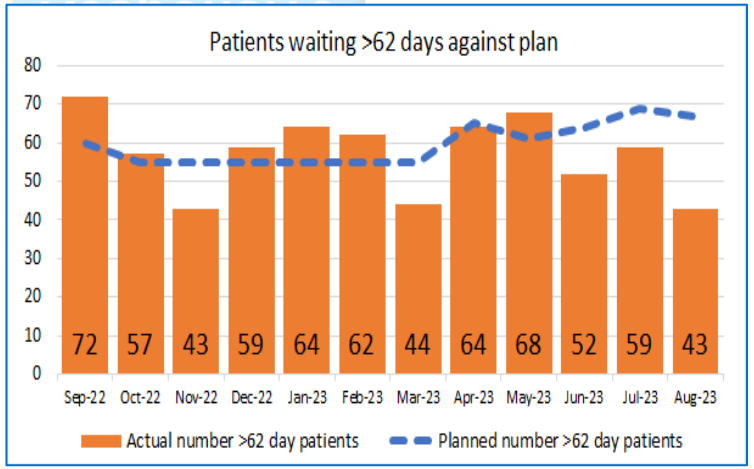
NHSI SOF Operational Performance & National Operational Standard

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



62 day performance	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Monthly Trend
Trust (85%)	69.7%	59.2%	67.9%	61.7%	56.5%	60.4%	66.9%	68.8%	69.2%	68.4%	70.4%	75.2%	
Breast (85%)	86.4%	81.1%	81.0%	76.0%	75.6%	93.2%	94.1%	100.0%	93.8%	87.8%	85.4%	97.7%	
Gynae and GynaeOnc Combined (85%)	53.3%	31.8%	52.2%	55.0%	25.0%	26.3%	56.3%	70.0%	60.0%	50.0%	57.9%	53.3%	
Gynae (85%)	100.0%	0.0%	50.0%	NA	NA	33.3%	45.5%	NA	NA	0.0%	NA	100.0%	
Gynaeoncology (85%)	50.0%	43.8%	52.6%	57.9%	25.0%	23.1%	60.0%	70.0%	60.0%	58.3%	57.9%	41.7%	
Lower GI (85%)	40.0%	47.1%	20.0%	0.0%	60.0%	100.0%	40.0%	62.5%	75.0%	100.0%	66.7%	0.0%	
Urology (85%)	51.5%	46.9%	62.2%	40.0%	41.0%	21.4%	15.4%	57.1%	18.9%	33.3%	51.9%	33.3%	
Haematology (85%)	60.0%	57.1%	83.3%	NA	100.0%	60.0%	100.0%	33.3%	100.0%	0.0%	86.7%	66.7%	
Lung (85%)	88.9%	80.0%	90.0%	60.0%	80.0%	33.3%	60.0%	62.5%	60.0%	66.7%	42.9%	70.8%	
Upper GI (85%)	60.0%	100.0%	33.3%	100.0%	50.0%	25.0%	54.5%	0.0%	40.0%	50.0%	88.9%	33.3%	

Indicative



Cancer - Patients waiting more than 62 days

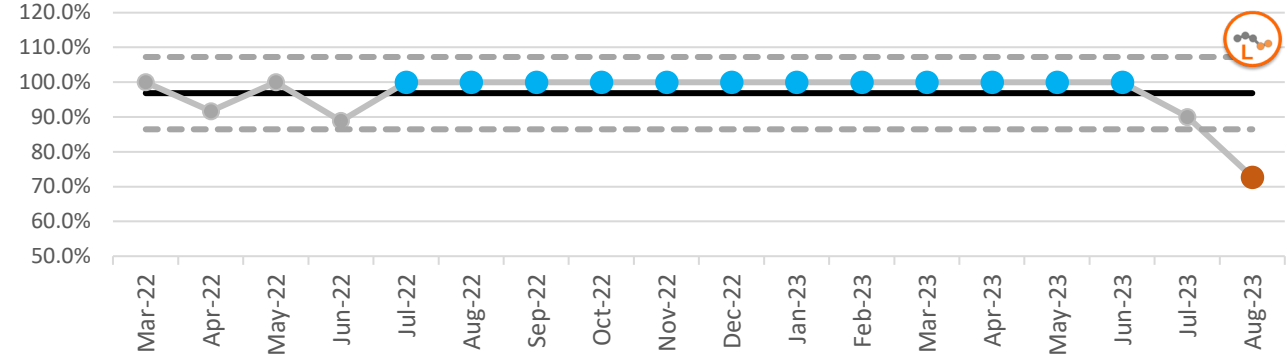
63 to 104 days	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	July	Aug
Breast	2	4	2	3	4	3	2	2	3	2	2	1
Gynaecology	17	14	12	17	18	9	5	13	6	8	13	15
Haematology	2	2	1	0	0	0	1	1	1	0	0	0
Lower Gastrointestinal	12	3	5	7	5	11	10	9	19	12	11	7
Lung	2	8	5	4	6	2	3	3	3	1	4	2
Upper Gastrointestinal	12	9	5	8	7	12	10	14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

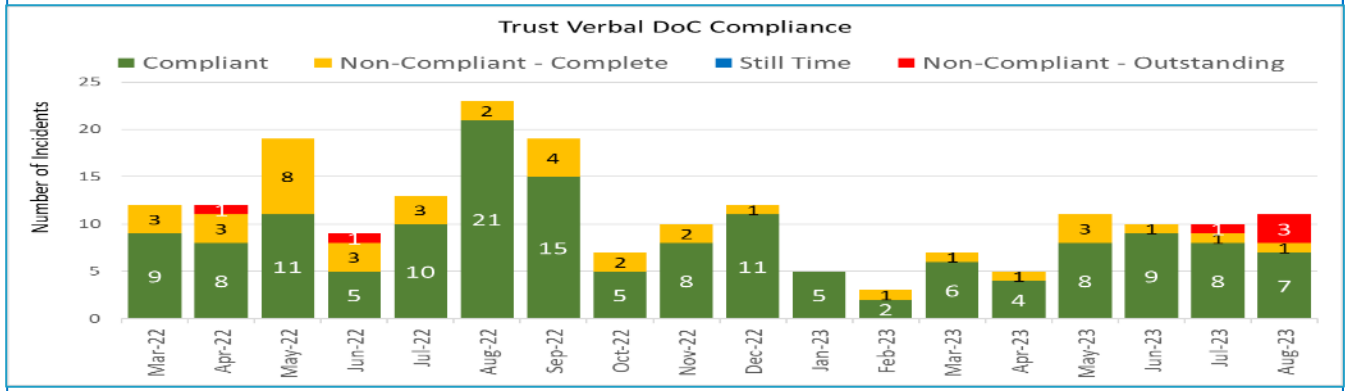
Over 104 days	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jun	Jun
Breast	1	0	0	0	0	0	0	0	1	0	0	0
Gynaecology	4	3	3	2	3	3	0	1	1	3	2	5
Haematology	0	1	0	1	0	0	0	0	0	0	0	0
Lower Gastrointestinal	1	3	1	2	5	2	2	5	4	0	2	0
Lung	1	0	3	0	1	1	0	0	1	2	0	1
Upper Gastrointestinal	7	1	1	4	2	1	2	2	2	2	1	2
Urological	0	3	1	2	1	2	3	2	2	2	1	1
Other	0	0	0	0	0	0	0	1	0	0	0	0
Over 104 day total	14	11	9	11	12	9	7	11	11	9	6	9

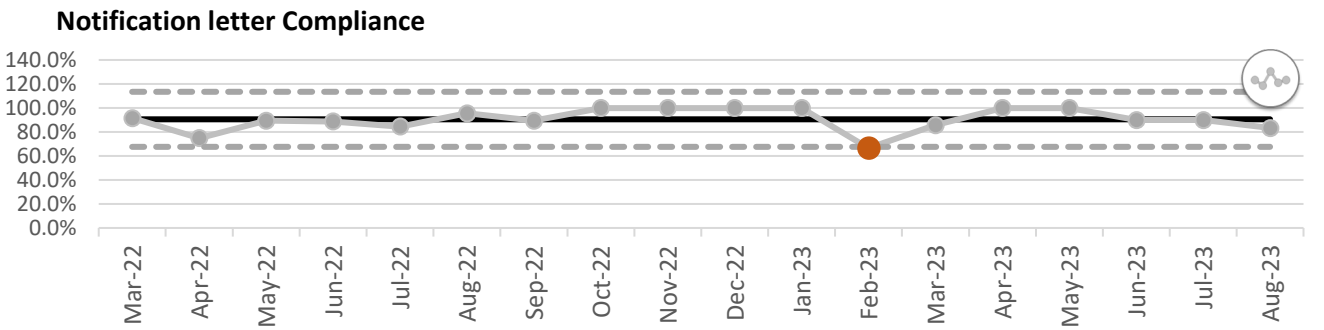
Report by exception: Responsive – Duty of Candour Compliance

Responsive

NHS Gateshead Health NHS Foundation Trust







Situation
Verbal Duty of Candour compliance is displaying special cause variation for concern in August 2023.
Notification letter compliance displaying common cause variation for August 2023

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

Assessment
Verbal duty of candour compliance is showing on the DATIX system as 72.7% for the month of August 2023. There are 3 incidents showing as non-compliant in relation to verbal enactment (114989, 115057 and 115060). The severity of harm in relation to incidents 114989 and 115060 has not yet been agreed by STG / executives and these incidents are to be discussed again at STG on 18 September 2023. Incident number 115057 was discussed at STG on 11 September 2023 and the severity of harm was agreed to remain as Moderate harm. Verbal duty of candour needs to therefore be enacted on or before 21 September 2023 so currently not non-complaint.

In relation to compliance for Notification letters, the report shows 1 letter outstanding in August 2023. This incident (114272) shows that a Notification letter remains outstanding. The legal team have contacted the handler and Patient Safety Lead to confirm non-compliance. It has been advised this will be picked up and completed by the Department imminently and the Datix system will be updated accordingly.

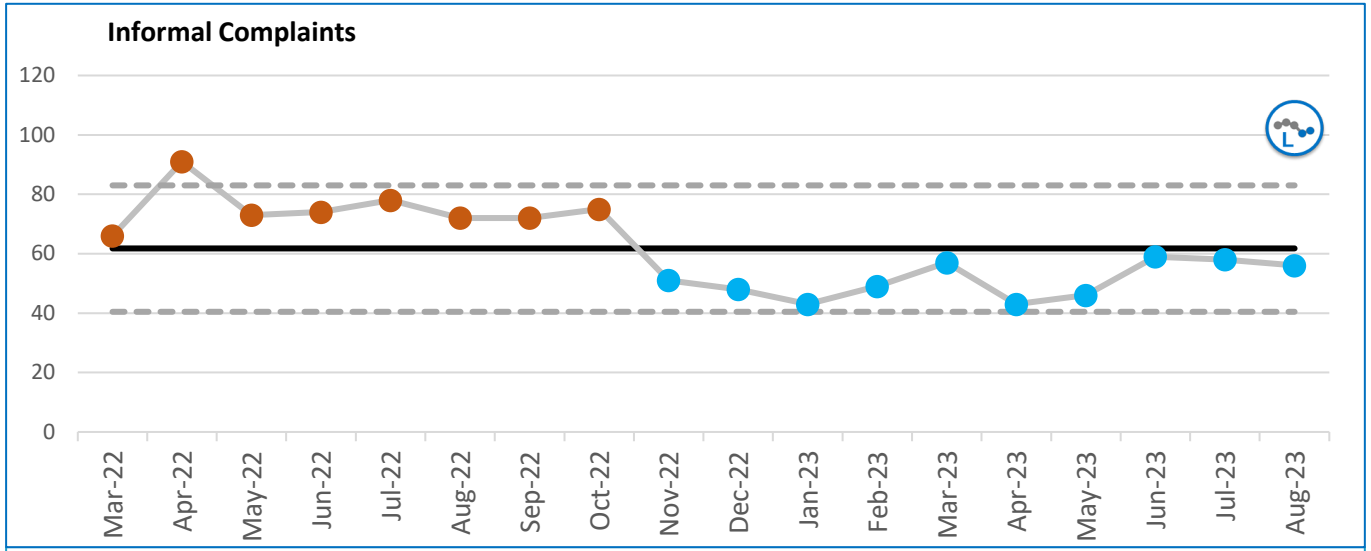
Actions
Currently, a manual review of incidents to establish those which have been formally signed off is being undertaken, so that we can provide definitive figures and assurances as to how many Findings letters are now due/ outstanding.

Report by exception: Informal Complaints

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

Responsive

NHS Gateshead Health NHS Foundation Trust



Analysis:
Even though there was a slight increase in numbers received each month from April, the number of informal complaints continues to achieve special cause variation and remain low, below numbers seen earlier in the year and have fallen slightly in each of the past 2 months. The focus of informal complaints varies significantly and is very broad. Analysis of informal complaints (November 2022 to May 2023 baseline) highlighted the two main overall subjects for complaints as *Communication. And facilities* mostly linked to Car parking issues. The tables (right) provide a breakdown of the most common issues for both themes between November to May, and then each of the past 3 months.

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

Facilities complaints - Car parking issues continue to be the most significant issue, the number of these type of complaints, increasing month on month since April. Complaints around inconsiderate parking in the local neighbourhood had reduced but were again prevalent in August's data. Parkin charge notices cause the largest volume.

Communications complaints by volume	Nov22 - May23	Jun-23	Jul-23	Aug-23
Electronic - Length of wait (telephone)	38	1	2	1
Verbal - Poor communication	43	11	6	10
Written - Incorrect information	9	1		5
Written - Poor communication	16	3	5	3
Verbal - Delay in diagnosis	3			
Verbal - Poor staff attitude	3	1		2
Written - Breach of confidentiality	2		1	
Verbal - Premature discharge	1			1
Written - Poor / incorrect signposting	1			
Verbal - Incorrect diagnosis	1		2	
Verbal - Delay in Treatment	9	5	1	
Electronic - Poor communication	1			1
General - Interpreter not available	5			1
Verbal - Lack of community service communications	1			
Verbal - Misunderstanding	1		1	
Verbal - proceedure / process error	3			1
General - Lost Mail	1			
Verbal - Language barrier	0		1	
Grand Total	**138**	**22**	**19**	**25**

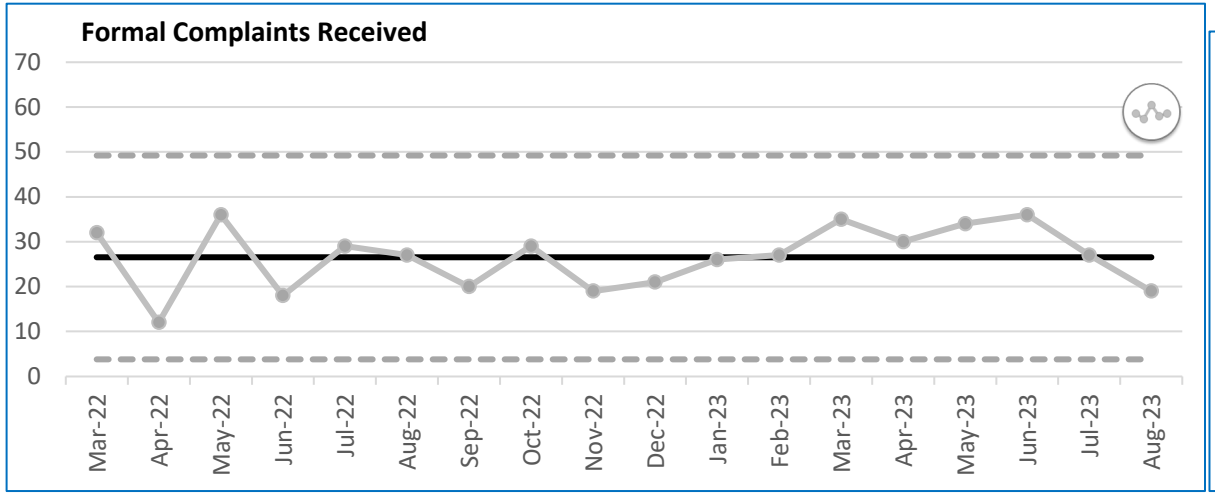
Facilities complaints by volume	Nov22 - May23	Jun-23	Jul-23	Aug-23
General - Car parking	24	1		
Car Parking - Parking Charge Notice (PCN)	16	3	3	7
Car parking - Issues with blue badge registration	7	3		
Car parking - inconsiderate parking (neighbourhood)	4	3		6
Lack of resources - No ward bed (Not ITU/CCU/HDU)	1			
Facilities - Incomplete maintenance works	1	1		
General - Lack of adequate facilities/equiptment	1			
Facilities - Temperature Control	1		3	
Grand Total	**55**	**11**	**6**	**13**

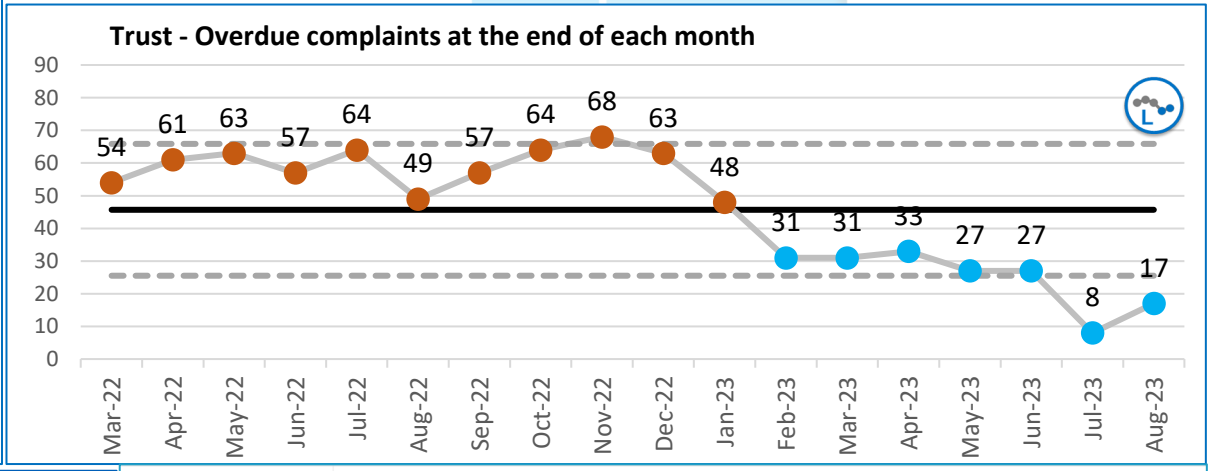
Report by exception: Formal Complaints

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

Responsive

NHS Gateshead Health NHS Foundation Trust





Analysis – Although increasing in May and now June, **t**he number of formal complaints reduced in July and now August and is demonstrating common cause variation, and within expected levels based on past trends. The number of overdue complaints at the end of August continues to triggering special cause variation and demonstrates significant improvement. However, the number of overdue complaints increase to 17, the first time in 9 months the numbers have increased. Analysis of recent formal complaints received since November continues to highlight two main subjects as below:

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

Overdue Complaints

- There were 17 overdue complaints remaining open at the end of August, an increase from 8 in July. 13 sat with the Medicine Business Unit, 2 Surgical Business Unit and 2 Clinical Support and Screening. This is the first time since November the number of overdue complaints has increased.

Friends and family test results - identify the following themes for patients whose experience was rated as 'Poor' or Very Poor' these related to Poor care and treatment received, long wait times, poor communication and staff attitude

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

	Accident and Emergency	Same Day Emergency Care (SDEC)	Emergency Admissions Units	Ward 8 (Cardiology)	Ward 9 (Respiratory)	Ward 10 (Respiratory)	Ward 11 (Gastroenterology)	Ward 12	Ward 14a (Trauma and Orthopaedics)	Ward 21 Escalation	Ward 22 (Care of the Elderly)	Ward 23 (Care of the Elderly)	Ward 24 (Care of the Elderly)	Ward 25 (Care of the Elderly)	T27 (General Surgery)	Trauman and Orthopaedics	Blaydon Urgent Treatment Centre	Gastroenterology - No specific Dept	General Surgery	Gynaecology	Delivery Suite (Maternity)	Cardiology (Specialty of) - Urgent Dept	Clinical Haematology (Specialty of) - No specific dept	CT (Radiology)	Obstetrics	Breast Screening	Paediatrics (outpatient)	PeaPod (Paediatric Emergency Assessment)	PIU Day Unit
Actions - Actions not carried out	39	2	1													1	1		1	3	1				1	1	2	3	
General - Inadequate/Inappropriate nursing care	1		3		1	3	5	3	2	1	3	1	2	3	4						1								1
General - Inadequate/Inappropriate medical care				1	1	1			1		1				1	3		1	2	1		4	1	1				1	
Total	40	2	4	1	2	4	5	3	3	1	4	1	2	3	5	4	1	1	3	4	2	4	1	1	1	1	2	4	1

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

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

Sickness Absence

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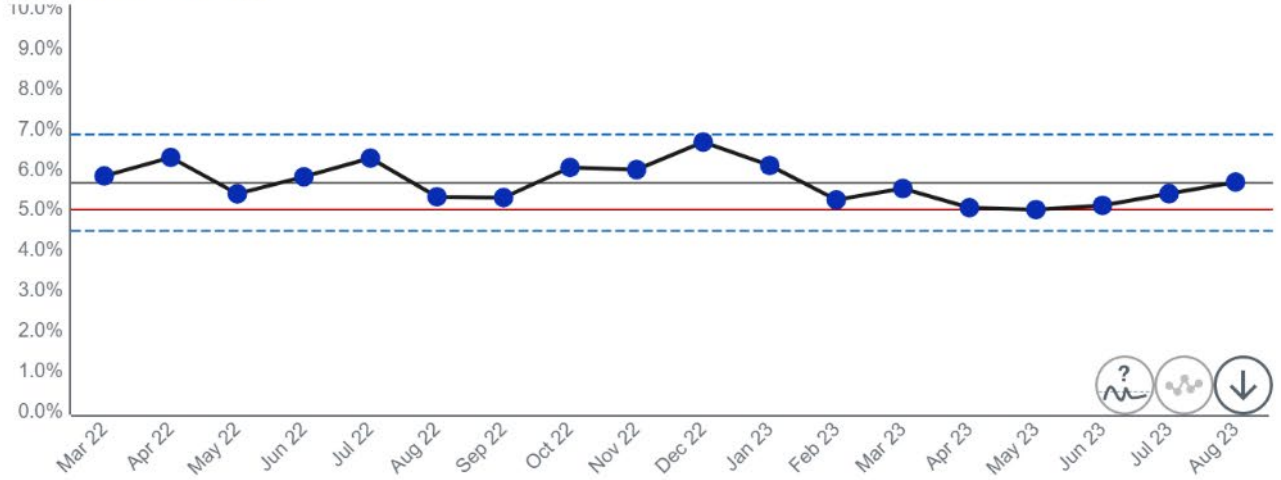
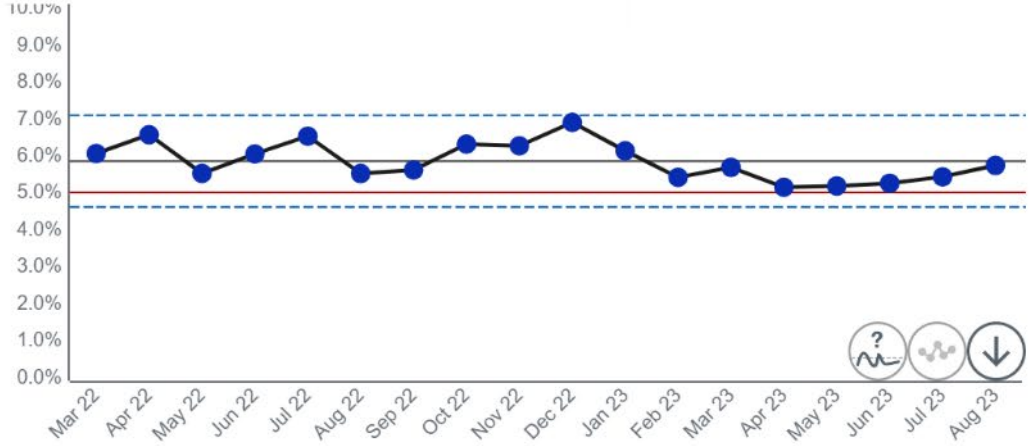
NHS Gateshead Health NHS Foundation Trust

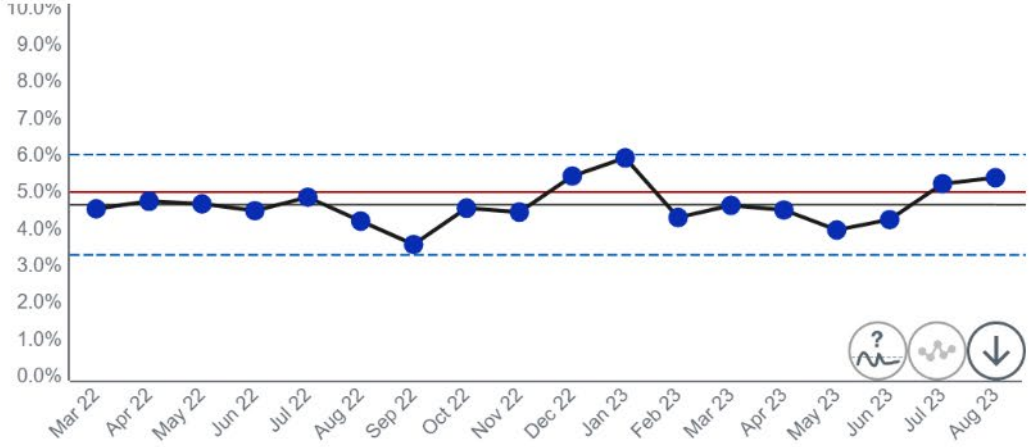
Sickness % - Group



Sickness % - Trust



Sickness % - QEF



What is the data telling us?

- The data shows that absence rates for the trust have remained steady since April, but absence has increased slight for QEF since May.

What is our plan and expected impact?

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

Appraisals

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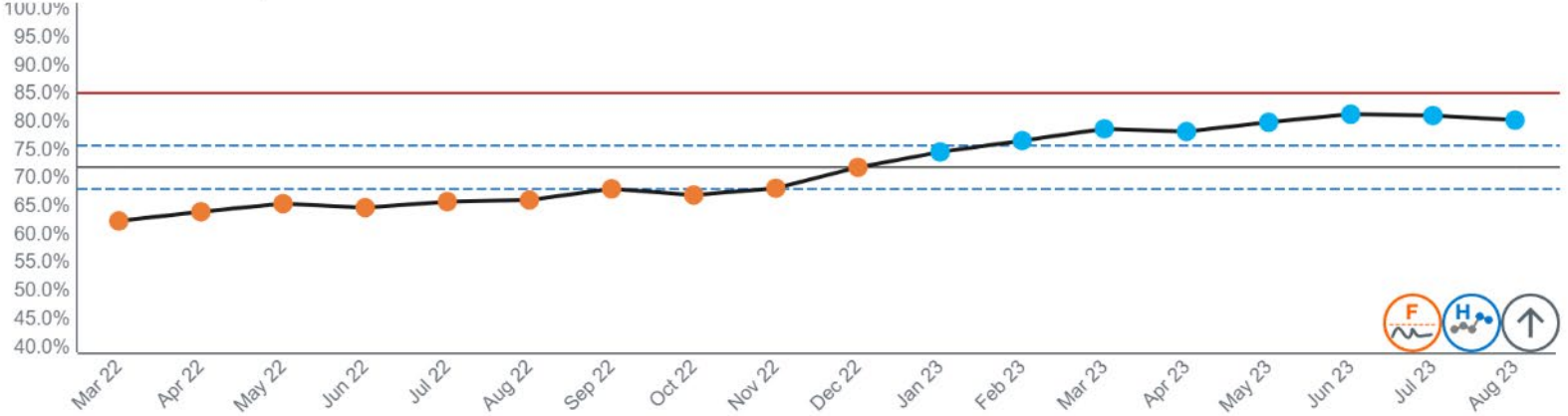
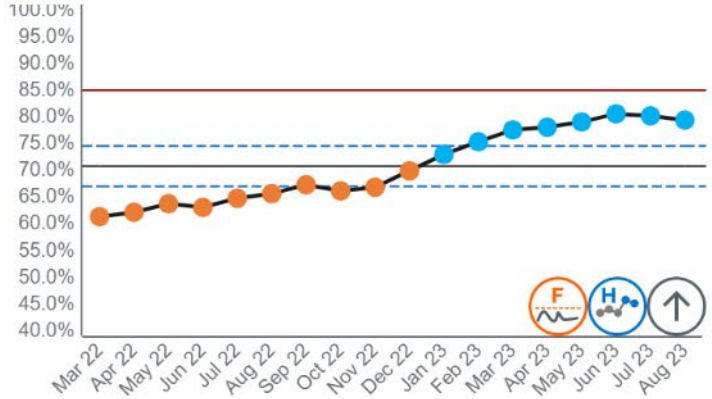
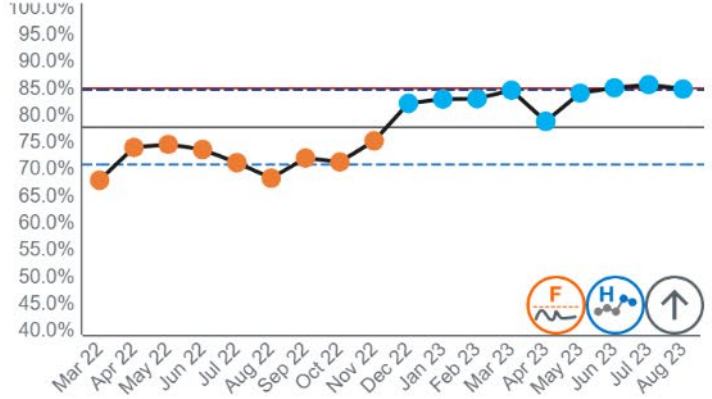
Appraisal % - Group



Appraisal % - Trust



Appraisal % - QEF



What is the data telling us?

- The target of 85% is consistently not being achieved. The data shows that there has been a slight decrease to 80.2% for the group. There has been a sustained improvement since May 2022 up until last month however this is the second consecutive drop in compliance. QEF has seen decreases in compliance this month to 84.8 with the Trust dropping slightly to 79.4% . Significant work has been undertaken to achieve the current levels
- There remain a number of areas of concern, with varying numbers of staff requiring an appraisal. There are areas of concern with regards to appraisal compliance, and a new way of inputting into ESR has been launched which will support managers.

What is our plan and expected impact?

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

Core Training

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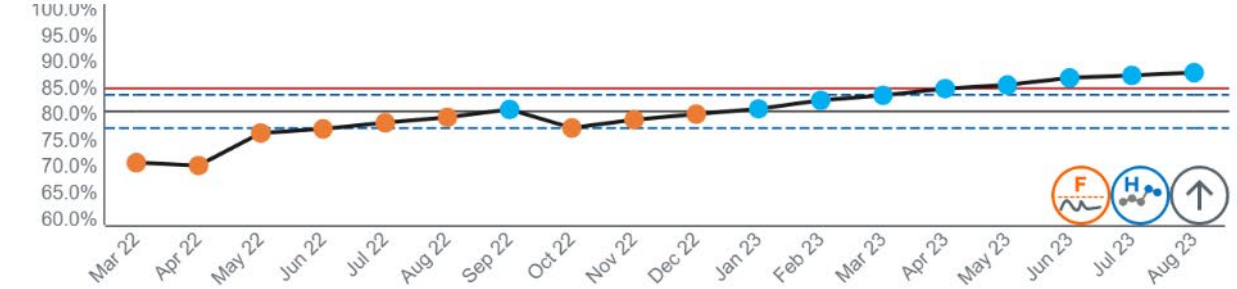
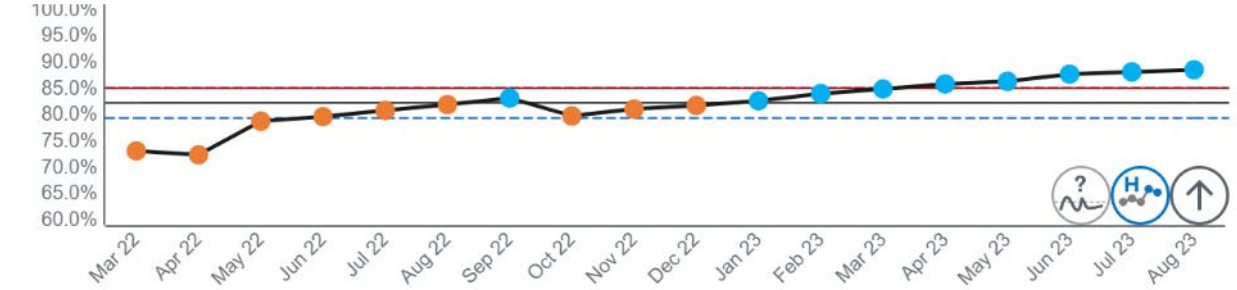
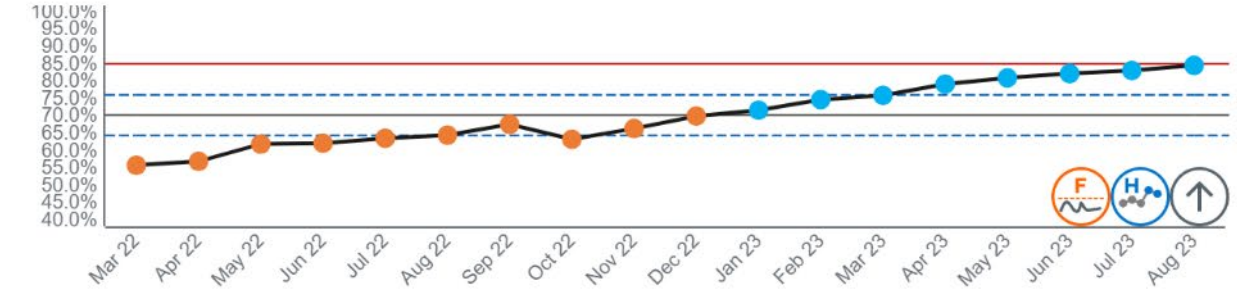
Core Skills % - Group



Core Skills % - Trust



Core Skills % - QEF



What is the data telling us?

- Another increase in compliance with a whole group compliance figure of 88% against an 85% target.
- QEF currently have a compliance level of 84.5% against the 85% target, which is another increase on the last metrics report. Managers are aware that continued work is required to improve that position; however, this is another positive improvement since the last report. The additional space for QEF staff for training is available and this continues to see an increase compliance.
- The Trust has increased to 88.5% against an 85% target.
- The topics that remain under compliance targets and provide a level of risk are-Moving and handling level 2, Level 2 and 3 PMVA, Safeguarding level 3 topics and Information Governance. Work is ongoing with the SME's for these topics to increase compliance. These remain a risk within the overall compliance target. However, it is noted that Safeguarding Children level 3 recorded a significant increase.
- PMVA training will remain a risk until further staff have completed the training. Dates have now been made available and staff are booking on to attend so there should continue to be sustained increases in compliance with this topic. Work is ongoing through the violence and aggression task and finish group to manage mapping of these topics.

What is our plan and expected impact?

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

SIP, Vacancies

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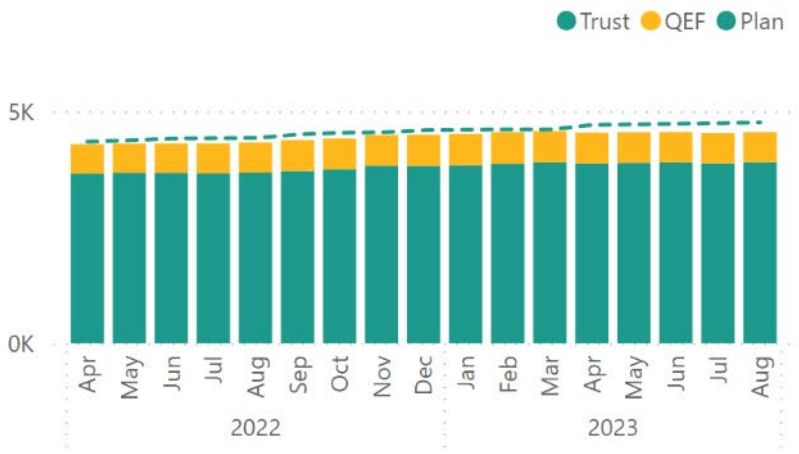
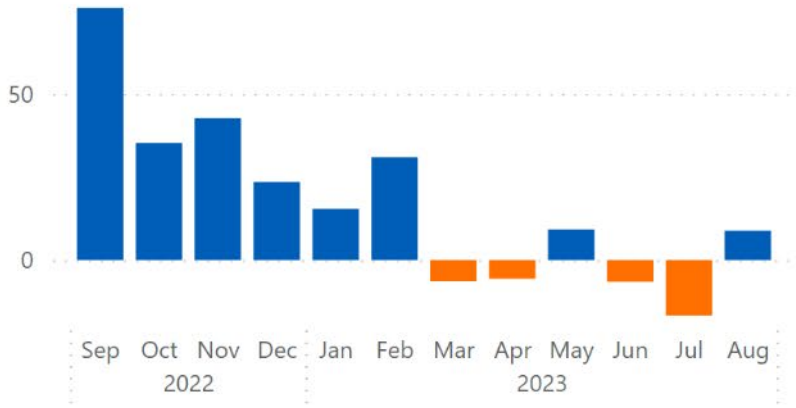
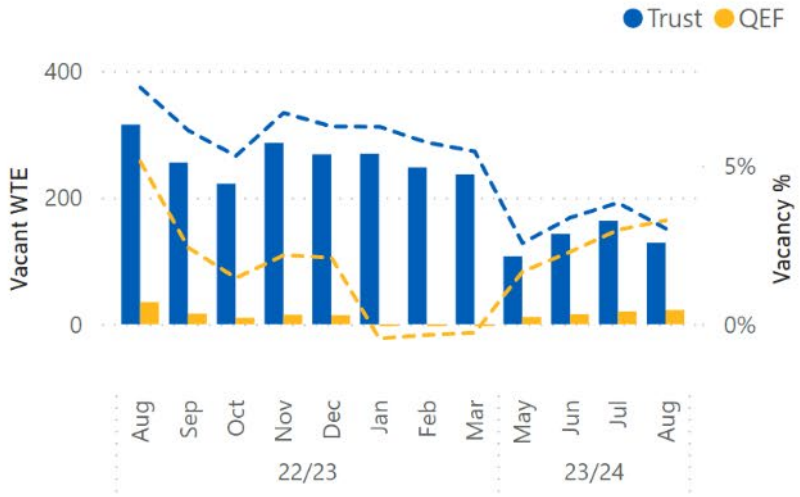
Plan vs Contracted SIP



Starters & Leavers - Net change



Vacant WTE & Vacancy %



Recruitment - Advert to starting letter (Av Days)

What is the data telling us?

- The Time to hire metric used by the Trust is Advertising Start Date to Starting Letter (T19 report). The time to hire metric has decreased for August . The team have been prioritising the newly qualified applicants for September start dates and Medics who are planned to support the Industrial Action which has impacted on the time to hire metric. The data covers all posts that are being processed by the recruitment team, including Medical posts, Non-medical posts, Volunteers and Bank staff. The only staff not included in the data are those who have been recruited by Yeovil Hospital.
- Trust vacancy rate is 3.0% as of Aug 23, a 0.8%, 34.5 WTE decrease since Jul23. QEF vacancy rate is 3.3%, a 0.3%, 2.0 WTE increase since Jul23. The trust vacancy rate has decreased due to an increase in contracted Trainee Grades and Registered Nurses. QEF vacancy rate has increased due to staffing levels decreasing by 2.0 WTE.
- Staff in post at the end of Aug was 3,898.6 WTE for the Trust and 650.7 WTE for QEF.

What is our plan and expected impact?

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

Agency and Bank Spend

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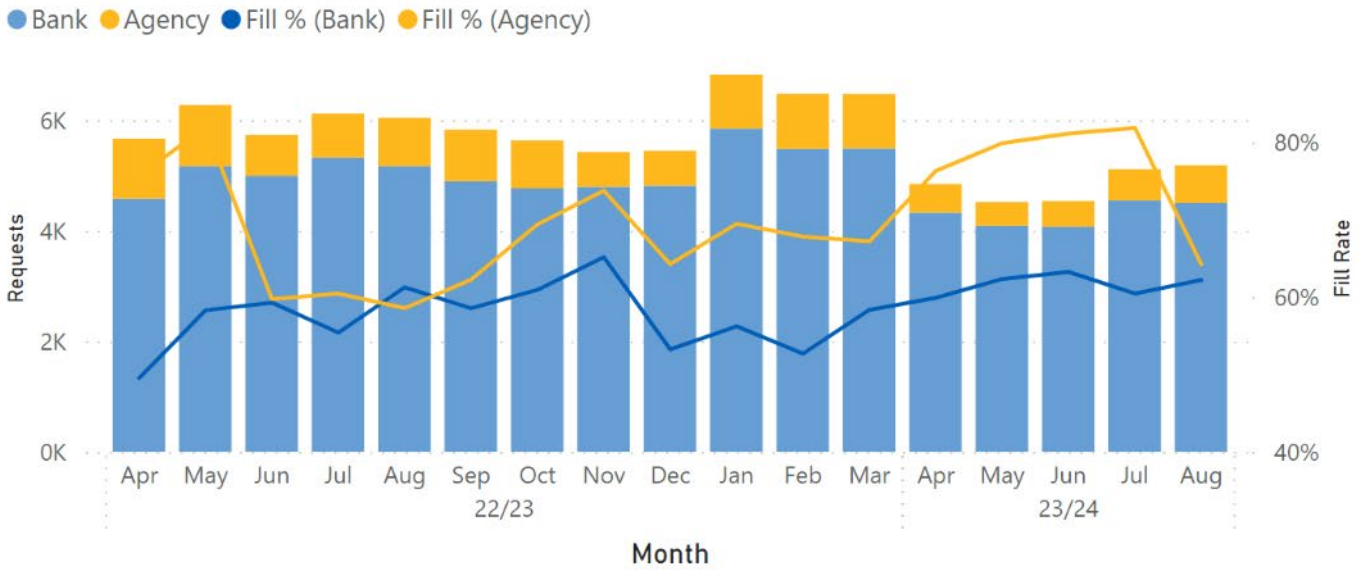
Temporary staffing fill rate and requests



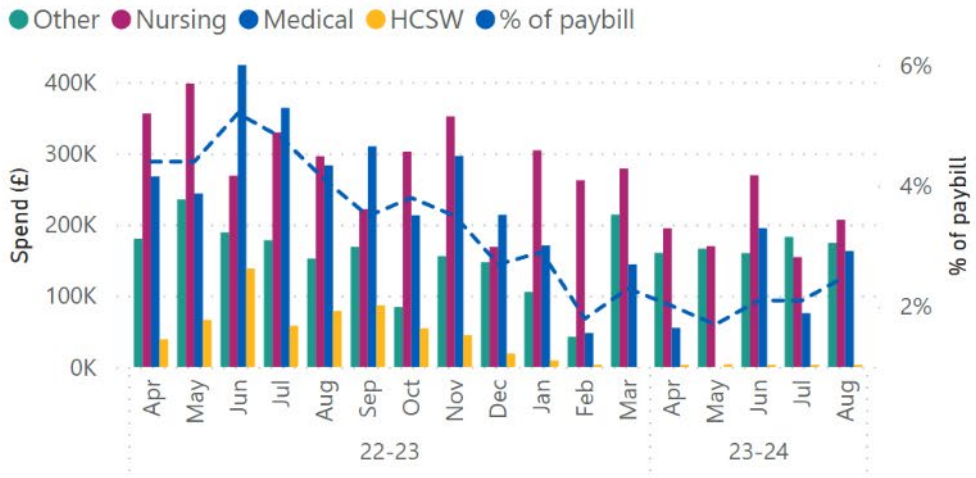
What is the data telling us? *Bank requests include all requests via Health Roster

- The month of August saw a further increase in agency requests, however, fill rates for agency staff reduced significantly. Bank requests remained consistent with a slight increase in fill rate. Total Agency spend has increased during the month of August, with increases in the nursing and medical workforce. Total bank has also demonstrated an increase in the month of August across all workforce groups.

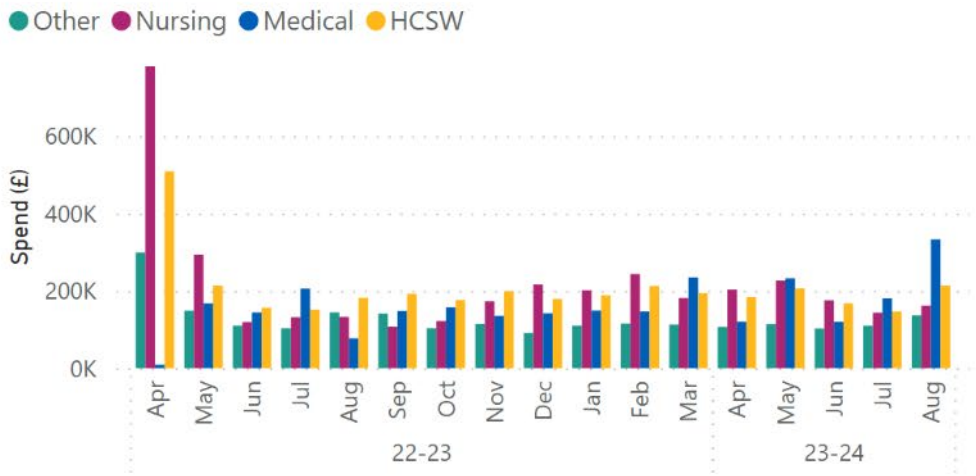
What is our plan and expected impact?

- Agency control procedures now require Chief Operating Officer/ Tactical on-call sign off for all 'break glass' requirements. A monthly audit to monitor governance and compliance with this practice is completed by the Healthroster team and reported into the Agency Control working group. The expectation of this work is to continue to reduce off-framework usage and above price cap nursing and Medical agency use within the Organisation.

Total Agency Spend (£)



Total Bank Spend (£)



Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 15ii

Report Title:	Leading Indicators			
Name of Meeting:	Board of Directors			
Date of Meeting:	27th September 2023			
Author:	Deborah Renwick / Jon Gaines			
Executive Sponsor:	Kris Mackenzie, Group Director of Finance and Digital			
Report presented by:	Kris Mackenzie, Group Director of Finance and Digital			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☒	**Assurance:** ☐	**Information:** ☐
	This report sets out progress in relation to the development of the Trusts Leading indicator reporting, and an overview in relation to performance against the measures for the latest reporting period, ending August 2023.			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☒ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☒
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*				
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development*	Leading indicators continues to be themed around the 4 strategic aims and objectives. Each indicator has been RAG rates along the following lines: • Green: indicator on target or achieving trajectory, forecast not at risk, • Red: indicator not on target or not achieving trajectory, forecast at risk, • Grey: target or trajectory to be agreed once baselines established In summary at the end of August: **We will improve productivity and efficiency of our operational services** • 4 of 4 Leading Indicators (LI's) RAG rated Red • 1 of 6 Break through objectives (BO) RAG rated Green & 5 of 6 RAG rated Red. 2 to set target/trajectory (grey)			

<table>
<tr><td>

- *Governance and legal*
- *Equality, diversity and inclusion*

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

- 2 of 2 Leading Indicators RAG rated Green, 1 to set target/trajectory
- 2 of 2 BO's RAG rated Green

We will be a great organisation with a highly engaged workforce

- 1 of 1 Lead Indicator RAG rated Red
- 1 of 2 BO's RAG rated Green, 1/2 BO's RAG rated Red

We will achieve financial sustainability

- 1 of 1 Lead Indicator RAG rated Red
- 2 of 2 BO's RAG rated Red

A more detailed summary for the metrics included in each outcome is provided in the full leading indicator pack.

This summary focusses on those metrics which are currently RAG rated red.

Engagement with operational Teams as part of the process continues to be positive, as a result and following feedback, two measures have been further refined this month. The CQC action plan monitoring measure has been refined to monitor compliance with a recently revised CQC Quality Improvement Plan now reported to SMT. And in the "We will achieve financial sustainability" measures an overall position against financial plan has been added.

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

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The recommendations to the Board are to receive this report, discuss the potential implications and note the improvement or challenge in key areas.

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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

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Aim 2
☒

</td><td>

We will be a great organisation with a highly engaged workforce

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Aim 3
☒

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

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Aim 4
☒

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

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Aim 5
☐

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We will develop and expand our services within and beyond Gateshead

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Trust corporate objectives that the report relates to:

</td><td colspan="2">

- Improving the productivity and efficiency of our operational services
- Improving the quality and safety of our services for our patients

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	• Being a great organisation with a highly engaged workforce • Achieving financial sustainability				
Links to CQC KLOE	Caring ☒	Responsive ☒	Well-led ☒	Effective ☒	Safe ☒
Risks / implications from this report (positive or negative):					
Links to risks (identify significant risks and DATIX reference)	• Achieving Flow and reducing Long waiters • Workforce engagement • Financial sustainability				
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒		

Leading Indicators – September Committees

1. Introduction

1.1 This report summarises performance across the Trust's Leading Indicators – linked to our strategic aims and objectives. Leading indicators provide a measurement framework against a set of priority areas linked to our Strategic Aims and Objectives. They enable clarity and a common purpose about what matters most from Ward to Board. Linked to our Strategic Aims and Strategic Objectives they help focus our efforts and make best use of time and resource to secure the biggest impact. Leading indicators are supported by breakthrough objectives, which are additional measures that provide balance to or support our leading indicators.

2. Indicator Summary *Heat Map

2.1 The table below details the LI hotspots against our strategic aims & objectives based on the latest August positions.

Figure 1 – Strategic Aims & Objectives, with RAG rated Lead Indicators and Breakthrough Objectives

Strategic Aims/Objectives	Lead Indicators (9)	Breakthough Objectives (14)
We will improve productivity and efficiency of our operational services	Increase the percentage of patients waiting less than 1 hour for a bed from the decision to admit	Patients moving to the right bed
		Reduce the average number of ward moves per patient
	Reduce the number of waits for a bed >12 hrs following a decision to admit (DTA breach)	Increase in the % of ambulance handovers within 15 minutes
	Reduction in overall Trust length of stay to the top quartile (<4)	Reduce the average number of patients that are in acute beds and who are fit for discharge (do not meet criteria to reside)
		Reduction in the time (days) between patients becoming medically optimised and discharge
		Readmission rates within the expected range
	Reduce to 0 the number of 52-week waiters on the RTT waiting list, by the year end	A reduction in the RTT PTL outpatient waiting list
		Increase new outpatient appointments
We will continually improve the quality and safety of our services for our patients	Increase the proportion of closed actions in the CQC action plan, reported to SMT	Summary Hospital-level Mortality Indicator (SHMI) within the expected range
	C.Diff per 100,000 bed days below or in line with national objective	Hospital Standardised Mortality Ratios (HSMR) within the expected range
	Reduction in the harm rate per 1,000 bed days from patient falls	
We will be a great organisation with a highly engaged workforce	Maintain a target score of 6.9 in Trust Staff Survey for engagement	Reduce the vacancy rate in line with the Operational Plan to below 5%
		Reduce the sickness absence rate in line with the Operational Plan to below 5%
We will achieve financial sustainability	CRP actioned to achieve £15.9m reductions	Pay spend no greater than £250m
		Non-pay spend no greater than £132.5m

Key to RAG - Green: indicator on target or achieving trajectory, forecast not at risk,
Red: indicator not on target or not achieving trajectory, forecast at risk,
Grey: target or trajectory to be agreed once baselines established

We will improve productivity and efficiency of our operational services

- **4 of 4** Leading Indicators (LI's) RAG rated **Red**
- **1of 6** Break through objectives (BO) RAG rated **Green** & **5 of 6** RAG rated **Red**. 2 to set target / trajectory (grey)

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

- **2 of 2** Leading Indicators RAG rated **Green**, 1 to set target / trajectory
- **2 of 2** BO's RAG rated **Green**

We will be a great organisation with a highly engaged workforce

- **1 of 1** Lead Indicator RAG rated **Red**
- **1 of 2** BO's RAG rated **Green**, **1 of 2** BO's RAG rated **Red**

We will achieve financial sustainability

- **1 of 1** Lead Indicator RAG rated **Red**
- **2 of 2** BO's RAG rated **Red**

3. Strategic Aims & Objectives

3.1 As requested at the Augusts F&P committee, this summary focussed on those metrics which are currently RAG rated red in the Leading Indicator pack.

3.2 Improving Productivity & Efficiency of our Operational Services

Measures: *Increase the percentage of patients waiting less than 1 hour for a bed from the decision to admit and Reduce the average number of ward per patient episode.*

3.21 **Aims:** To increase the percentage of patients waiting less than an hour for a bed from the decision to admit (DTA). This measure supports flow from ED and counter measures against crowding affecting clinical care, quality standards and patient experience. We are also aiming to get the patient in the right bed and minimise the number of wards a patient experience when admitted to the hospital.

3.2.2 **Status: Red** - The target of 60% of patients being admitted to a bed in 1 hour of decision to admit is not being met, with performance at 12.22% in August. The average number of wards a patient experience is staying fairly stable at 1.70, similar to other months.

Casual factors affecting performance	Actions being taken
• Patients remaining in the bed base with no criteria to reside. • Reduced bed availability for acute admissions • Temporary reduction in base ward beds due to the final stages of the NOM programme delivery.	• Completion of the NOM programme. • Formal review of the patient flow form and function with amended information flows. • Programme to relaunch and engage the organisation in criteria to reside.

- Digital solution and consistency of reporting linked to the criteria to reside information data set.
- Further work needed on the BO metrics.
- Review of the BO metrics as part of the leading indicators to link to operational actions

Measures: *Reduce the number of waits for a bed >12 hrs following a decision to admit (DTA breach) and Increase in the % of ambulance handovers within 15 minutes.*

3.2.3 **Aims:** To reduce delayed transfers from the Emergency Department leading to an overcrowded department, extended waits within the ED, poor patient outcomes, poor patient and staff experience. And to reduce the risk of ambulance handover delays resulting in an undifferentiated risk in the community due to unavailability of resources to respond, poor patient outcomes and poor patient and staff experience.

3.2.4 **Status: Red** - The target of zero 12-hour DTA breaches has not been met with 16 recorded between April and the end of August. However, there were none in August and in the same period last year, 140 were recorded. The target of 65% of ambulance handovers within 15 minutes is also not met, with 48.3% achieved in August.

Casual factors affecting performance

- Estates work is continuing resulting in a temporary decant of wards (due to complete Oct 23, extended from September).
- Reduced bed availability for acute admissions
- 'Clustering' of ambulance arrivals making handover difficult at peak times due to environmental constraints within the department.
- Decision to place in patients within the Same Day Emergency Care environment – reducing SDEC capacity and increasing delays within the Emergency Department

Actions being taken

- Completion of the NOM programme.
- Review of the ambulance conveyances and identification of 'peak' clustering periods.
- Meeting with NEAS set up to review conveyance levels and timings. Internal ED action plan progressing to reduce delays.
- Review of the impact of SDEC being used as additional inpatient capacity
- Review of internal escalation processes and digital triggers for patient's who have a DTA

Measures: *Reduce the average number of patients that are in acute beds and who are fit for discharge (do not meet criteria to reside) and a reduction in the time (days) between patients becoming medically optimised and discharge*

3.2.5 **Aims:** To reduce the number of patients who do not meet the criteria to reside and bed days lost through occupation of acute beds in order to minimise the risks of long waits in ED, cancellation of planned procedures and the risk of opening additional beds with associated staffing implications & patient risk management. Patients remaining within hospital beds longer than necessary

for treatment have increased risk of deconditioning and hospital acquired infection.

3.2.6 **Status: Red** - The Trust has an improvement trajectory of no more than 18 patients on average who don't meet the criteria to reside, to date the target has not been met, with 46 patients recorded in August. While no actual target value has been set for the number of bed days lost each month, the plan is to reduce. Since June the number of bed days lost have increased to 2467 in August.

Casual factors affecting performance	Actions being taken
• % of patients on P1-P3 remain the greatest challenge, internally referral to the discharge hub is a pressure. • Individual patients contribute significantly to the increased bed days lost. • Out of area patients awaiting discharge on pathways 1-3 have seen a significant increase in July and August • There has been an issue with procuring packages of care in the Washington area (Sunderland Social Care) which has led to some patients admitted in May remaining in hospital.	• Daily review of patients on list of patients who are medically optimised. • Daily allocation of patients to appropriate out of hospital placements. • Strategic planning with social care to identify and appropriately and commission system capacity to reduce pathway 1-3 delays. • Further work with Sunderland Transfer of Care hub to address their long stay patients in Gateshead Trust. • Trust to embark on a programme of re-launching 'criteria to reside' with digital support to promote discharge and improved data collection at the board round.

Measures: *Reduction in overall Trust length of stay to the top quartile (<4Days)*

3.2.7 **Aims:** To reduce the length of stay in hospital to provide patients with a better care experience by ensuring they are discharged from hospital without unnecessary delay. Prolonged stays in hospital are bad for patients, especially for those who are frail or elderly. As a Trust we are aiming to be in the nationally benchmarked top-quartile of all Acute Trusts, this will be reducing our length of stay to less than 4 days.

3.2.8 **Status: Red -** There has been some improvement in this metric, since the high of February 23 when the average was 5.19 days. However, the trust achieved 4.56 in days in August, against a target length of stay of <4 days to support upper quartile national benchmark status. So far this financial year monthly figures have ranged between 4.26 and 4.68 days.

Casual factors affecting performance	Actions being taken
• Length of stay is Influenced by both internal (hospital/community) and external (system wide) factors.	• System wide resilience group established, creating opportunities to explore system wide solutions to

- Factors include internal processing delays, separate data collection systems and delayed decisions to support speedier discharge.
- System wide factors include access to care outside of hospital.

collaboratively address challenges explore wider solution opportunities.
- The Clinical Strategy Group are identifying priority pathways and particular areas requiring support to drive clinically led length of stay projects on a task and finish basis.
- Medicine are further developing their front of house frailty model to prevent avoidable admissions for our frail and elderly patients
- Trust to embark on a programme of re-launching 'criteria to reside' with digital support to promote discharge and improved data collection at the board round.

Measures: *Reduce to 0 the number of 52 week waiters on the RTT waiting list, by the year end*

3.2.9 **Aims:** To reduce to Zero the number of patients that wait more than 52 weeks on a Referral to Treatment pathway, as long waits result in poor patient experience & risk of complaints, increased clinical risk & litigation, reputational risk of not meeting constitutional standards and Operational Plan targets.

3.2.10 **Status: Red** – at the end of August the Trust had 237 patients who had been waiting more than 52 weeks. This is 177 above planned for levels at this point in the year and an increase from 100 in April. Projections at present are for the number to continue to rise, to circa 283 by the end of September. The largest pressure specialities are Paediatrics, Pain, Trauma and Orthopaedics.

Casual factors affecting performance

- Below planned elective activity levels: (-2,729 cumulative deficit)
- Site pressures resulting in the loss of elective beds and activity
- Demand and capacity challenges to accommodate longest waiters in Pain, Paediatrics, T&O, Gynaecology, and General Surgery.
- Financial pressures to support additional capacity to recover the long waiter position.
- Decentralized management of waiting list
- Data quality and inconsistency of practice in RTT management

Actions being taken

- Recovery plans developed and agreed as part of weekly Performance Clinics to focus on the reduction of long waiter cohort.
- Revised format of weekly performance clinics to focus on broader performance that may impact long waiters, such as diagnostics.
- Weekly patient level review of long waiters as part of weekly performance clinic, focus including potential 65-week cohort to ensure plans in place for these patients.
- Exploring digital mutual aid/IS

- Business case progression for increased capacity in challenged specialities where applicable.
- Review of clinical pathways and transformation through the elective care programme board.
- Exploring a review of the waiting list and existing validation processes.

Measures: *A reduction in the RTT PTL outpatient waiting list*

3.2.11 **Aims:** To reduce the number of patients on the outpatient RTT waiting list and who wait long period for treatment, in order to reduce poor patient experience & risk of complaints, increased clinical risk & litigation, reputational risk of not meeting constitutional standards and Operational Plan targets.

3.2.12 **Status: Red -** Having increased month on months since April, the number of patients on the RTT outpatient waiting list fell between June and August by 4% to 10,387 however, this remains well above the local trajectories.

Casual factors affecting performance	Actions being taken
• Elective activity below plan • Industrial action and staffing issues impacting position due to cancellation of elective activity • Issues around data quality and validation the waiting list of outpatient waiters • DNA rates in some clinics are high	• Productivity opportunity by implementation pilot of partial booking. • Activity plans discussed weekly through performance clinics and divisional meetings. • Scoping opportunities for additional activity through additional clinics. • Review of OP clinic templates in progress to understand any potential opportunities. • Potential of clinical triage of referrals to manage demand - scoping in the SBU presently. • Exploring a review of the waiting list and existing validation processes • Targeted validation.

3.3 We will be a great place to work with a highly engaged workforce

Measures: *Maintain a target score of 6.9 in Trust Staff Survey for engagement*

3.3.1 **Aims:** To have a revised focus on increasing engagement, particularly clinical engagement, to help develop and understand work force practices to reduce vacancy and absence rates to improve staffing levels, which is cited as a key area of concern for colleagues.

3.3.2 **Status: Red** – Trust score has consistently been below the 6.9 target since January 2023, achieving 5.92 in the latest set of results for July. The trust was achieving the target in the previous year.

Casual factors affecting performance	Actions being taken
• Low levels of engagement with both Annual and Pulse Survey Results, bringing validity of measure into question	• A revised focus on increasing engagement, particularly clinical engagement • Diversify engagement measurement tools to gain a more rounded picture. • Involve a more targeted focus on the 3 elements of the Engagement Score i.e. Motivation, Involvement and Advocacy

Measures: *Reduce the sickness absence rate in line with the Operational Plan to below 5%*

3.3.3 **Aims:** To reduce vacancy rates as higher absence rates add pressure to the Trust, staff wise and financially, and therefore impact our ability to provide a safe and high quality service.

3.3.4 **Status: Red** - With the exception of May 2023, the overall sickness levels have been consistently above the 5% target, in every month so far this year. Achieving 5.7% in August, this is the highest so far of any month since January 2023.

Casual factors affecting performance	Actions being taken
• Volume of individuals triggering and continuing to trigger the absence management policy. • Pockets of strong engagement with sickness management processes, but this is not universal.	• Robust system of absence management introduced – new policy in place >12 months. • Absence management training package available. • Focused work including monthly case reviews, target setting and sickness clinics. • Monthly case management approach of all long term absence cases. • Business Units provided with monthly short term absence reports highlighting all employees who have triggered short term absence procedure. • Ongoing training and development being explored internally to support managers.

3.4 We will achieve financial sustainability

Measures: *CRP actioned to achieve £15.9m reductions, Pay spend no greater than £250m, Non-pay spend no greater than £132.5m*

3.4.1 **Aims:** The Trust to achieve financial sustainability, through a focus on key financial plans and actions such as reducing overspends against delegated budgets, achievement of cost reduction programme and achievement of activity trajectories and income targets.

3.4.2 **Status: Red –** At the end of August all key metrics were failing to meet their targets, however some areas are seeing improvement. Year to date CRP target is circa £133k below planned levels, £1.1m transacted in month to close the gap. Pay spend is £3,414m above planned for levels year to date, in August pay spend was £1,320m above planned levels. Non pay spend is £2,019m above planned for levels year to date, with Augusts in month position at £1,656m above plan. Cumulative year to date with a planned deficit at the end of August of -£6,594m, the Trust stood at -£8,872m, £2,278 million more than planned. This was largely driven the overspends against plan recorded for August.

Casual factors affecting performance

- Opening of non-funded escalation beds contributing to overspends against delegated budgets.
- Medical & Nursing staff pay budgets due to bank and agency spend.
- Identification of schemes to bridge £5m gap against annual target.
- Availability of resource to support project management of identified schemes.
- Industrial action contributing towards reduced activity and increased cost base.
- Unscheduled care operational pressures impacting on elective recovery.

Actions being taken

- Investment in admission avoidance and discharge schemes.
- Implementation of new ward configuration.
- Unscheduled care transformation programme.
- Deep dive into Medicine Business Unit and production of financial recovery plan.
- Additional expenditure controls approved by Executive Management Team including minimising discretionary spend and use of agency staff.
- Analysis of top ten highest earners including waiting list and internal locum payments.
- Investment in international nurse recruitment to fill substantive vacancies.
- Deep dive into senior medical funded establishments, job plans and actual payments.
- Elective care transformation programme.

Gateshead Health NHS Foundation Trust

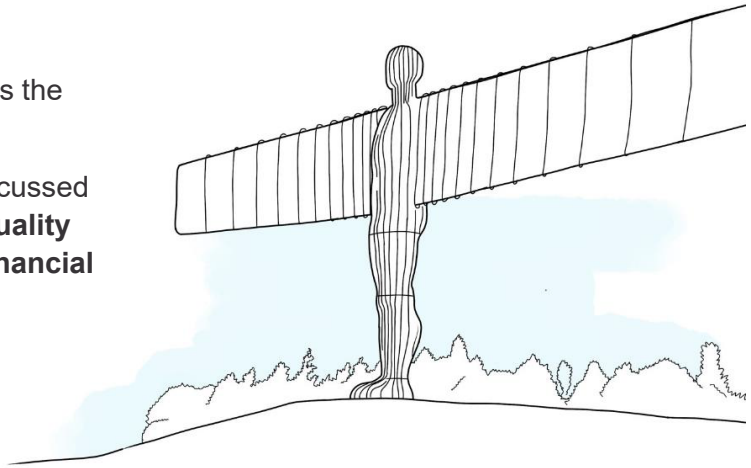
Leading Indicators

September 2023

The Trust has developed a draft set Leading Indicators, which aim to report and monitor on a set of priorities that staff from across the Trust can rally around, and focus efforts to make best use of time and resource to secure the biggest impact on our patients.

At present the Trust has identified 9 leading indicators, which are supported by 12 breakthrough objectives. The indicators are focussed around 4 strategic objectives of I**mprove productivity and efficiency of our operational services, continually improve the quality and safety of our services for our patients, being a great organisation with a highly engaged workforce and achieving financial sustainability**

This pack is the third iteration of the metrics, which are continuing to be refined and developed.



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	RAG	Pages	Comment
We will improve productivity and efficiency of our operational services			
Increase the percentage of patients waiting less than 1 hour for a bed from the decision to admit	LI	4	
Reduce the average number of ward moves per patient	BO		Under development
Patients moving to the right bed	BO		Under development
Reduce the number of waits for a bed >12 hrs following a decision to admit (DTA breach)	LI	5	
Increase in the % of ambulance handovers within 15 minutes	BO		
Reduction in the time (days) between patients becoming medically optimised and discharge	BO	6	
Reduce the average number of patients that are in acute beds and who are fit for discharge (do not meet criteria to reside)	BO		
Reduction in overall Trust length of stay to the top quartile (<4)	LI	7	
Readmission rates within the expected range	BO		
Reduce to 0 the number of 52-week waiters on the RTT waiting list, by the year end	LI	8	
A reduction in the RTT PTL outpatient waiting list	BO	9	
Increase in new outpatient appointments by 25%	BO		Under development
We will continually improve the quality and safety of our services for our patients			
C.Diff per 100,000 bed days below or in line with national objective	LI	11	
Increase the proportion of closed actions in the CQC action plan, reported to SMT	LI	12	
Reduction in the harm rate per 1,000 bed days from patient falls	LI	13	
Summary Hospital-level Mortality Indicator (SHMI) within the expected range / <1	BO	14	
Hospital Standardised Mortality Ratios (HSMR) within the expected range / <100	BO		
We will be a great organisation with a highly engaged workforce			
Maintain a target score of 6.9 in Trust Staff Survey for engagement	LI	16	
Reduce the vacancy rate in line with the Operational Plan to below 5%	BO		
Reduce the sickness absence rate in line with the Operational Plan to below 5%	BO		
We will achieve financial sustainability			
CRP actioned to achieve £15.9m reductions	LI	18	
Pay spend no greater than £250m	BO		
Non-pay spend no greater than £132.5m	BO		

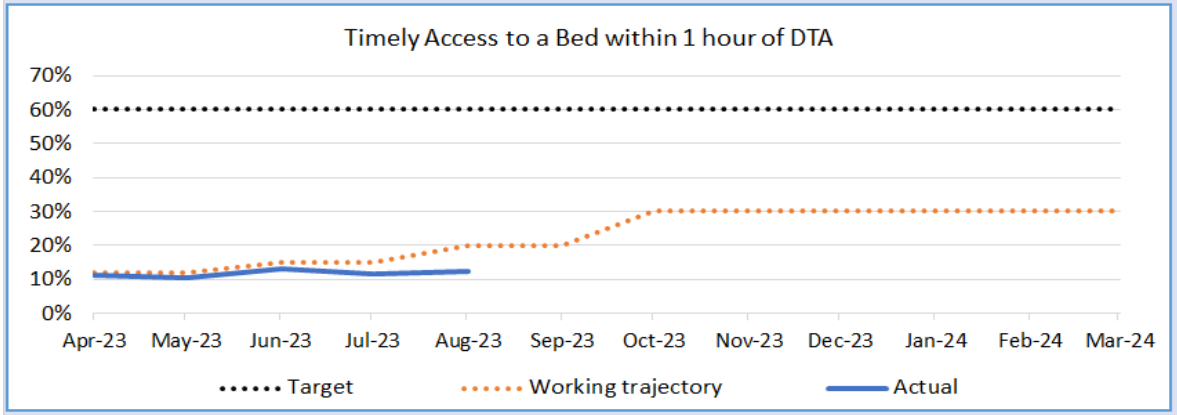
Gateshead Health NHS Foundation Trust

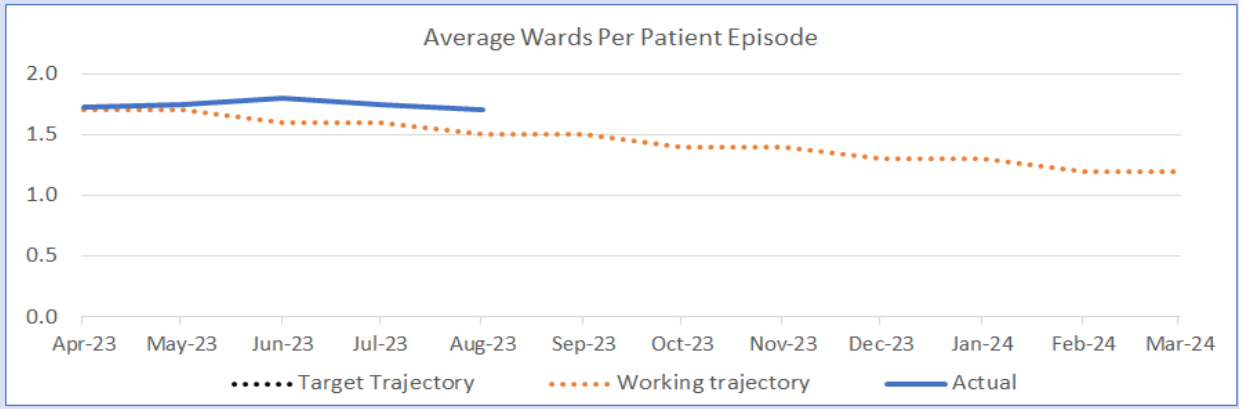
We will improve productivity and efficiency of our operational services

We will improve productivity and efficiency of our operational services

	Status		
LI: Increase the percentage of patients waiting less than 1 hour for a bed from the decision to admit	LI	Director:	Joanna Clark
BO: Reduce the average number of ward per patient episode	BO	Ops Lead:	Mark Dale
BO: Patients moving to the right bed (this measure is currently not available as under development)	BO	Oversight:	Unscheduled Care Programme

NOTE: The indicators in this template "Patients moving to the right bed" and "Reduce the average number of ward moves per patient" are new metrics. Futher work will be undertaken on them to make them as meaningful as possible.





Indicator	Leading Indicator	Period	Target	Target Type	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Trend
Timely Access to a Bed within an Hour of DTA	LI	Aug-23	>60%	Loc	8.37%	7.81%	11.60%	7.77%	8.92%	7.49%	9.58%	11.01%	10.49%	12.92%	11.61%	12.22%	
Reduction in the average number of wards per patient episode	BO	Aug-23	TBA	Loc	1.70	1.67	1.69	1.71	1.74	1.77	1.81	1.73	1.75	1.80	1.75	1.70	
Patients Moving to the Right Bed	BO		TBA	Loc	(this measure is currently not available as under development)												

Risks: Risk of delayed transfers from the Emergency Department leading to an overcrowded department, extended waits within the ED, poor patient outcomes, poor patient and staff experience.

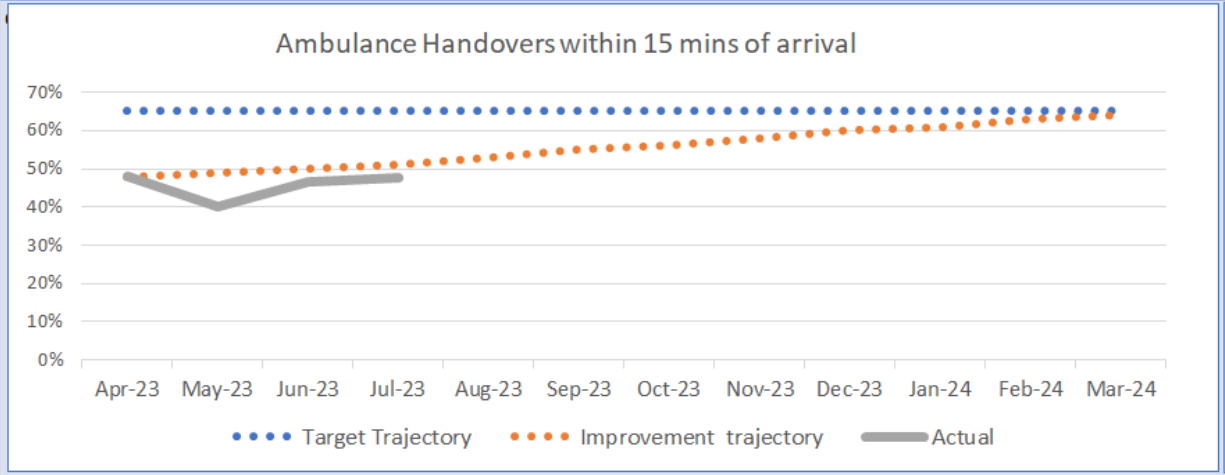
Risk Mitigation: Unscheduled care programme of work incorporating operational efficiencies, effectiveness and patient flow focus across the place with an emphasis on discharge processes, admission avoidance and attendance alternatives. Formal review of the form and function of the patient flow resource for the organisation. Development of a Task and Finish Group linked to the delivery of a Hospital at Night / Deteriorating Patient Response Model. Relaunch of the Criteria to Reside initiative to improve visibility of our bed occupancy linked to patients with No Reason to Reside.

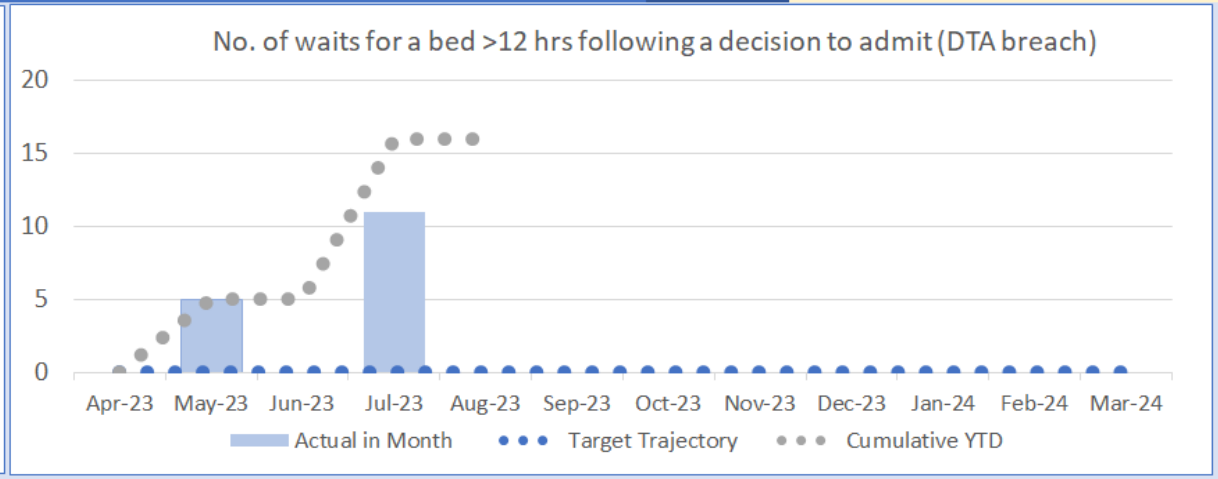
Causal Factors: Patients remaining in the bed base with no criteria to reside. Reducing bed availability for acute admissions. Temporary reduction in base ward beds due to the final stages of the NOM programme delivery. Digital solution and consistency of reporting linked to the criteria to reside information data set. Further work needed on the BO metrics.

Actions being taken: Completion of the NOM programme. Formal review of the patient flow form and function with amended information flows. Programme to relaunch and engage the organisation in criteria to reside. Review of the BO metrics as part of the leading indicators to link to operational actions.

We will improve productivity and efficiency of our operational services

	Status		
LI: Reduce the number of waits for a bed >12 hrs following a decision to admit (DTA breach)	LI	Director:	Joanna Clark
BO: Increase in the % of ambulance handovers within 15 minutes	BO	Ops Lead:	Mark Dale
		Oversight:	Unscheduled Care Programme





Indicator	Leading Indicator	Period	Target	Target Type	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Trend
Ambulance Handovers within 15 mins from arrival	BO	Aug-23	65%	Nat.	38.2%	34.7%	33.6%	24.7%	39.5%	48.6%	48.0%	48.0%	40.3%	46.6%	47.8%	48.3%	
Waits for a bed >12 hrs following a decision to admit (DTA breach)	LI	Aug-23	Zero	Nat.	164	134	172	538	320	40	80	0	5	0	11	0	

Risks:
Risk of delayed transfers from the Emergency Department leading to an overcrowded department, extended waits within the ED, poor patient outcomes, poor patient and staff experience
Risk of ambulance handover delays resulting in an undifferentiated risk in the community due to unavailability of resources to respond, poor patient outcomes and poor patient and staff experience.

Risk Mitigation:
Unscheduled care programme of work incorporating operational efficiencies, effectiveness and patient flow focus across the place.

Causal Factors: Estates work is continuing resulting in a temporary decant of wards (due to complete Oct 23, extended from September). 'Clustering' of ambulance arrivals making handover difficult at peak times due to environmental constraints within the department. Decision to place in patients within the Same Day Emergency Care environment – reducing SDEC capacity and increasing delays within the Emergency Department.

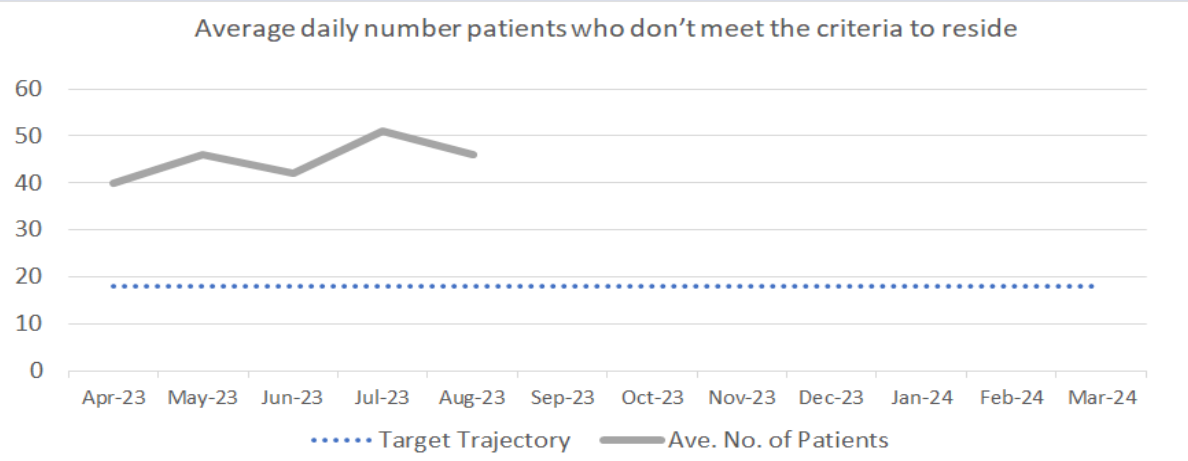
Actions being taken: Completion of the NOM programme. Review of the ambulance conveyances and identification of 'peak' clustering periods. Meeting with NEAS set up to review conveyance levels and timings. Internal ED action plan progressing to reduce delays.

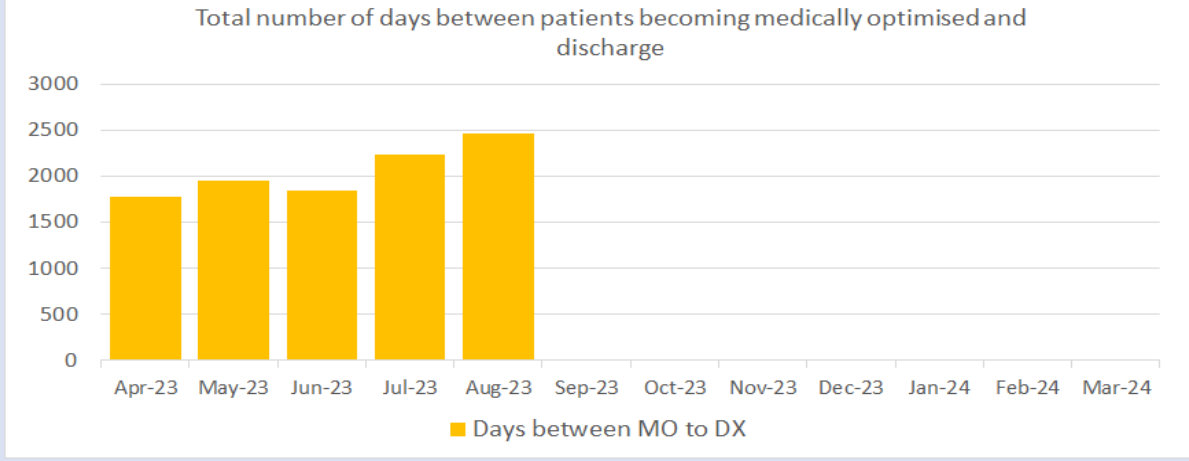
Review of the impact of SDEC being used as additional inpatient capacity

We will improve productivity and efficiency of our operational services

	Status		
BO: Reduction in the time (days) between patients becoming medically optimised and discharge	BO	Director:	Joanna Clark
BO: Reduce the average number of patients that are in acute beds and who are fit for discharge (do not meet criteria to reside)	BO	Ops Lead:	Stephanie Robinson
		Oversight:	Transformation Board

NOTE: The Trust is currently reviewing management of these patients to reflect NHSE terminology of "criteria to reside". Our intention is to reduce patients in acute beds who no longer meet the criteria to reside so this indicator will be subject to change.





Indicator	Leading Indicator	Period	Target	Target Type	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Trend
Average daily number patients who don't meet the criteria to reside	BO	Aug-23	≤18	Loc.	52	40	52	56	53	51	43	40	46	42	51	46	
Total days between patients becoming MO and discharged	BO	Aug-23	Monitor	Loc.	1943	1896	2175	2677	2259	2391	2798	1783	1952	1851	2236	2467	

Risks: The Trust has an improvement trajectory of no more than 18 patients who are MOFD. There are risks of long waits in ED, cancellation of planned procedures and the risk of opening additional beds with associated staffing implications & patient risk management. Patients remaining within hospital beds longer than necessary for treatment have increased risk of deconditioning and hospital acquired infection

Risk Mitigation: Risks are managed dynamically through two routes: Operationally this involves daily liaison with social care to identify services outside hospital and increased capacity on surge days for trusted assessment. Strategically this involves working with Commissioners and colleagues at "Place" to ensure that the correct step up step down capacity is in place to facilitate discharge. System partners are working with providers of care outside Gateshead to determine whether discharges to these areas can be expedited.

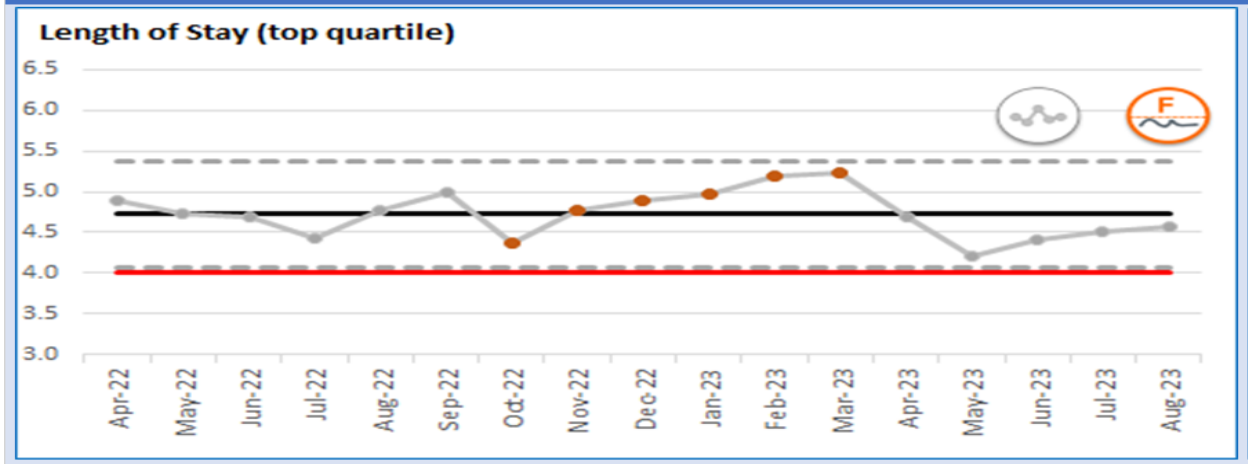
Causal Factors: % of patients on P1-P3 remain our greatest challenge, internally referral to the discharge hub is the greatest pressure. Out of area patients awaiting discharge on pathways 1-3 have seen a significant increase in July and August but we are now seeing a reduction. There has been an issue with procuring packages of care in the Washington area (Sunderland Social Care) which has led to some patients admitted in May remaining in hospital. Individual patients contribute significantly to the increased bed days lost.

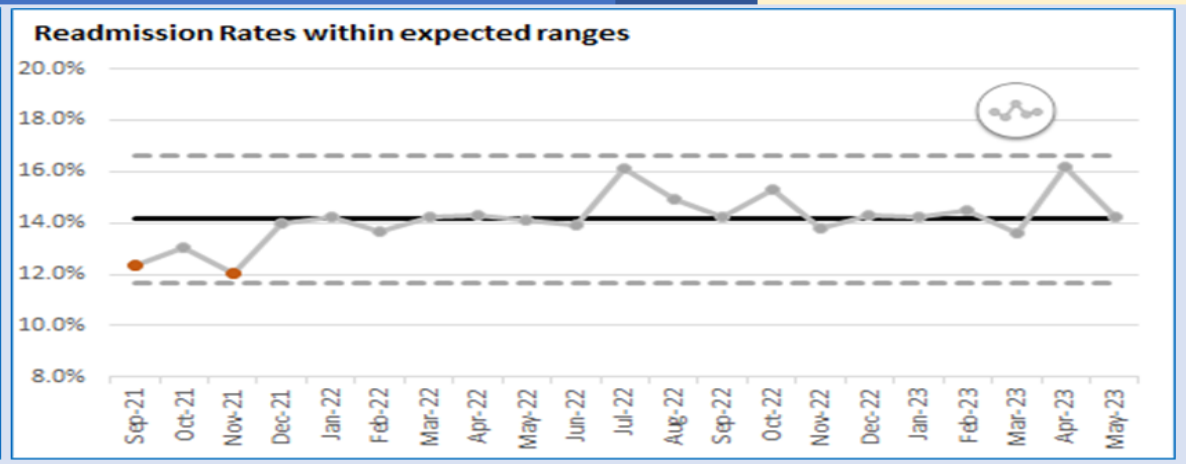
Actions being taken: Daily review of patients on list of patients who are medically optimised. Daily allocation of patients to appropriate out of hospital placements. Strategic planning with social care to identify and appropriately and commission system capacity to reduce pathway 1-3 delays.

Further work with Sunderland Transfer of Care hub to address their long stay patients in Gateshead Trust.

We will improve productivity and efficiency of our operational services

	Status		
LI: Reduction in overall Trust length of stay to the top quartile (<4)	LI	Director:	Neil Halford
BO: Readmission rates within the expected range	BO	Ops Lead:	TBC
		Oversight:	Unscheduled Care Transformation





Indicator	Leading Indicator	Period	Target	Target Type	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Trend
Trust overall length of stay	LI	Aug-23	Top Quartile <4	Loc.	4.99	4.37	4.77	4.9	4.98	5.19	5.23	4.68	4.26	4.44	4.5	4.56	
Elective (exc. DC)		Aug-23	Monitor	Loc.	4.77	2.6	3.9	3.32	4.44	4.7	3.09	4.26	2.52	2.66	3.91	2.48	
Non Elective		Aug-23	Monitor	Loc.	5.02	4.57	4.88	5.05	5.04	5.24	5.45	4.72	4.43	4.6	4.55	4.66	
Readmission Rates	BO	May-23	Monitor	Loc.	14.2%	15.3%	13.8%	14.3%	14.2%	14.5%	13.6%	16.2%	14.2%				

Risks

Prolonged stays in hospital are deconditioning patients, especially for those who are frail or elderly, and can provide patients with a poorer care experience, therefore there is a focus on patients being discharged from hospital without unnecessary delay.

Artificially high readmission rates due to all SDEC attendances being captured as NEL Admissions.

Risk Mitigation

Length of stay – Being managed and monitored by Business Unit and Service Line. Forms part of Unscheduled Care Transformation Programme.

Re-admissions - Being managed and monitored by Business Unit and Service Line. Forms part of Unscheduled Care Transformation Programme.

Causal Factors:

Length of stay – Influenced by factors external to the Trust with respect to discharge. Improve discharges to earlier in the day and improving transfer of care. Getting people to the right place first time. Keeping the system flowing well.

Re-admissions - Data capture of SDEC return patients as NEL admissions inflates re-admission rate. Digital capacity to implement change to Type 5 is limited - Risk of deferring.

Actions being taken:

Length of stay – Work closely and into the system wide winter plan. Identify priorities within clinical pathways to allow timely and appropriate resource allocation (outputs from CSG). Further development of frailty at the front door to reduce admissions, embedded use of the virtual ward, criteria led discharge, red and green days, development of the discharge lounge and better use of digital enablers.

Re-admissions - Remodel SDEC Follow-ups, deduct from NEL to determine real rate, and continue to monitor. Develop integrated flow across the integrated care model.

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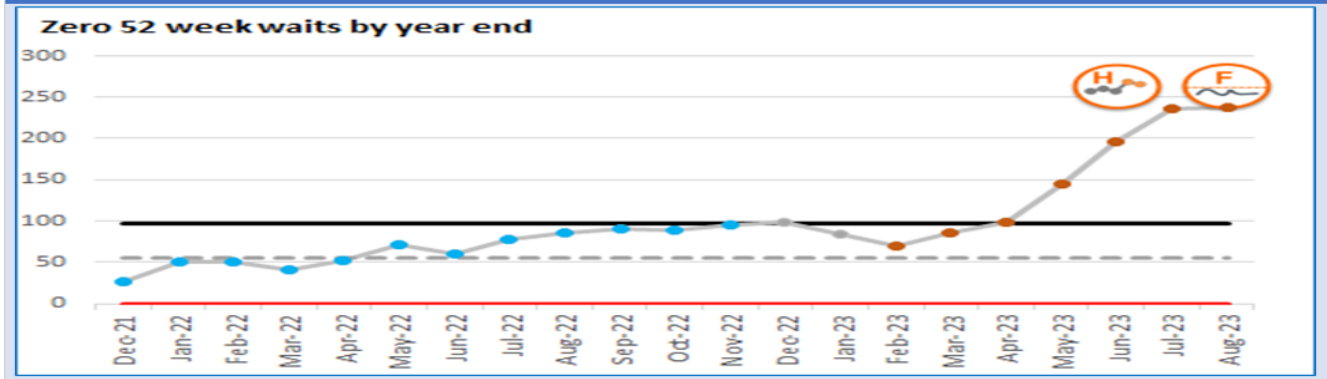
We will improve productivity and efficiency of our operational services

LI: Reduce to 0 the number of 52 week waiters on the RTT waiting list, by the year end

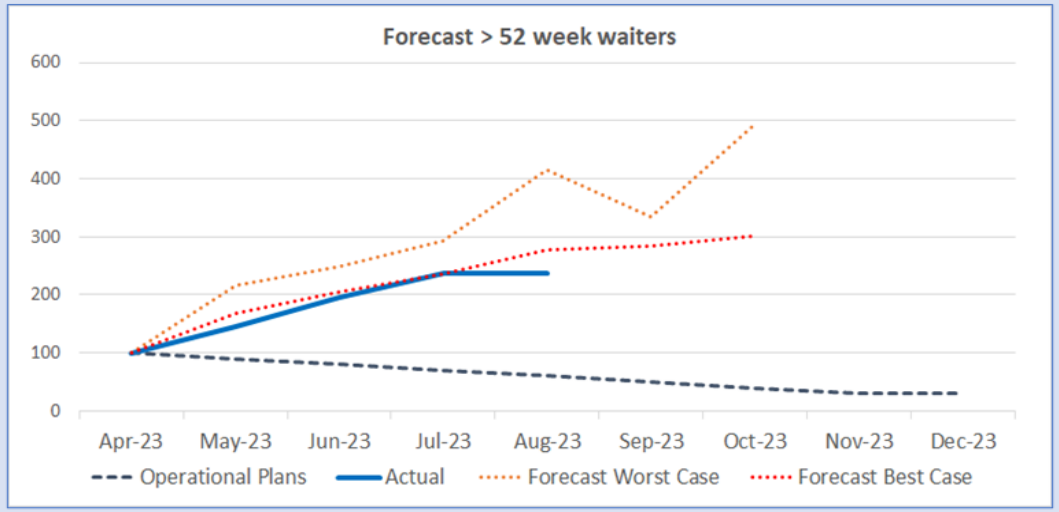
Status: LI

Director: Amy Muldoon
Ops Lead: Ross Peddie
Oversight: Elective Care Programme



52 week waits numbers / actual and projections	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Operational Plans	100	90	80	70	60	50	40	30	30	20	10	0
Actual	100	145	196	236	237							
Forecast Worst Case	100	217	249	292	415	335	493					
Forecast Best Case	100	169	205	236	278	283	302					
Forcasted		02-May	05-Jun	17-Jul	17-Jul	19-Sep	19-Sep					

Specialty Forecast (best case)	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
Paediatrics				104	93	112
Pain				67	77	79
Orthopaedics				29	49	42
General Surgery				18	26	27
Urology				8	9	8
Gynae				4	7	9
Gastro				2	2	3
Cardiology				0	0	1



Risks: Long waits resulting in poor patient experience & risk of complaints. Increased clinical risk & litigation. Reputational risk of not meeting Constitutional standards and Operational Plan targets.

Risk Mitigation: Weekly performance clinics to support specialty level recovery plans, specifically reviewing patients over 52w/65w. Service line recovery plans which suggest zero 52 week waits by March 24 won't be achieved are escalated to Senior Management Team for awareness and support. Continue to explore mutual aid support at a system level for specialties with long waiters. Full plans for the "65-week" cohort patients being presented at performance clinics.

Causal Factors: Industrial action leading to cancellation of elective activity and site pressures resulting in the loss of elective beds and activity, with 17% of routine working days lost due to IA in 2023/24 financial year to date (September 2023). Data quality and inconsistency of practice in RTT management. Decentralized management of waiting list. Demand and capacity challenges to accommodate longest waiters in Pain, Paediatrics, T&O, Gynaecology, and General Surgery. Financial pressures to support additional capacity to recover the long waiter position.

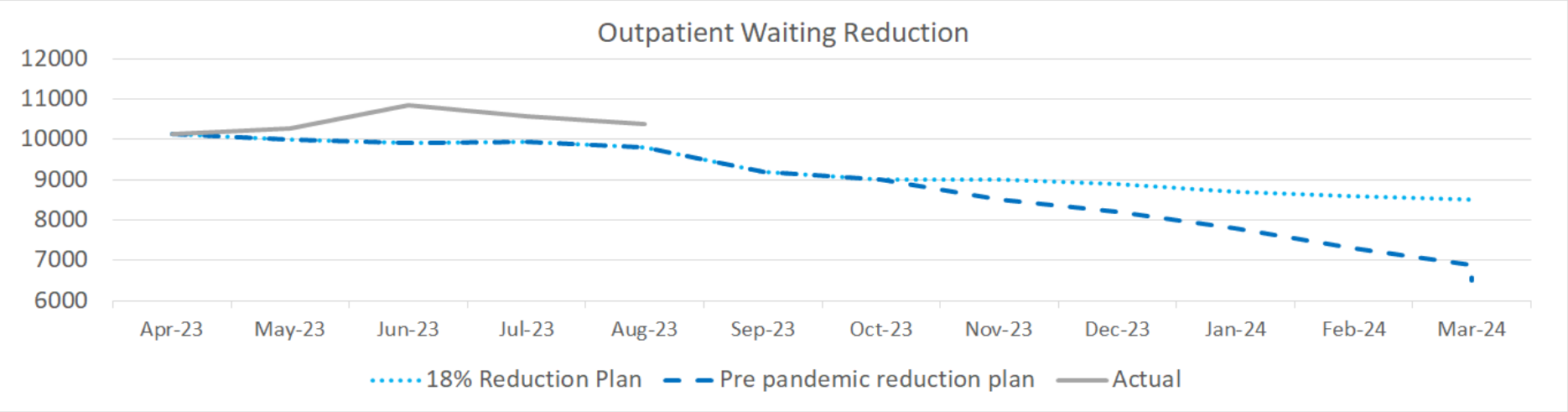
Actions being taken: Recovery plans developed and agreed as part of weekly Performance Clinics to focus on the reduction of long waiter cohort. Revised format of weekly performance clinics to focus on broader performance that may impact, such as diagnostics. Weekly patient level review of long waiters as part of weekly performance clinic, focus including potential 65 week cohort to ensure plans in place for these patients. Business case progression for increased capacity in challenged specialities where applicable. Review of clinical pathways and transformation through the elective care programme board.

We will improve productivity and efficiency of our operational services

BO: A reduction in the RTT PTL outpatient waiting list

Status: BO

Director: Amy Muldoon / Mike Graham
Ops Lead: Ross Peddie / Jason Crawford
Oversight: Elective Care Programme



Indicator	Leading Indicator	Period	Target	Target Type	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Trend
No of outpatient on the RTT waiting list	BO	Aug-23	7,500	Loc.	9528	9906	9607	9441	9558	9784	9643	10146	10283	10835	10584	10387	

Risks: Demand is back to pre-covid levels; Capacity planning difficult without up-to-date job plans. Forecast waits above planned levels: reputational risk. Risk of ability to achieve target of Zero 52w by year end.

Risk Mitigation
Weekly performance clinics to identify specialty level improvement plans led by Ops Director. Pathway reviews to understand bottle necks.

Causal Factors: Elective activity below plan- IA and Staffing issues impacting position due to cancellaton of elective activity. Waiting list cleanse underway, pilot specialty General Surgery but early feedback highlights DQ issues with current waiting list.

Actions being taken: Productivity opportunity by implementation pilot of partial booking. Activity plans discussed weekly through performance clinics and divisional meetings. Scoping opportunities for additional activity through additional clinics. Review of OP clinic templates in progress to understand any potential opportunities. Potential of clinical triage of referrals to manage demand- scoping in the SBU presently.

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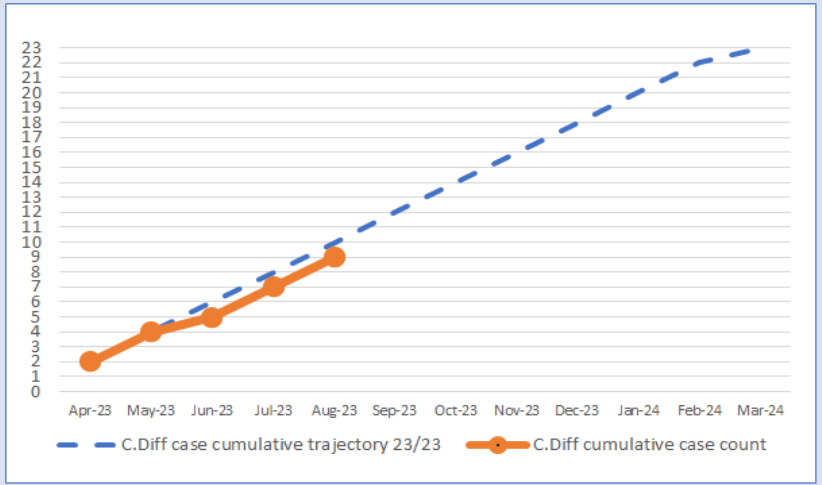
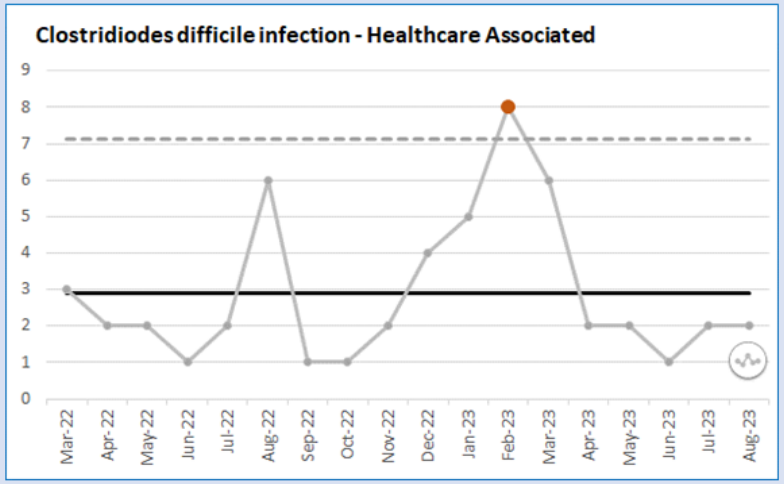
We will continually improve the quality and safety of our services for our patients

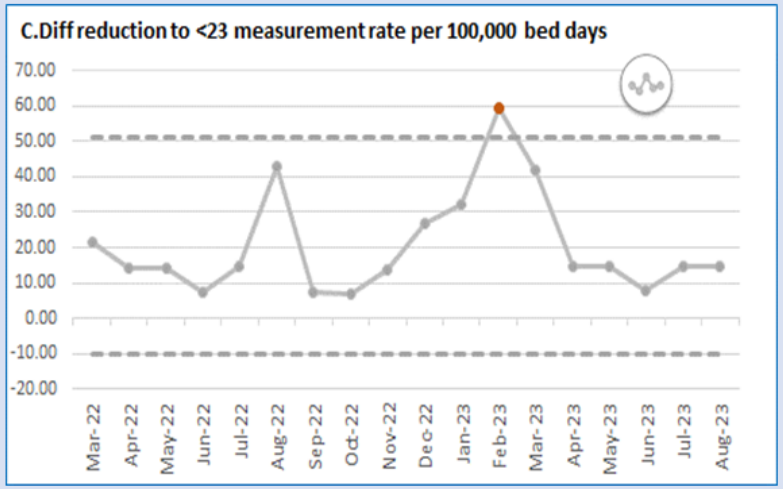
We will continually improve the quality and safety of our services for our patients

LI: Rate per 100,000 bed days below or inline with national objective

Status		
LI	Director:	Gill Findley
	Ops Lead:	Gareth Armstrong
	Oversight:	QGC







C Difficile	C.Diff Reduction target of <23 actual incidents for 2023/24											
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Healthcare Associated	2	2	1	2	2							
Total YTD	2	4	5	7	9							
Community Associated	2	0	0	0	2							

Risks: Risk of patients getting c diff and experiencing poor outcomes, extended stays and potential death. Reputational risk of not hitting national targets. Due to the severely decreased threshold for 23/24, there is a risk that the threshold is not met/exceeded.

Risk Mitigation: Education for front line staff. Good hand hygiene monitored by matrons monthly. Cleanliness of the hospital is monitored daily. All Healthcare Associated Infections are investigated, and any learning shared with the relevant business units.

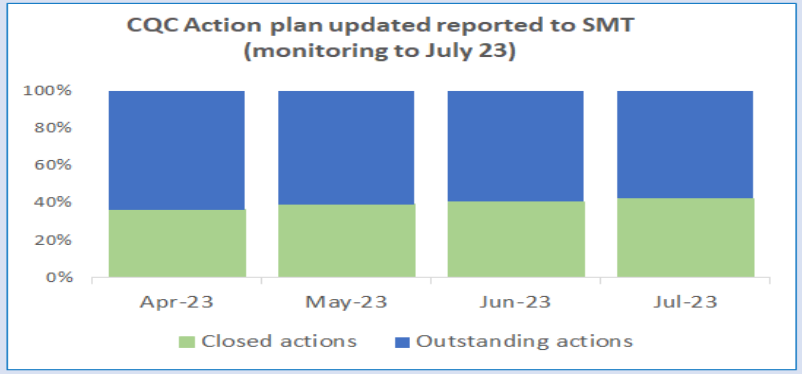
Causal Factors: High levels of C Diff currently circulating in the community. High level of antibiotic prescribing in some areas. As such this is an extremely challenging target. It is by some distance the lowest threshold set for any trust in our region. The IPC team are proud they have been set such a low threshold based on excellent past performance.

Actions being taken: Careful monitoring of antibiotic prescribing. Increased work on improving hand hygiene. Introduction of faecal transplanting for some patients. A 10 point action plan has been developed by the IPC team and the consultant microbiologists. This reflects the regional strategy for Clostridioides *difficile* reduction rate across our ICB. The 10 actions covered within the plan have been discussed and approved at the IPCC and are as follows; education, information campaign, hand hygiene drive, digital record keeping, thematic review and feedback, antimicrobial stewardship, diagnostic stewardship, prevent onward spread, cleaning and disinfection and prevent recurrent cases through enhancing treatment.

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

LI: Increase the proprtion of complete actions in the CQC Quality Improvement Plan, reported to SMT

Status		
LI	Director:	Gill Findlay
	Ops Lead:	Andrew Rayner / Lindsay Grieves
	Oversight:	SMT



	CQC Action Plan updated reported to SMT											
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Total number of actions	154	151	158	158	Old monitoring to July 23 - replaced from Aug 23 onwards, see below.							
Outstanding actions	98	92	94	91								
Closed actions	56	59	64	67								

	CQC Quality Improvement Plan updated reported to SMT											
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Total Actions	New monitoring from Aug 23 onwards				25	25	25	25	25	25	25	25
Overdue					2							
Risk of non achievement					6							
On track for achievement					11							
Not yet due					2							
Complete					4							

Risks:
Non-compliance with CQC regulations. Risk of harm to patients if regulations not followed. Reputational damage if CQC visit and we are in breach of licence.

Risk Mitigation:
CQC compliance officer in post. Regular reporting to SMT. Actions clearly allocated to identified leads with clear timescales.

Causal Factors:
Changes to CQC regulations and requirements.

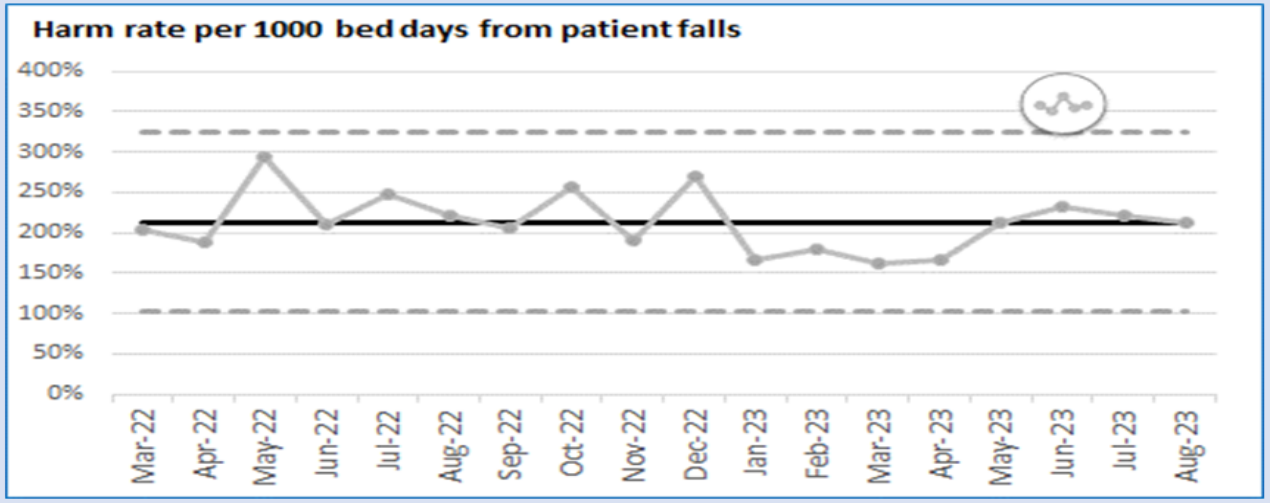
Actions being taken:
Continuous monitoring of the Quality Improvement Plan and regular meetings with action owners will take place. Bi-monthly updates on the plan will be taken to SMT to monitor progress and escalate any issues when necessary.

Note: 1 outstanding action remains on the 2019 CQC action plan. This action is currently rated as amber and is in relation to staff appraisals rates with a focus on Surgery where the initial issue was raised.

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

LI: Reduction in the harm rate per 1,000 bed days from patient falls

Status		
LI	Director:	Gill Findlay
	Ops Lead:	Shelley Dyson / Louise Lodge
	Oversight:	Quality Governance Committee



	Monthly harm from falls											
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Harm rate per 1,000 bed days from patient falls	1.67	2.13	2.31	2.21	2.13							
Improvement Trajectory	TBA	TBA	TBA	TBA	TBA							

Risks: Inpatient falls are the leading patient safety event reported in the Trust. These can vary from no harm to severe harm, and whilst the majority reported are no harm/low harm, we still have a number where patients sustain fractured neck of femurs or sustain significant head injuries from falling.

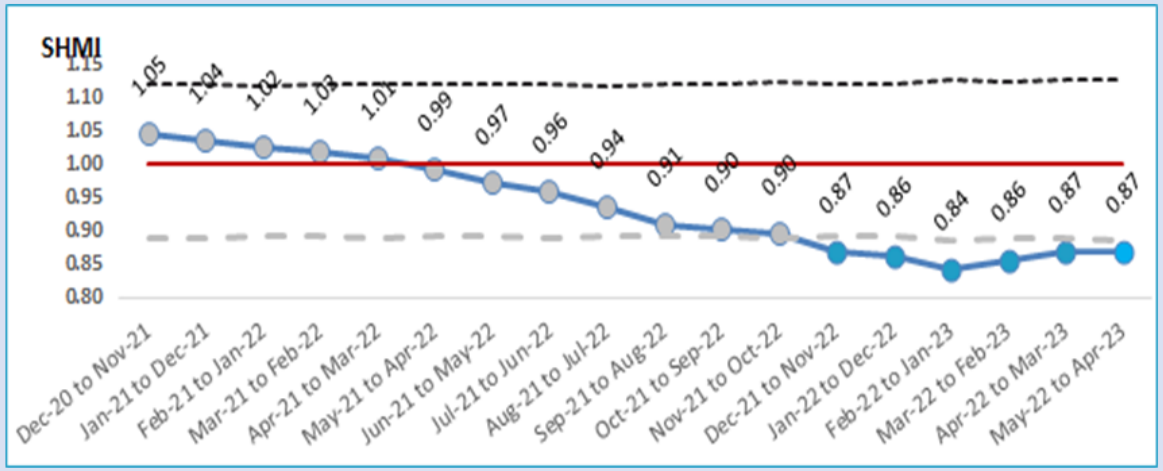
Risk Mitigation: Falls reviews and learning responses are managed at a ward level but overseen by the patient safety lead for that area. All falls learning responses are reviewed at learning panels, and the Trust also supports wider improvement initiatives via a Trust Falls Prevention Group/workstream. This supports the new PSIRF (patient safety incident response framework) which replaces the SIF (serious incident framework). This allows Trusts to focus on prevention work/quality improvement initiatives by investigating themes instead of every individual fall (that invariably generates no new learning). Falls are a leading quality Metrix, reported monthly and reviewed and action planned at ward level. Competency based assessment training for registered and HCSW staff is available and supported.

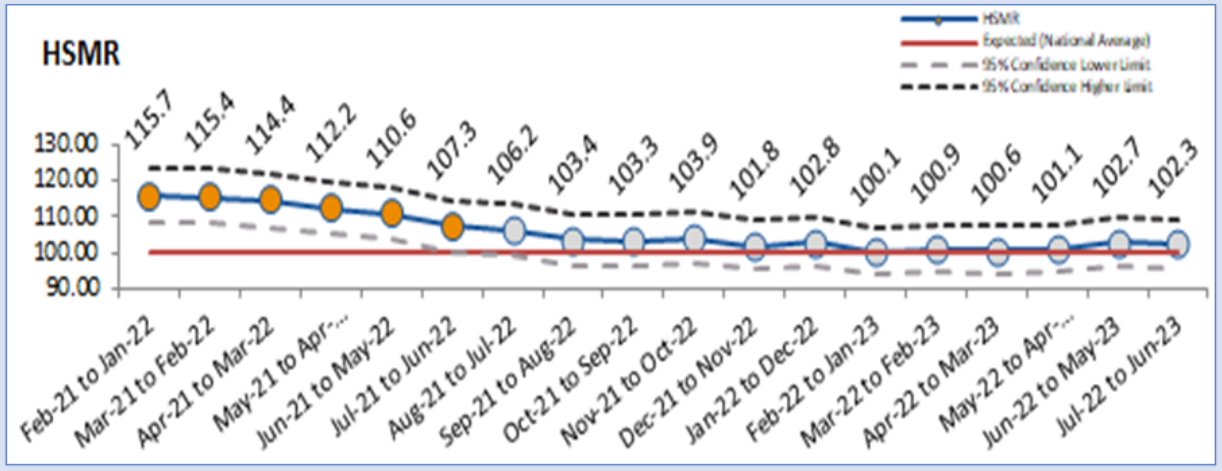
Causal Factors: No inpatient falls provision to support with training, education, and expertise.

Actions being taken: Review of how we monitor falls and learn from incidents. Introduction of 'Avoiding Falls Level of Observation Assessment Tool (AFLOAT)', the aim was to reduce specific falls risk, improve patient safety and improve patient outcomes and experience. Audits of compliance will now be commenced. Numbers of falls have reduced to the median for the past three months suggesting targeted improvement work is beginning to be successful in preventing falls.

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

	Status		
BO: Summary Hospital-level Mortality Indicator (SHMI) within the expected range / <1	BO	Director:	Andy Beeby
BO: Hospital Standardised Mortality Ratios (HSMR) within the expected range / <100	BO	Ops Lead:	Wendy McFadden
		Oversight:	Quality Governance Committee





Indicator	Leading Indicator	Period	Target	Target Type	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Trend
Summary Hospital Mortaility Indicator (SHMI) (rolling 12 months)	BO	Apr-23	≤1	Nat.	0.9	0.9	0.87	0.86	0.84	0.86	0.87	0.87			
Hospital Standard Mortality Ratio (HSMR) (rolling 12 months)	BO	Jun-23	≤100	Nat.	103.3	103.9	101.8	102.8	100.1	100.9	100.6	101.1	102.7	102.3	

Risks: Both the HSMR and SHMI are quality benchmarking metrics, that monitor Trust performance in relation to mortality against statistical expectation calculated from national datasets. Both currently for the Trust are in or below expected ranges. A likely explanation for the reduction in the SHMI score is the inclusion of SDEC activity within the inpatient dataset from Sep-21. Observed deaths will remain the same, however the increased volume of activity will result in higher expected deaths being calculated by the model. Once SDEC activity moves to Type 5 S&E activity then the SHMI score is likely to increase at that point.

Risk Mitigation: Cases scoring more than Hogan 1 are subject to a review at Mortality Council, a proportion of these cases are also patient safety incidents and would go through the Trusts Serious Incident Panel. Since the inception of the Medical Examiner Service in September 2020, all deaths are reviewed and cases may be escalated for additional investigations i.e., Mortality Council, patient safety investigation. Mortality review data for the last 12 months demonstrates that 99.1% of deaths reviewed were 'Definitely not preventable' with 96.2% of cases reviewed identified as 'Good practice'.

Casual Factors: Reviewing of deaths of under 65 with a serious mental illness diagnosis. Outstanding ward level reviews in Medicine and Surgical BU's. Lack of representation at Mortality Council meetings. Cancellation of Mortality Council due to industrial action increases the backlog of cases to review.

Actions being taken: Process agreed with CNTW for the reviewing of deaths of those aged under 65 with serious mental illness diagnosis, cases will be presented to Mortality Council over next couple of months. Outstanding ward level reviews have been escalated to the SafeCare Lead to be discussed with the Clinical Leads to agree a way forward. An advert to promote attendance by medical staff at the Mortality Council will feature in the staff newsletter week commencing 17th July and also the MD bulletin, with an aim to decrease the occasions when the meeting cannot go ahead due to lack of representation.

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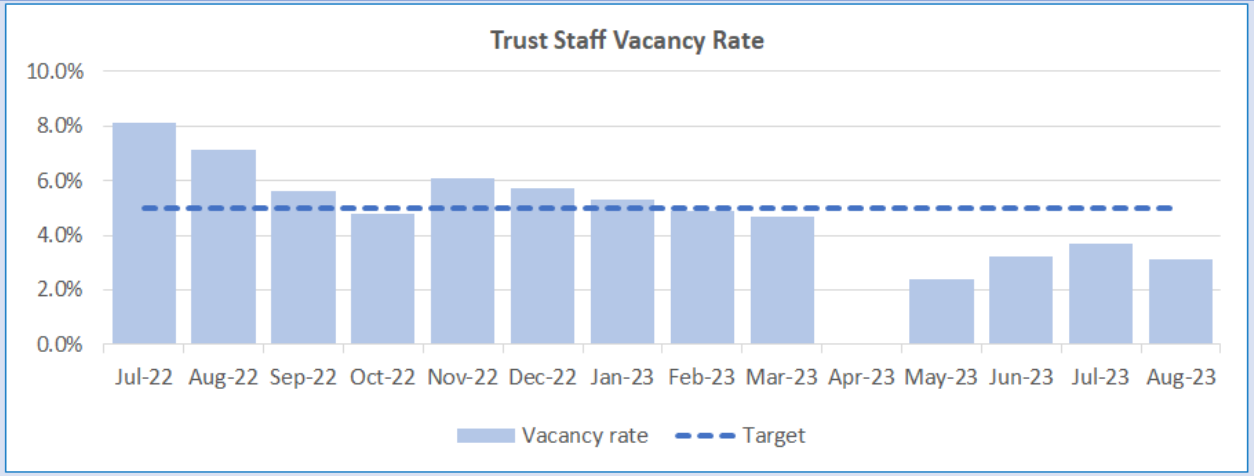
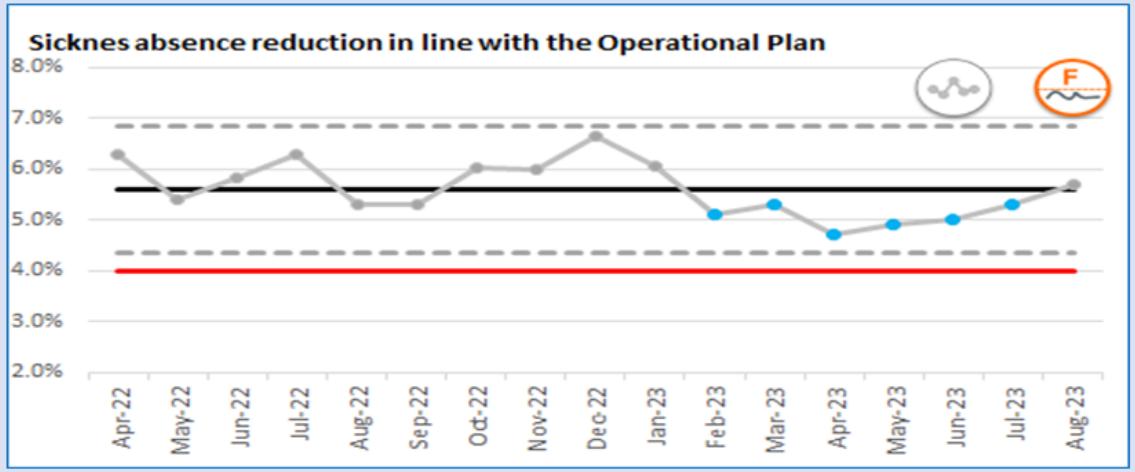
We will be a great organisation with a highly engaged workforce

	Status		
LI: Maintain a target score of 6.9 in Trust Staff Survey for engagement	LI	Director:	Amanda Venner
BO: Reduce the vacancy rate in line with the Operational Plan to below 5%	BO	Ops Lead:	Natasha Botto
BO: Reduce the sickness absence rate in line with the Operational Plan to below 5%	BO	Oversight:	P&OD Committee





Indicator	Leading Indicator	Period	Target	Target Type	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Trend
Trust Staff Survey rate - Engagement score	LI	Q1	SS: 6.9	Loc.	6.35			6.9	6.47			6.77			5.92		
Group Staff Vacancy rates	BO	Aug-23	≤5%	Loc.	5.6%	4.8%	6.1%	5.7%	5.3%	4.9%	4.7%	Not Available	2.6%	3.4%	3.7%	3.1%	
Group Sickness Absence	BO	Aug-23	≤5%	Loc.	5.3%	6.0%	6.0%	6.7%	6.1%	5.1%	5.30%	5.0%	4.9%	5.0%	5.3%	5.7%	

Risks: Engagement Score: Low levels of engagement with both Annual and Pulse Survey Results, bringing validity of measure into question. Annual Engagement score has been declining since 2018 and 2022 saw this steady for the second year at 6.9. **Vacancy Rates:** Vacancies add pressure to the group and our ability to provide a safe and high quality service. **Absence rates:** Absence adds pressure to the group and our ability to provide a safe and high quality service.

Mitigation of Risk; Engagement Score: A revised focus on increasing engagement, particularly clinical engagement, reducing vacancy and absence rates to improve staffing levels, which is cited as a key area of concern for colleagues. **Vacancy Rates:** Continued monitoring of group vacancy rates at a granular level. **Absence rates:** Robust system of absence management introduced – new policy in place >12 months. Absence management training package available. Focused work including monthly case reviews, target setting and sickness clinics.

Causal Factors:
Vacancy Rates: Local & national qualified staff shortages. **Absence rates:** Volume of individuals triggering and continuing to trigger the absence management policy. Pockets of strong engagement, but not universal.

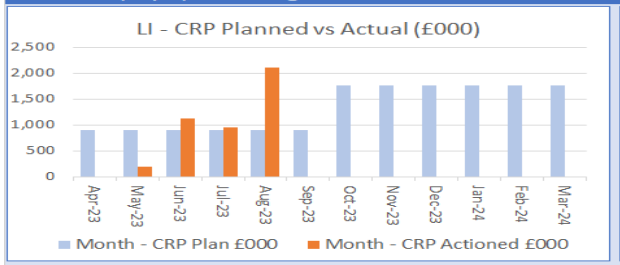
Actions beign taken: Engagement Score: Plans in place to encourage engagement, as well diversify engagement measurement tools to gain a more rounded picture. Likely this will involve a more targeted focus on the 3 elements of the Engagement Score i.e. Motivation, Involvement and Advocacy. **Vacancy Rates:** POD strategies including focusing on retention, absence management, health & wellbeing, international recruitment. Consideration of the NHS long term plan and implications at a local level. Begin to develop robust workforce planning processes across the organisation considering skills requirements and utilisation of new roles e.g. RDNA programme. **Absence rates:** Continue with monthly case management approach of all long term absence cases. Business Units provided with monthly short term absence reports highlighting all employees who have triggered short term absence procedure. Ongoing training and development being explored internally to support managers.

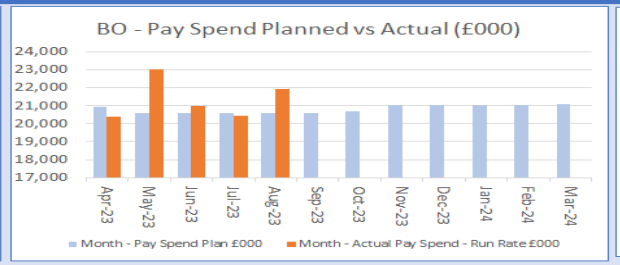
NHS
Gateshead Health
NHS Foundation Trust

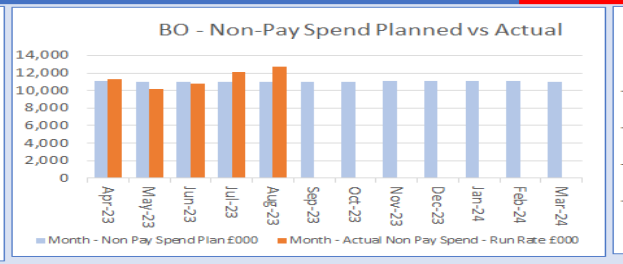
We will achieve financial sustainability

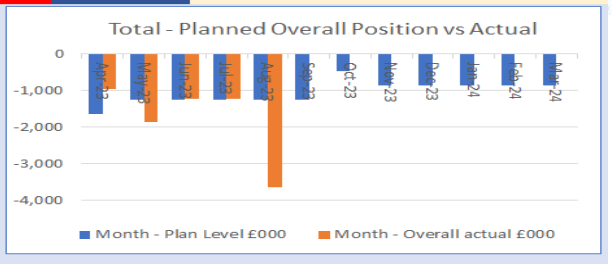
We will achieve financial sustainability

	Status		
LI: CRP actioned to achive £15.9m reductions	LI	Director:	Kris Mckenzie
BO: Pay spend no greater than £250m	BO	Ops Lead:	Jane Faye
BO: Non-pay spend no greater than than £132.5m	BO	Oversight:	Finance & Performance Committee









	Leading Indicator	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Total
Month - CRP Plan £000	LI	897	897	897	897	897	897	1,753	1,753	1,753	1,753	1,753	1,753	15,900
Month - CRP Actioned £000		0	191	1116	949	2096								4,352
Month - Variance £000		-897	-706	219	52	1,199								-11,548
YTD - CRP Plan £000		897	1,794	2,691	3,588	4,485	7,135	7,135	8,888	10,641	12,394	14,147	15,900	
YTD - CRP Actioned £000		0	191	1,307	2,256	4,352								
YTD - Variance £000		-897	-1,603	-1,384	-1,332	-133								
Month - Pay Spend Plan £000	BO	20,953	20,593	20,593	20,593	20,593	20,593	20,677	21,037	21,037	21,037	21,037	21,068	249,811
Month - Actual Pay Spend - Run Rate £000		20,379	23,002	20,994	20,451	21,913								106,739
Month - Variance £000		-574	2,409	401	-142	1,320								-143,072
YTD - Pay Spend Plan £000		20,953	41,546	62,139	82,732	103,325	144,595	144,595	165,632	186,669	207,706	228,743	249,811	
YTD - Actual Pay Spend - Run Rate £000		20,379	43,381	64,375	84,826	106,739								
YTD - Variance £000		-574	1,835	2,236	2,094	3,414								
Month - Non Pay Spend Plan £000	BO	11,051	11,025	11,025	11,025	11,025	11,025	11,027	11,053	11,053	11,053	11,053	11,009	132,424
Month - Actual Non Pay Spend - Run Rate £000		11,311	10,203	10,823	12152	12681								57,170
Month - Variance £000		260	-822	-202	1,127	1,656								-75,254
YTD - Non Pay Spend Plan £000		11,051	22,076	33,101	44,126	55,151	77,203	77,203	88,256	99,309	110,362	121,415	132,424	
YTD - Actual Non Pay Spend - Run Rate £000		11,311	21,514	32,337	44,489	57,170								
YTD - Variance £000		260	-562	-764	363	2,019								
		Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Total
Month - Plan Level £000	Overall position against plan	-1,628	-1,242	-1,240	-1,242	-1,242	-1,239	-472	-858	-857	-857	-856	-855	-12,588
Month - Overall actual £000		-954	-1866	-1211	-1216	-3625								-8,872
Month - Variance £000		674	-624	29	26	-2,383								3,716
YTD - - Plan Level £000		-1,628	-2,870	-4,110	-5,352	-6,594	-8,305	-8,305	-9,163	-10,020	-10,877	-11,733	-12,588	
YTD - Overall actual £000		-954	-2,820	-4,031	-5,247	-8,872								
YTD - Variance £000		674	50	79	105	-2,278								

Risks: Overspend against delegated budgets. Non achievement of cost reduction programme. Non achievement of activity trajectories and income targets.

Risk Mitigation: Performance monitoring and identified support in accordance with Trusts accountability programme. Performance monitoring as part of oversight meetings and cost reduction governance framework. Weekly activity performance dashboards and introduction of new financial controls including limiting discretionary spend and use of agency staff.

Causal Factrors: Opening of non-funded escalation beds contributing to overspends against delegated budgets. Medical & Nursing staff pay budgets due to bank and agency spend. Identification of schemes to bridge £5m gap against annual target. Availability of resource to support project management of identified schemes. Industrial action contributing towards reduced activity and increased cost base. Unscheduled care operational pressures impacting on elective recovery.

Actions being taken: Investment in admission avoidance and discharge schemes. Implementation of new operating model ward configuration. Unscheduled care transformation programme. Deep dive into Medicine Business Unit and production of financial recovery plan. Additional expenditure controls approved by Executive Management Team including minimising discretionary spend and use of agency staff. Analysis of top ten highest earners including waiting list and internal locum payments. Investment in international nurse recruitment to fill substantive vacancies. Deep dive into senior medical funded establishments, job plans and actual payments. Elective care transformation programme.

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 16

Report Title:	**Nursing Staffing Exception Report**			
Name of Meeting:	Board of Directors			
Date of Meeting:	27th September 2023			
Author:	Andrew Rayner, Deputy Chief Nurse Laura Edgar, People Data and Information Lead			
Executive Sponsor:	Gillian Findley, Chief Nurse and Professional Lead for Midwifery and AHP's			
Report presented by:				
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☒
	This report is to provide assurance to the Board that staffing establishments are being monitored on a shift-to-shift basis.			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☐ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*				
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	This report provides information relating to ward staffing levels (funded against actual) and details of the actions taken to address any shortfalls within the month of August 2023. August has demonstrated some staffing challenges relating to vacancies and short term sickness absence alongside ward movements to accommodate maintenance across the Trust. Within August we continued to experience periods of increased patient activity with surge pressure resulting in escalation areas. This has impacted on staffing resource and the clinical operating model, which is supportive of maintaining elective recovery. There is continued focused work around the recruitment and retention of staff and managing staff attendance. Wards where staffing fell below 75% of the funded establishment are shown within the paper. Detailed context and actions taken to mitigate risk are documented. A staffing escalation protocol is now in			

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

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

1. Introduction

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

2. Staffing

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

Table 1: Whole Trust wards staffing August 2023

Day	Day	Night	Night
Average fill rate - registered nurses/midwives (%)	**Average fill rate - care staff (%)**	**Average fill rate - registered nurses/midwives (%)**	**Average fill rate - care staff (%)**
88.2%	119.8%	92.6%	95.9%

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

Exceptions:

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

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

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

Contextual information and actions taken

Ward 21/28 moved to the permanent base ward of 28 on 27th August therefore have nurse staffing and care hours combined for the month of August. They have demonstrated reduced fill rates over the month, however have seen reduced bed occupancy. Care hours per patient day (CHPPD) overall was 19.3 which exceeds peer benchmarking.

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

The exceptions to report for August are as below:

August 2023	
Registered Nurse Days	**%**
Ward 21/28 Elective Ortho	72.9%
Registered Nurse Nights	**%**
Ward 21/28 Elective Ortho	72.2%
Healthcare Support Worker Days	**%**
N/a	0
Healthcare Support Worker Nights	**%**
Ward 21/28 Elective Ortho	50.8%

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

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

3. Care Hours Per Patient Day (CHPPD)

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

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

Ward level CHPPD is outlined in Appendix 1. For the month of August, the Trust total CHPPD was 8.9. This compares very well when benchmarked with other peer-reviewed hospitals and when compared with the same month last year.

4. Monitoring Nurse Staffing via Incident Reporting system

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

A report of staffing concern related incidents is generated monthly and discussed at the Nursing Professional Forum. There were two staffing incidents raised via the incident reporting system. Both staffing incidents were reported as no and low harm.

5. Nursing Red Flags

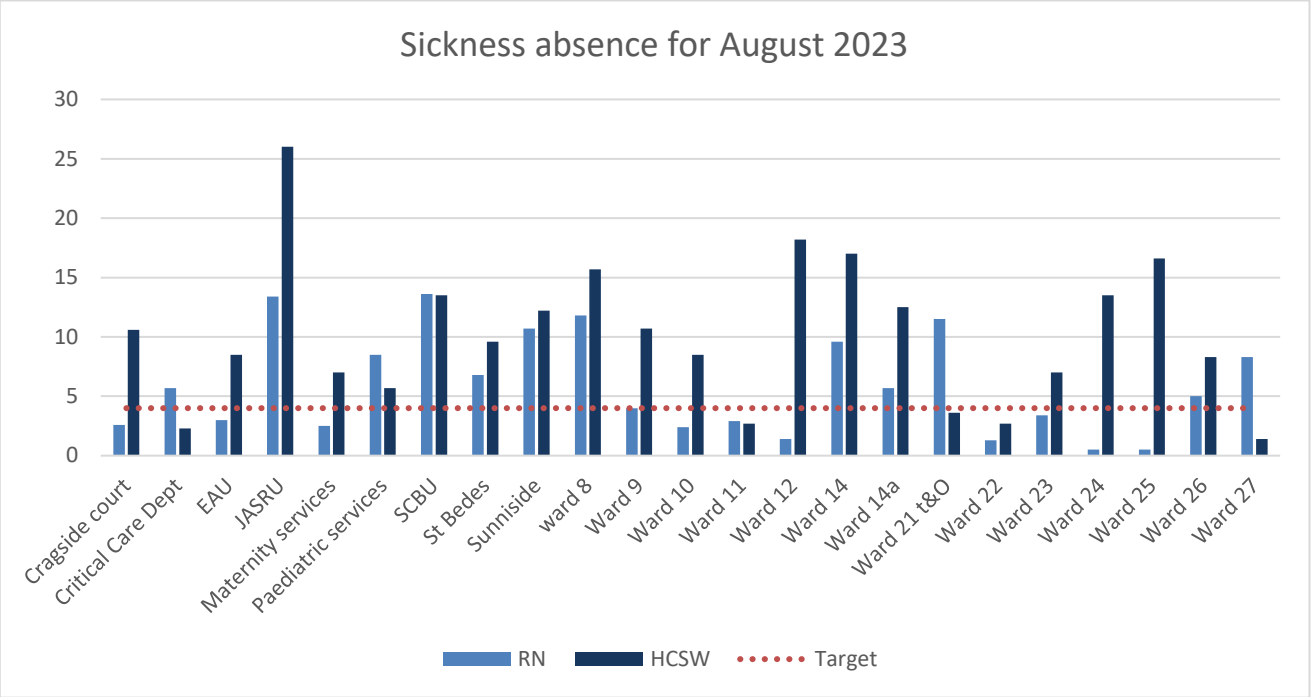
The National Institute for Health and Care Excellence (NICE) guideline for Safe Staffing for nursing in adult inpatient wards in acute hospitals (2014) recommend the use of nursing Red Flag reporting. A Nursing red flag can be raised directly as a result of rostering practice/shortfall in staffing or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

Date	Shift type	Ward	Flag Type	Notes
07/08/2023 07:36	Day	Ward 25	Missed 'intentional rounding'	Only 2 NA on shift 2 areas of special unable to carry out basic patient care due to this.
09/08/2023 18:23	Night	Ward 25	Shortfall in RN time	Multiple areas of enhanced care. High patient acuity with several unwell patients. escalation open.
14/08/2023 09:16	Day	Ward 10	Shortfall in RN time	Staff sickness on ward leading to shortfalls in RN and Non registered nurses to provide patient care adequately.
21/08/2023 12:29	Day	Ward 14	Shortfall in RN time	Stretched ratios on ward to support ward area with 1 qualified on duty due to late sickness.
21/08/2023 Early shift	Day	Ward 22	Shortfall in RN time	-
21/08/2023 Late shift	Day	Ward 22	Shortfall in RN time	-
22/08/2023 12:29	Day	Ward 25	Missed 'intentional rounding'	for some reason safe care didn't up date with the numbers inputted this morning to do off site escort which has been all morning not enough staff on the floor to assist with intentional rounding

Of the above recorded red flags, all were escalated to the senior nurse and captured on the on-call resilience bulletin. Staff redeployments were initiated to support the above areas when possible.

6. Attendance of Nursing workforce

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



7. Governance

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

8. Conclusion

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

9. Recommendations

The Board is asked to receive this report for assurance.

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

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

	Day		Night		Care Hours Per Patient Per Day (CHPPD)			
Ward	**Average fill rate - registered nurses/midwives (%)**	**Average fill rate - care staff (%)**	**Average fill rate - registered nurses/midwives (%)**	**Average fill rate - care staff (%)**	**Cumulative patient count over the month**	**Registered midwives / nurses**	**Care Staff**	**Overall**
Cragside Court	80.9%	133.5%	79.7%	83.1%	276	6.0	7.7	13.7
Critical Care Dept	81.3%	135.7%	92.0%	103.1%	243	30.2	6.9	37.0
Emergency Care Centre - EAU	78.1%	127.9%	76.7%	126.8%	1408	5.4	4.4	9.8
JASRU	82.9%	85.0%	98.2%	142.2%	605	3.1	4.4	7.5
Maternity Unit	148.1%	169.9%	106.4%	94.1%	621	14.0	5.3	19.3
Paediatrics	128.5%	114.8%	106.1%		26	95.7	25.1	120.7
Special Care Baby Unit	88.4%	116.9%	98.1%	93.3%	85	19.7	7.6	27.3
St. Bedes	96.9%	210.1%	101.7%	85.1%	274	5.7	6.1	11.8
Sunniside Unit	88.8%	152.3%	112.7%	100.3%	303	5.5	4.5	9.9
Ward 08	116.3%	147.3%	115.6%	107.3%	615	4.1	3.9	8.0
Ward 09	93.7%	122.7%	116.4%	93.6%	772	2.8	2.7	5.5
Ward 10	84.8%	141.0%	103.4%	117.0%	672	2.9	3.6	6.5

	Day		Night		Care Hours Per Patient Per Day (CHPPD)			
Ward	**Average fill rate - nurses/midwives (%)**	**Average fill rate - care staff (%)**	**Average fill rate - nurses/midwives (%)**	**Average fill rate - care staff (%)**	**Cumulative patient count over the month**	**Registered midwives / nurses**	**Care Staff**	**Overall**
Ward 11	86.1%	122.9%	116.5%	111.5%	655	3.2	3.8	7.0
Ward 12	80.7%	110.7%	99.6%	107.2%	688	2.7	3.3	6.0
Ward 14 Medicine	121.1%	123.7%	105.5%	113.2%	736	3.4	3.2	6.6
Ward 14A Trauma	87.7%	164.8%	104.9%	109.5%	714	2.9	4.7	7.6
Ward 21/28 Elective Ortho	72.9%	107.3%	72.2%	50.8%	116	9.8	9.4	19.3
Ward 22	75.2%	129.4%	129.1%	96.5%	904	2.4	3.6	6.0
Ward 23	82.1%	161.1%	101.4%	102.7%	727	2.4	4.5	6.9
Ward 24	86.0%	122.1%	125.6%	91.5%	932	2.5	3.3	5.8
Ward 25	105.5%	105.9%	151.4%	89.5%	932	3.0	2.9	5.9
Ward 26	98.0%	133.8%	123.1%	137.5%	777	3.3	4.1	7.4
Ward 27	106.4%	136.7%	133.9%	114.5%	748	3.7	4.1	7.8
QUEEN ELIZABETH HOSPITAL - RR7EN	88.2%	119.8%	92.6%	95.9%	13829	4.7	4.1	8.9

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 17i

Report Title:	**Maternity Integrated Oversight Report**			
Name of Meeting:	Board of Directors – Part 1			
Date of Meeting:	Wednesday 27th September 2023			
Author:	Ms Karen Hooper, Lead Midwife for Risk and Patient Safety, Mrs Jane Conroy, Head of Midwifery and Ms Kate Hewitson, Service Line Manager			
Executive Sponsor:	Dr Gill Findley, Chief Nurse and Professional Lead for Midwifery and AHPs and Deputy Chief Executive			
Report presented by:	Ms Karen Hooper, Lead Midwife for Risk and Patient Safety			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
	This report presents a summary of maternity indicators for the Trust from the month of July 2023.			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☒ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	This paper has been considered by the BU Safecare and the Trustwide Safecare/Risk and Safety Council.			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	**Maternity dashboard:** • In July 2023, we had 166 births. • National targets for CO monitoring have now been confirmed at 90% at booking and 80% at 36 weeks. The maternity team achieved 85.53% and 80.93% respectively in July which is below the new target for booking. A multifaceted improvement approach is in place including implementation of NICE NG209 guidance and mandatory training in line with the NENC training needs analysis (MIS) from 4th September 2023 • Maternity Continuity of Carer is currently triggering as low on SPC. Of note, national reporting of this metric was paused in September 2022 following the Ockenden Report. The Trust are currently fulfilling requirements to focus additional support for areas with high vulnerable and minority groups with the aim of reducing inequalities through one continuity of care team, one enhanced care team and a traditional/integrated community Midwifery Team			

<table>
<tr><td></td><td colspan="2">Perinatal Clinical Quality Surveillance Model – national minimal data set reporting:
A range of metrics are presented including staff feedback from frontline champions and walk-abouts.
Perinatal Mortality Review Tool (PMRT) – Q1 2023/24 reports:
The maternity team sadly present oversight of three cases - one still birth, one late pregnancy loss and one neonatal death (at another NHS Trust) where an element of care had been provided at the Trust. The Trust was compliant with all reporting measures and we extend our sincere sympathies to the families involved.
Slides for information:

UNICEF UK Baby Friendly Initiative Accreditation Assessment:
Excellent feedback received. One element requires a further audit, then the Trust will submit this evidence to receive the Level 2 Accreditation (pending review through UNICEF governance processes)
2023 GMC Obstetrics and Gynaecology Trainee Survey:
Green outlier in the top 10% with clinical supervision out of hours ranked 1st nationally
Incidents :
No SIs reported in July 2023
No HSIB cases reported in July 2023
0 perinatal losses</td></tr>
<tr><td>Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper</td><td colspan="2">The Board of Directors are asked to review the detail provided within this report for assurance and to note that a revised format for the Maternity Integrated Oversight Report will be presented at the next Board of Directors.</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:</td><td>Aim 1
☒</td><td>We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>Aim 2
☐</td><td>We will be a great organisation with a highly engaged workforce</td></tr>
<tr><td>Aim 3
☐</td><td>We will enhance our productivity and efficiency to make the best use of resources</td></tr>
<tr><td>Aim 4
☐</td><td>We will be an effective partner and be ambitious in our commitment to improving health outcomes</td></tr>
<tr><td>Aim 5
☐</td><td>We will develop and expand our services within and beyond Gateshead</td></tr>
<tr><td>Trust corporate objectives that the report relates to:</td><td colspan="2"></td></tr>
</table>

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

Gateshead Health NHS Foundation Trust

Maternity Integrated Oversight Report

Maternity data from July 2023

Maternity IOR contents

- Maternity Dashboard 2023/24:
    - July 2023 data
- Exception reports:
    - Maternity dashboard SPC Exceptions
    - Perinatal Clinical Quality Surveillance Model – minimal data set reporting
    - Perinatal Mortality Review Tool (PMRT) – Q1 2023/24 reports
- Slides for information:
    - Maternity UNICEF Stage 2 Assessment
    - GMC Trainee Survey feedback
    - Perinatal Mortality and Morbidity Update
    - Incidents
        - No SIs reported in July 2023
        - No HSIB cases reported in July 2023

Maternity Dashboard 2023/24

Maternity

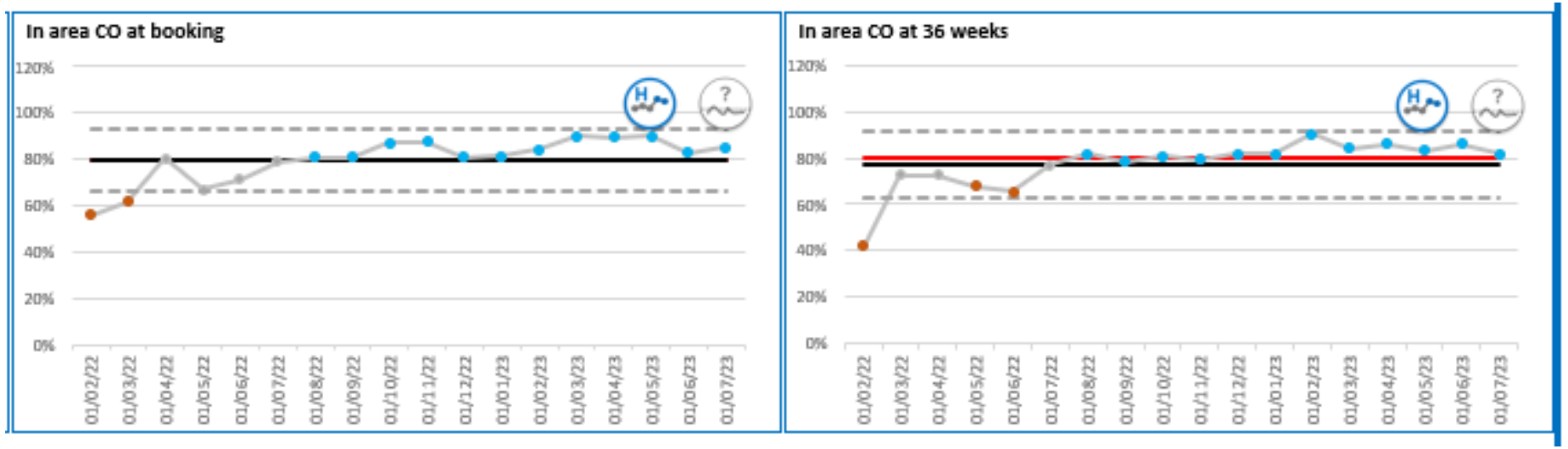
NHS Gateshead Health NHS Foundation Trust

Safe

Responsive

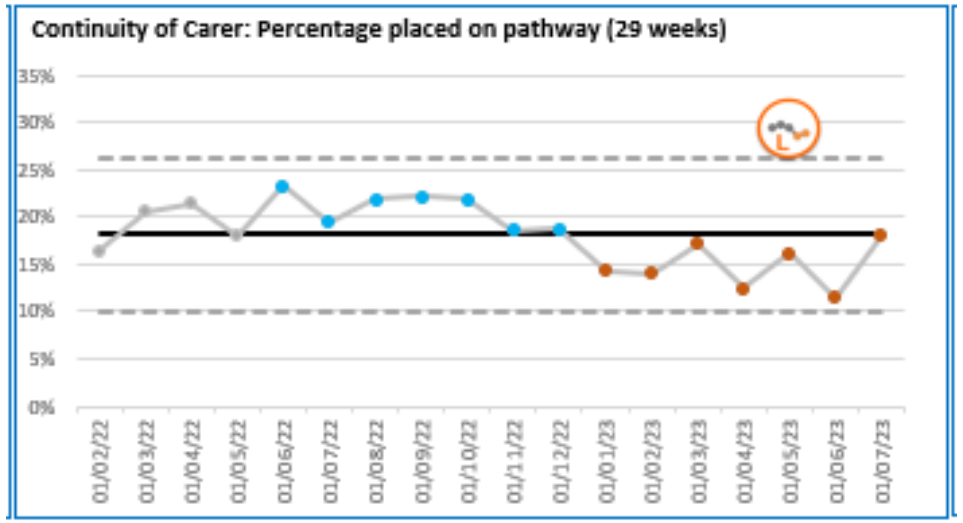
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Total Births	Jul 23	166	-			146	106	186
Spontaneous vaginal deliveries	Jul 23	81	-			76	49	104
Assited births	Jul 23	85	-			70	39	100
Induction of Labour	Jul 23	69.00	-			65	44	85
Maternity Readmissions	Jul 23	4	-			3	0	5
Neonatal Readmissions	Jul 23	4	-			5	-2	11
Smoking at time of booking	Jul 23	11.86%	15.00%		?	11.41%	6.30%	16.53%
Smoking at time of delivery	Jul 23	8.54%	6.00%		?	11.11%	4.01%	18.20%
In area CO at booking	Jul 23	85.33%	80.00%	H	?	79.81%	66.60%	93.01%
In area CO at 36 weeks	Jul 23	81.93%	80.00%	H	?	77.33%	63.17%	91.48%
Admitted directly to NNU (SCBU) (>37 weeks)	Jul 23	2	4		?	3	-3	8
Percentage Admitted directly to NNU (SCBU) (>37 we	Jul 23	1.25%	6.00%		?	2.03%	-1.84%	5.91%
Preterm birth rate <=36+6 weeks at birth	Jul 23	3.61%	6.00%		?	5.67%	1.43%	9.90%
Continuity of Carer: Percentage placed on pathway (2	Jul 23	18.01%	-	L		18.10%	10.09%	26.11%
Continuity of Carer: Percentage from BAME backgrou	Jul 23	26.09%	-			29.91%	5.96%	53.86%
Spontaneous Vaginal Births (%)	Jul 23	48.80%	-			52.48%	36.33%	68.62%
Induction Rate	Jul 23	42.07%	-			44.88%	32.98%	56.79%
Instrumental Delivery Rate	Jul 23	10.98%	-			11.59%	2.50%	20.67%
Elective C Section Rate	Jul 23	25.30%	-			18.68%	11.09%	26.27%
Emergency C Section Rate	Jul 23	15.06%	-			17.05%	6.38%	27.72%
C Section Rate	Jul 23	40.36%	-			35.73%	24.50%	46.95%
3rd or 4th degree tear (Total) Precentage	Jul 23	0.00%	5.00%		?	1.72%	-1.74%	5.19%
Massive PPH >=1.5L (All births)	Jul 23	11	2		?	7	-1	14
Breastfeeding: Percentage of Initiated Breasfeeding	Jul 23	74.39%	66.20%		?	68.96%	49.36%	88.56%
Breastfeeding: Breasfeeding at Discharge (Transfer to	Jul 23	58.43%	56.20%		?	51.68%	38.73%	64.63%

Dashboard exceptions



- **Background**
  - Maternity Incentive Scheme Safety Action 6 requires compliance with Saving Babies Lives care Bundle – Element 1; reducing smoking in pregnancy
- **Assessment**
  - Year 4 MIS compliance of 80% CO monitoring at booking and 36 weeks – full compliance declared
  - Year 5 new standards require 90% at booking and 80% at 36 weeks
- **Actions**
  - Update target compliance on dashboard
  - Additional engagement by Tobacco team with community midwives around increased target
  - Updated NICE NG209 guidance implemented on 1/8/2023 - additional CO testing of smokers at every contact including all acute contacts
  - Mandatory training within NENC training needs analysis – to commence 4/9/2023
- **Recommendations**
  - Risk of non-compliance added to departmental risk register
  - Audit of declines required
  - Audit of NG209 compliance – from Q3 2023/24

Dashboard exceptions



- **Background**
  - Midwifery Continuity of Carer targets rolled out as part of the Better Births programme
  - Letter to all Trusts following Ockenden report – September 2022 to pause all reporting targets for MCOC
- **Assessment**
  - Remains on Service Specification for consideration of progressions on MCOC when safe staffing levels allow
- **Actions**
  - Service review of MCOC completed including staff listening events
  - 1 MCOC team, 1 enhanced care team and traditional/integrated community midwifery teams in place
- **Recommendations**
  - Service currently fully recruited – workforce distributed in areas
  - Currently fulfilling requirement to focus additional support for areas with high vulnerable and minority groups to reduce inequalities
  - Continue to consider MCOC following Birthrate+ assessment and in line with safe staffing
  - Retain MCOC on maternity dashboard but targets to be removed in line with Ockenden recommendation

Perinatal Clinical Quality Surveillance Model – minimal data set reporting (Page 1)

Gateshead Health NHS Foundation Trust

CQC Maternity Ratings		Overall	Safe	Effective	Caring	Well-Led	Responsive						
		Good	Good	Not assessed	Not assessed	Good	Not assessed						
Maternity Safety Support Programme		No	N/A										
							2023						
		Jan	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Findings of review of all perinatal deaths using the real time data monitoring tool		1 stillbirth, antepartum, 28-31 weeks, Codac cause unknown	1 late fetal loss, antepartum, 22-23 weeks, Codac cause placenta	N/A	N/A	1 stillbirth, 24-27 weeks, Codac cause unknown	1 late fetal loss, 22-23 weeks, Codac cause unknown. 1 stillbirth, 24-27 weeks, Codac cause unkown	N/A					
Findings of review all cases eligible for referral to HSIB		N/A	N/A	N/A	N/A	N/A	N/A	N/A					
The number of incidents logged graded as moderate or above (please see slides by exception for detail on actions taken)		0	0	0	0	1	3	1					
Minimum safe staffing in maternity services to include Obstetric cover on Labour Ward		100%	100%	100%	100%	100%	100%	100%					
Minimum safe staffing in maternity services to include Midwifery cover on maternity including Labour Ward	**Day - average fill rates RMs (%)**	146%	151.30%	150.10%	145.30%	161%	156.10%	155.20%					
	Day - average fill rates Care Staff (%)	167%	150.70%	154.30%	173.70%	187.50%	175.80%	183.40%					
	Night - average fill rates RMs (%)	104.60%	101.40%	102.30%	107.90%	108.10%	104.10%	101.70%					
	Night - average fill rates Care Staff (%)	97.10%	99%	94.50%	90.10%	96.40%	94%	98%					
	Overall Care Hours Per Patient Per Day (CHPPD)	20.7	21.4	20.8	21.6	20.6	21.2	20.6					

Perinatal Clinical Quality Surveillance Model – minimal data set reporting (Page 2)

Gateshead Health NHS Foundation Trust

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Service User Voice feedback - Friends and Family Test "Overall how was your experience of our service?" (Total score for 'very good' and 'good' responses)	100%	100%	100%	100%	100%	100%	100%					
Number of maternity complaints	1	1	1	0	0	1	0					
Staff feedback from frontline champions and walk-abouts	see reporting from last financial year	see reporting from last financial year	see reporting from last financial year	Postnatal ward experiencing issues with supplies; Anaesthetic team concern with duration of clean cycle on machines; new door mat required by theatre exit door	Comms around planned staff moves onto community, lone worker devices, Labour ward triage when planned home births report labour commenced	SCBU listening meeting - pressures on rota, workforce (ability to attract and recruit)	SCBU - improvements noted in comms, plan for more skills drills for neonatal team					
HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	0	0	0	0	0	0	0					
Coroner Reg 28 made directly to Trust	0	0	0	0	0	0	0					
Progress in achievement of CNST/MIS 10	100%	100%	100%	100%	100%	100%	100%					
Proportion of midwives responding with 'Agree or Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment (Reported annually)				94%								
Score from specialty trainees in Obstetrics & Gynaecology of clinical supervision out of hours (Reported annually)				97.50%								

Exception reporting by schedule

Maternity

NHS

Gateshead Health
NHS Foundation Trust

Caring

Responsive

Safe

Perinatal Mortality Review Tool (PMRT) – Q1 2023/24 reports

- **Detailed quarterly PMRT reports are presented to the Trust Mortality & Morbidity steering group**

MBRRACE ID	Gestation & Outcome	DOB	Reported to MBRRACE within 7 working days (compliance required 100%)	Surveillance information completed within 1 month of death (compliance required 100%)	PMRT review started within 2 months of death (compliance required 95%)	PMRT review completed to draft stage within 4 months of death (compliance required 60%)	PMRT review published within 6 months of death (compliance required 60%)	Parental engagement (compliance required 100%)	External clinician (if appropriate)
Case 1 87489	24+1 Antepartum stillbirth	13/5/2023	16/5/2023	22/5/2023	6/6/2023	21/6/2023	21/6/2023	Yes	Yes
Case 2 87963	22+4 Antepartum late pregnancy loss	8/6/2023	14/6/2023	14/6/2023	20/6/2023	1/8/2023	1/8/2023	Yes	n/a
Case 3 Datix 113092	34+3 Neonatal death	26/5/2023	*PMRT review led by Trust B (location of baby's death)						

Gateshead Health NHS Foundation Trust

Maternity Integrated Oversight Report: Slides for information

UNICEF UK Baby Friendly Initiative: Summary of assessment findings

Maternity

Gateshead Health NHS Foundation Trust

Caring Effective

Stage 2: An educated workforce – maternity services

Please note that these results are preliminary only and will be confirmed in the full report.

- Assessment date 26-27 July 2023
- 31 staff interviewed

Standard	Theme	Criteria	Standard required	Result
1	Antenatal information	Staff who were able to give effective information about feeding / explain the importance of close relationships	80%	96% 100%
2	Care at birth	Staff who were able to: • explain the importance of skin contact and how long it should last • describe how they would support the mother with the first feed	80%	100%
3	Supporting mothers to learn to breastfeed: Positioning and attachment	Staff who were able to demonstrate/describe how they would support a mother with positioning and attachment	80%	93%
	Hand expression	Staff who were able to demonstrate/describe how they would support a mother with hand expression	80%	93%
	Recognising effective feeding	Staff who were able to describe how they would recognise effective feeding	80%	74%
	Responsive feeding	Staff who were able to describe baby led feeding and how to recognise feeding cues / who were able to describe responsive feeding	80%	100% 88%
	Challenging situations	Staff who demonstrated understanding of how to manage challenging situations	80%	94%

UNICEF UK Baby Friendly Initiative

Maternity

NHS Gateshead Health ...tion Trust

Standard	Theme	Criteria	Standard required	Result
4	Protecting exclusive breastfeeding	Staff who demonstrated understanding of how to support mothers to maximise breastmilk given, including why supplements should be avoided unless clinically indicated	80%	95%
		Staff who demonstrated understanding of how to support formula feeding mothers with making up feeds / understanding of responsive bottle feeding	80%	80%
				84%
		Staff who were able to discuss the International Code of Marketing of Breastmilk Substitutes	80%	81%
5	Support with relationships	Staff who understood the importance of close and loving relationships and how to support this	80%	100%
All	Communication	Staff who demonstrate that they could communicate in a mother centred way	Yes	Yes 93% Partial 7% No

Supporting information			Achieving Sustainability standards		
Observations within the facility	No advertising	N/A	Leadership	Meets standards	Yes
Staff who have been orientated to the policy	80%	100%	Audit and evaluation	Meets standards	Yes
Staff who have completed the training programme	80%	Mat 82% NN N/K	Collaborative working	Meets standards	Yes
The written curriculum meets the standards	Meets standards	Yes			

Well Led

Caring

UNICEF UK Baby Friendly Initiative

Maternity

NHS Gateshead Health NHS Foundation Trust

A huge thank you to all of the staff involved in the UNICEF staff interviews over the 2-day assessment on 26th & 27th July 2023, in particular our infant feeding specialist midwives Catherine Wood & Nikki Reeve, & our Infant feeding champions MSWs Jane Puntin and Vicky Nesbitt, for all of their hard work with display boards, posters, practical skills reviews, parent education sessions and for being amazing role models and champions!

The two UNICEF assessors commented that overall staff have '**an excellent knowledge and skill base'** in relation to the UNICEF standards

'Antenatal Care Standard 1' response was **'top notch'** and staff talked with confidence about relationship building in the antenatal period which linked with responsive parenting following delivery. They stated that it is rare for a maternity service to demonstrate this element to such a high standard **(96%** and **100%)** and asked 'what is your secret?'.

'Close and Loving Relationships Standard 5' was '**outstanding'** (**100%)** and responsive parenting and brain development was discussed in a **'sensitive and compassionate way'**.

The Achieving Sustainability standards were all met – demonstration of Leadership, Audit and Evaluation and Collaborative Working.

There is only 1 element of care standard 3 that did not quite meet the required 80% 'pass mark', this relates to 'recognising effective feeding' and in particular nappy output (**74%).**

Our assessment documentation will be reviewed at the UNICEF designation committee for moderation purposes, and we will receive our final report in around one months' time. It is likely that we will have to do a small internal audit to demonstrate that staff can meet this element prior to officially achieving our Maternity UNICEF accreditation stage 2.

Overall, we have achieved a **91%** required response rate to the UNICEF standards criteria- which is absolutely incredible!

The assessors commented that this was a '**storming result'** and '**very impressive'**. They also mentioned that we have '**lovely staff'** and they picked up on a '**very positive culture'**

We are the only Trust in NENC to have been assessed at Stage 2

Effective

Well Led

Caring

2023 GMC Obstetrics and Gynaecology Trainee Survey

Maternity

NHS Gateshead Health NHS Foundation Trust

- National survey carried between April and May 2023
- More than 70,000 trainees from all aspects of GP and specialty training
- 147 O&G training units involved

- QE Results
  - Green outlier (top 10th centile) for;
    - Supportive environment – Ranked 11th nationally
    - Clinical supervision – Ranked 3rd nationally
    - Clinical supervision out of hours – Ranked 1st nationally
  - No red outliers
  - Overall satisfaction score 79.2% - ranked 33rd nationally

Perinatal Mortality and Morbidity update

Maternity

NHS Gateshead Health NHS Foundation Trust

Safe

Responsive

- **Response to the Lucy Letby trial and conviction**
  - Senior midwifery team has been present on SCBU unit to listen to staff thoughts and to support at this time
  - Detailed PMRT reports are presented quarterly to the Mortality & Morbidity Steering Group
  - Summary of quarterly PMRT reports scheduled in maternity IOR for Trust board (Q1 2023/24 to be reported in next month's IOR report)
  - Additional monthly exception slide added from this month to report any perinatal losses directly to Trust board

- **July 2023 cases:**
  - 0 perinatal losses

- **Incidents**
  - No SIs reported in July 2023
  - No HSIB cases reported in July 2023

NHS
Gateshead Health
NHS Foundation Trust

Report Cover Sheet Agenda Item: 18

Report Title:	Staff Survey Results Action Plan Update			
Name of Meeting:	Trust Board			
Date of Meeting:	27 September 2023			
Authors:	Laura Farrington, Head of Leadership, OD & Staff Experience			
Executive Sponsor:	Amanda Venner, Interim Executive Director of People & OD			
Report presented by:	Gemma Rutherford, Interim Deputy Director of People & OD			
Purpose of Report	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☒
	Following the introduction of People Action Plans in 2022, an update on themes from across the Business Units, proposed actions, and activity to date.			
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:	POD Committee – 12 September 2023.			
Key issues:	• Common themes identified re: behaviour, relationships and team dynamics. • Management development highlighted as a key area of focus. • Increasing engagement with staff survey noted in a number of areas and work underway to support this for 2023.			
Recommended actions for this meeting:	The Board is asked to receive this paper by way of providing an update on the work underway in relation to people action pans across corporate and operational teams.			
Trust Strategic Aims that the report relates to:	***Aim 1*** ☐	*We will continuously improve the quality and safety of our services for our patients*		
	Aim 2 ☒	*We will be a great organisation with a highly engaged workforce*		
	Aim 3 ☐	*We will enhance our productivity and efficiency to make the best use of resources*		
	Aim 4 ☐	*We will be an effective partner and be ambitious in our commitment to improving health outcomes*		

	Aim 5 ☐	*We will develop and expand our services within and beyond Gateshead*			
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)	Although there is no specific risk listed on risk register there is the risk of overall staff engagement linked to leading Indicator and achievement of strategic objective No. 2.				
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒		

1. Introduction

Following the introduction of People Action Plans in 2022, as a means of capturing business unit people actions and tracking progress, this summary report highlights the themes that emerged, the actions that were agreed and an update on progress towards these actions.

2. Summary Position

2.1 Surgical Business Unit

A key themes review was undertaken by the People and OD Lead, OD Practitioner and BU Operations director during which areas of concern/improvements were identified and a people action plan created. The following key themes were identified.

Key Themes

- Poor morale and engagement scores.
- Behavioural issues and poor relationships.
- Empowering managers to take ownership of 'people' challenges.
- Focus on reward and a need for a team vision/shared objectives
- Lack of development opportunities.

Activity Update

During the key themes review meeting potential actions were identified and the below key activities agreed. The actions were assigned to senior BU personnel the People and OD Lead and the OD practitioner, with expected timeframes for completion.

- Retention and Recruitment Premia Project (relating to reward but also development pathways for specific roles).
- Delivery of development days such as 'Civility Saves Lives' and a 'Datix Awareness' session.
- Planned OD interventions to support managers/teams.
- Managers to attend Managing Well and Leading Well.
- Increasing engagement with staff survey.
- Ongoing work with the Theatre team to improve engagement with staff survey.
- Working with Maternity teams (hospital and community) to improve engagement with staff survey, inter-departmental relationships, incivility etc.
- Learning from the 2022 staff survey roll out and identification of improvements to the 2023 staff survey BU communications and roll out programme.

2.2 Corporate Services

Key Themes

- Poor morale and engagement scores.
- Identified patterns of silo working.
- Behavioural issues and poor relationships.
- Need to empower managers.
- Focus on challenging team dynamics.

Activity Update

- OD contracted work to support managers/teams.
- Design and delivery of a number of development days.

- Work with Digital teams to identify specific issues and challenges, and to understand stakeholder perceptions, including workshops/focus groups/1:1 interviews.
- Work with Medical Education team to support a re-setting of team dynamics/ expectations.
- Work with Health Roster team (including feedback from TED) to celebrate success and to understand how 'fairness' is perceived.
- Work with Site Resilience Team to support with issues around behaviours, org. change, development, reputation.

2.3 Community Services

A key themes review was undertaken by the People and OD Lead, OD Practitioner and BU Operations director during which areas of concern/improvements were identified and a people action plan created. The following key themes were identified.

Key Themes
- Team development.
- Team dynamics.
- Support during change/transformation.
- Management development.

Activity Update

Staff Survey results led (in the main) to the development and formation of an Education and Learning Workforce forum within Older Persons Mental Health with key stakeholders identifying specific needs of OPMH staff. This live forum has helped identify targeted support to those areas that required greater compliance or specific learning needs. Other key areas of activity are detailed below.

- OD contracted work to support managers/teams.
- TED surveys undertaken by a number of teams.
- Delivery of a number of team development days / feedback sessions.
- Managers attending Manging Well and Leading Well.
- Ongoing work with Older Persons Mental Health to improve engagement with staff survey.
- Working with a number of community teams to support with TED feedback and actions around team working.

2.4 Medicine

A concerted effort was made to improve Staff Survey engagement which resulted in Medicine having the largest percentage increase across the Trust for the 2022 survey.

Again, a key themes review was undertaken by the People and OD Lead, OD Practitioner and BU Operations director during which areas of concern/improvements were identified and a people action plan created. The following key themes were identified.

Key Themes
- Concerns re: staffing / turnover
- Behaviour and relationship challenges
- Team dynamics

- Management development

Activity Update

It remains a challenging environment (with particular regards to the base wards) to fully engage with these areas due to the sustained service demands. With the impact of dedicated Management time for Band 7's, we are extremely hopeful that we can use the Staff Survey data of 2022/23 to help formulate more support and development for these areas moving forward. Other key areas of activity are detailed below.

- OD contracted work to support managers/ teams.
- Design and deliver a number of development days.
- Upskilling Managers attending Managing Well and Leading Well.
- Work with UTC / ED to identify specific issues and challenges around behaviours (on-going).
- Work with a number of ward/department teams around team dynamics and team development (on-going).
- Ward 4 (winter ward) feedback on experience to feed into actions for 2023 (completed and findings fed back into BU).

2.5 Clinical Support & Screening (CSS)

To support the CSS structure, it was agreed there would be 6 Service Line People Plans, rather than 1 overarching plan. A number of activities lead by the SLMs and departmental managers and supported by the OD Practitioner and People and OD Lead and tailored to individual departmental needs helped identify key themes in CSS. This included a series of departmental workshops, support at assessments centres with the view of improving the assessment of culture and behaviour in leadership positions, dedicated sessions at team away days, use of the TED tool, targeted OD work, focus groups and RPIW. September Operational Board will focus on Staff Survey preparation and People Plans review.

Key Themes

- Flexible working for staff, continuing communication and health and wellbeing work.
- Enhanced team morale through tackling behaviour, improved contact with line manager, review of office space.
- Networking with regional partners, increasing awareness and access to CPD/professional development.
- Reintroduction of team meetings.
- Review working patterns for needs of service.
- Away days, continued focus on HWB check ins and appraisals.
- Planning for risk of retirement of staff.
- Upskilling managers through attendance at managing and leading well.
- Team Leaders to embed work already started around reward and recognition.
- Contract a piece of OD work around cultural beliefs and expectations in teams

Activity Update

During the departmental workshops, dedicated sessions at team away days, via the TED tool results, focus groups, RPIW and targeted OD work potential actions were identified. The below key activities were agreed for the teams and managers to take forward with oversight from SLMs and BU Operations director and with support from the OD practitioner, POD lead and deputy.

- Work underway to support service line managers to understand their results and develop their local plans.
- Managers attending Managing Well and Leading Well.
- Investment in professional and role development. Commenced work (via funding bid) for Critical Care upskilling for Physiotherapy and Dietician professions. Further work to follow with Occupational Therapist and Audiology professions.
- Job planning exercise being established across OT/Physio/Dietetics to clarify both clinical capacity, and supporting professional activity time for the workforce.
- Development of Band 4 Call Centre manager to aid with service provision, staff retention, career progression and managerial support.
- Therapy services wide staff voice and health & wellbeing initiatives. Specific plan developed for each department.
- Seeking to increase regional relationships and strengthen peer support with service specific forums.

2.6 QEF

In July 2023 a People and OD Lead was temporarily seconded into QEF to provide a HR presence and ensure consistency of support. The 2022 staff survey results were immediately reviewed, and actions identified in support of the wider workforce. A people action plan was created and shared with QEF senior leadership team and board. Following the creation and agreement of the People Action Plan work is now underway to align the QEF approach with the Trust and key themes identified this work that have been actioned or pending are:

- Improve staff engagement activities.
- Recognition and reward through the identification and implementation of Training and Development opportunities.
- Review appraisal process and core skills compliance.
- Review of recruitment process.
- Creation of QEF bank staff facility for those ‘hard to recruit to’ areas.
- SLT visibility
- Flexible working opportunities
- Address bullying and harassment concerns
- Communication of company strategy and targets
- Identify improvements to wellbeing, through promoting and supporting attendance at work and the use of health and wellbeing check ins.

3. Next steps

POD teams will continue to work with Business Units on delivery against actions identified and build on this work when the 2023 Annual Staff Survey launches.

4. Recommendations

The Board is asked to receive this paper by way of providing an update on the work underway in relation to people action pans across corporate and operational teams.

Laura Farrington
Head of Leadership, OD & Staff Experience
September 2023

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 19

Report Title:	**Freedom to Speak Up Guardian Report**			
Name of Meeting:	Trust Board			
Date of Meeting:	27 September 2023			
Author:	Gareth Rowlands, Freedom to Speak Up Guardian (FTSUG)			
Executive Sponsor:	Amanda Venner, Interim Executive Director of People and OD			
Report presented by:	Andy Beeby, Executive Medical Director			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
	To provide an update of FTSU activity for Q1 April – June 2023.			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☒ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	Q1 position reported to POD Committee – 11 July 2023.			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	For this period. - Most concerns could be regarded as “cultural” - 7 concerns in the reporting period. All of which are now closed. Where concerns have been raised, these are being managed in a variety of ways with those of greater significance/risk notified to the executive team. Local FTSU Policy updated and agreed to reflect new national policy. Nine FTSU Champions have been recruited, trained and inducted, providing a more diverse and inclusive network to be approached should someone wish to raise concerns. New full time FTSU Guardian appointed, Tracy Healy. Tracy has been phasing into this role and is due to start in post full time from 2nd October 2023. National Guardian’s Office (NGO) training completed.			

<table>
<tr><td></td><td colspan="5">New FTSU Guardian has already attended the AHP conference to raise awareness of the role and has circulated a FTSU questionnaire to gather feedback from staff generally about the role/service that is provided. Comms/roadshow introduction planned including a Facebook live Q&A session with Chief Executive.

Work also underway to review reporting of the FTSU systems, including a review of the current board report.

In October 2022 it was agreed all Board member undertake the necessary three levels of FTSU training. At the time of writing, 5 out of 15 Board members had completed this (33%).</td></tr>
<tr><td>Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper</td><td colspan="5">1. The Board is asked to receive this report by way of assurance on FTSU concerns and broader activity.

2. The Board is asked to note that all the concerns raised within the period have been resolved and closed.

3. The Board is asked to note current Board member training compliance and support completion.</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:</td><td>Aim 1
☒</td><td colspan="4">We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>Aim 2
☒</td><td colspan="4">We will be a great organisation with a highly engaged workforce</td></tr>
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<tr><td>Aim 5
☐</td><td colspan="4">We will develop and expand our services within and beyond Gateshead</td></tr>
<tr><td>Trust corporate objectives that the report relates to:</td><td colspan="5">• Cross covers the following objectives that sit under strategic aim two: we will be a great organisation with a highly engaged workforce.SA2.1 Protect and understand the health and well-being of our staff by looking after our workforce;
• SA2.3 Development and implementation of a culture programme.</td></tr>
<tr><td>Links to CQC KLOE</td><td>Caring
☐</td><td>Responsive
☐</td><td>Well-led
☒</td><td>Effective
☐</td><td>Safe
☒</td></tr>
<tr><td colspan="6">Risks / implications from this report (positive or negative):</td></tr>
<tr><td>Links to risks (identify significant risks and DATIX reference)</td><td colspan="5">Risk to lone workers in community midwifery.</td></tr>
<tr><td>Has a Quality and Equality Impact Assessment (QEIA) been completed?</td><td colspan="2">Yes
☐</td><td colspan="2">No
☒</td><td>Not applicable
☐</td></tr>
</table>

Freedom to Speak Up Guardian Report

1. Executive Summary

1.1. 7 concerns raised in the current reporting period (*April 1- June 30, 2023*).

1.2. Total concerns for 2022-23 was 34.

1.3. Our updated FTSU Policy has now been amended and ratified (Based on the new National Policy).

1.4. In October 2022 it was agreed that all Board members should complete all three levels of FTSU training. At the time of writing, 5 out of 15 Board members had completed this (33%).

1.5. Nine FTSU Champions have been recruited, trained and inducted, providing a more diverse and inclusive network to be approached should someone wish to raise concerns.

1.6. New full time FTSU Guardian appointed, Tracy Healy. Tracy has been phasing into this role and is due to start in post full time from 2nd October 2023. National Guardian's Office (NGO) training completed.

1.7. New FTSU Guardian has already attended the AHP conference to raise awareness of the role and has circulated a FTSU questionnaire to gather feedback from staff generally about the role/service that is provided. Comms/roadshow introduction planned including a Facebook live Q&A session with Chief Executive.

1.8. Work also underway to review reporting of the FTSU systems, including a review of the current board report.

2. Introduction

2.1. The Board has a key role in shaping the culture of the Trust. Freedom to Speak Up (FTSU) is an important component in respect of developing an open, transparent and learning culture.

2.2. The National Guardian's Office (NGO) expects Boards to lead in this area, ensuring that the Board actively promotes learnings, encourages staff to speak up and sends a clear message that the victimisation of workers who speak up will not be tolerated. It is also the responsibility of the Board to ensure that there is a well-resourced Guardian with named Board lead and to ensure that there is investment in leadership and development.

2.3. At a Trust Board Development Day in October 2022 it was agreed that all Board members have undertaken the necessary 3 levels of FTSU training. At the time of writing, 5 out of 15 Board members had completed this (33%).

2.4. The FTSUG reports to the Board twice per annum and also presents a paper to the People and OD Committee and the Audit Committee.

2.5. This Report provides the Committee with a summary of FTSU activity from April 1, 2023 – June30, 2023 (Q1)

3. Cases

7 concerns raised in the current reporting period April 1 - June 30,2023 (0% Anonymous)

In 2021-22, 34 concerns were raised. (25% were anonymous).

In 2022-23, 34 concerns were raised. (9% were anonymous).

3.1. Q 1 2023-24

3.2. All cases have been discussed with Deputy CEO and Executive Director of People & OD. All of the cases which are showing as open at the point in time the report was ran (03 July 2023) have now been resolved and closed.

4. Guardian Activity

4.1. During this reporting period, the previous FTSUG received 7 concerns, had individual 90 meetings/contacts and delivered face to face training to members of staff as well as providing additional training via video presentations for all corporate inductions.

4.2. The previous FTSUG continued to maintain a comprehensive log of all activity and submitted data on a quarterly basis to the National Guardian's Office

4.3. The previous FTSUG was (and continues to be) actively involved in staff induction, medical staff induction and the "Managing Well" programme. The FTSUG has trained 400 mangers in Speaking Up and Listening Well on the Managing Well course since its inception in April 2023.

4.4. The previous FTSUG has attended all the monthly Northeast and Cumbria Regional FTSUG meetings in this reporting period.

4.5. FTSU is now part of the core skills programme in the Trust, with mandatory training modules for all workers; managers and VSM/ Board.

4.6. Nine FTSU Champions have been recruited, trained and inducted, providing a more diverse and inclusive network to be approached should someone wish to raise concerns.

4.7. A new full time FTSU Guardian has been appointed, Tracy Healy. Tracy has been phasing into this role and is due to start in post full time from 2nd October 2023. Tracy has completed her National Guardian's Office (NGO) training and will be registered with them as the FTSU Guardian from 2nd October 2023.

4.8. New FTSU Guardian has already attended the AHP conference to raise awareness of the role and has circulated a FTSU questionnaire to gather feedback from staff generally about the role/service that is provided. A comms/roadshow introduction is being planned as the new FTSU Guardian starts in role and a Q&A session via Facebook live with the Chief Executive is planned for October 2023.

4.9. Work also underway to review reporting of the FTSU systems, including a review of the current board report.

5. Recommendations

5.1. The Board is asked to receive this report by way of assurance on FTSU concerns and broader activity.

5.2. The Board is asked to note that all of the concerns raised during the period have been resolved and closed.

5.3. The Board is asked to note current Board member training compliance and support completion.

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 20

Report Title:	WRES and WDES Action Plans			
Name of Meeting:	Board of Directors			
Date of Meeting:	27 September 2023			
Author:	Kuldip Sohanpal, Equality Diversity Inclusion and Engagement Manager			
Executive Sponsor:	Amanda Venner, Interim Executive Director of People and OD			
Report presented by:	Gemma Rutherford, Interim Deputy Director of People and OD			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
	The purpose of this paper is to provide an update on progress against the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) indicators and propose future actions. These actions form part of the Trust's Equality Objectives and overarching Equality Diversity & Inclusion Work Plan which started in 2021.			
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*	People and OD Committee – 12 September 2023.			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	**Background** The Workforce Race Equality Standard (WRES) was first mandated in July 2015 to ensure employees from black and minority ethnic (BAME) backgrounds have equal access to career opportunities and receive fair and equal treatment in the workplace. The Workforce Disability Equality Standard (WDES) was first mandated in July 2018 and seeks to promote the concept of disability as an asset, as research has found that disabled people have poorer experience of working in the NHS in England than non-disabled colleagues.			

The information provided in the attached papers provides an overview of the data captured for the 2023 submissions for both the WRES and WDES.

Also attached is the overarching EDI Action plan cross referencing key areas of work.

Engagement undertaken
The EDI data questions and survey results have been shared with the Networks.

Business units have also been involved, ensuring EDI is embedded in everything that we do to ensure that this is covered within business unit plans.

The action plans and the findings have been discussed at the Human Rights Equality Diversity Inclusion Programme Board which has a cross-section of organisational representation as well as the Networks Chairs.

Overall rating
The overall rating for both the WRES and the WDES is amber – partially compliant. The associated action plans for both reports identify actions required to move the ratings from amber to green – fully compliant.

Key highlights
In respect of both the WRES and WDES, the key highlights are as follows:

WRES
Further work required in respect of bullying and harassment, specifically around:

- The percentage of BME staff experiencing harassment, bullying or abuse.
- The percentage of BME staff compared to White staff reporting harassment, bullying or abuse at work.
- Percentage of staff experiencing harassment, bullying or abuse from patients/service users, mangers and colleagues.

Data collected shows that in some of the KPI's there has been an decrease in incidents, but the numbers of BME staff reporting was proportionally very small. Further work is required to ensure a zero tolerance approach is implemented in the Trust.

Other key significant areas identified are:

- Staff views on whether the organisation provides equal opportunities for career progression / promotion have been consistent by ethnicity (between the 45% and 47%), there is however a

widening gap between the BME and White category , which has remained at the 60% (this however increased to 65%).
- The Trust rolled out Reverse / reciprocal mentoring, however due to lack of numbers accessing this the programme is being relooked at.
- A couple of sessions around Cultural Competency have been delivered and are being assessed for further delivery.
- Analysis of the Ambassador role into our disciplinary and grievance processes is being undertaken

WDES
Further work required in respect of Bullying and harassment, specifically around:

- The percentage of disabled staff experiencing harassment, bullying or abuse from members of the public.
- The percentage of disabled staff compared to non-disabled staff reporting harassment, bullying or abuse at work.
- Percentage of staff experiencing harassment, bullying or abuse from patients/service users, mangers and colleagues.

Data collected shows a small decrease in the figures for harassment / abuse from patients and service users for disabled staff (down from 31% to 25.5%). Detailed work is required to ensure a zero tolerance approach is implemented in the Trust.

Other key significant areas identified are:

- Declaration rates around disability are also low and we need to continue to promote staff to declare their disability status to improve the reliability of equalities monitoring.
- Recruitment processes will also be examined to assess why disabled applicants are shortlisted but are unsuccessful at interview.
- The Trust's status has moved from a Disability Confident employer to Disability Confident Leader. We will start assessing what extra work is required to achieve the next level.

Recommendations

WRES
A priority in addressing the following:

- Data aligned to the WRES KPIs has resulted in a specific WRES action plan indicating all areas that need improvement.

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

- Specifically refreshing the recruitment and selection process across all bands.
- Implementing a Race and Gender Disparity Audit.
- Assessing external / internal development programs for all staff across all bands.
- Working towards a Zero Tolerance policy.

WDES

- Adopt a program of review and development to include recommendations for change across all of the ten WDES indicators.
- Data aligned to the WDES KPIs has resulted in a specific WDES action plan indicating all areas that need improvement.

The Human Rights Equality Diversity Inclusion Programme Board will be monitoring the ongoing progress of actions. This group reports into the People and OD Portfolio Board.

The overarching EDI Action plan has been developed in line with the approved Equal Opportunities Strategy and has been discussed with all members of the HREDI Programme Board.
</td></tr>
<tr><td>Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper</td><td colspan="6">The Board is asked to note the content of this report and agree the overarching EDI Action Plan.</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:</td><td>Aim 1
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☐</td><td colspan="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">SA2.3 Being a great place to work in order to improve staff survey outcomes and impact upon patient outcomes within 2-years.</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 2760 - The People Plan places equality, diversity and inclusion as a critical strategic workforce priority; further work is needed to embed this fully across the trust</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>

Workforce Race Equality Standard (WRES) - way forward

1.0 Summary and Background

The purpose of this paper is to provide an update on progress against the Workforce Race Equality Standard indicators and propose future actions. These actions form part of the Trust's Equality Objectives and overarching Equality Diversity & Inclusion Work Plan started in 2021. **The HREDI action plan at Appendix 2 is also cross referenced to the EDI strategy that has been ratified at Board.**

The WRES was first mandated in July 2015 to ensure employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair and equal treatment in the workplace. The WRES standard is also cross referenced to:

- the Equality Delivery System 2 (EDS2).
- the recently launched NHS Equality diversity and Inclusion Plan.

The above programmes of work should support performance review, set equality objectives and deliver on the Public Sector Equality Duty (PSED which sets out the **'general'** and **'specific'** duties on public authorities as indicted below.

2.0 The General Duty to:

- Eliminate unlawful discrimination, harassment and victimisation, and other conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

3.0 The Specific Duty to:

- Publish equality information at least once a year to show how they've complied with the equality duty.
- Prepare and publish equality objectives at least every 4 years.

To put the WRES into context the NHS People Plan states that…
'… to embed the important interventions that improve the experience of our people, we will develop a new offer with our people setting out explicitly the support they can expect from the NHS as a modern employer…'

This will be framed around the broad themes of:
'… creating a healthy, inclusive and compassionate culture, enabling great development and fulfilling careers, and ensuring everyone feels they have voice, control and influence…'

The interim plan then expands on 'Creating a healthy, inclusive and compassionate culture' *by setting out 'action to improve equality will need to run through all elements of the work on this new offer. This will include further action to embed the Workforce Race Equality Standard…..'*

4.0 Recommendations

1. Adopt a program of review and development to include recommendations for change across all of the 9 WRES indicators. Additionally cross reference the actions as per the newly published NHS equality, diversity and Inclusion Improvement Plan. The Key Priorities are;

    - Review and refresh the policy around Recruitment and Selection.
    - Undertake a Gender Pay Gap analysis and cross reference actions to Recruitment and Selection training on offer.
    - Undertake a Race Disparity Audit across the Specialities and Banding.
    - Assess the viability to deliver external development programs (leadership and personal development).
    - Work towards a Zero Tolerance policy.

2. Incorporate data from the WRES and continue to deliver on the actions indicated within the attached action plan.

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1 Introduction

In recent years there have been a number of major developments in equality legislation and codes of practice. The Stephen Lawrence Enquiry which lead to the McPherson Report gave impetus to the issue pertaining to race equality, and introduced the term ‘institutional discrimination’ to describe the way in which organisational systems, structures, processes and procedures can operate against equality of opportunity. This debate in its own right paved the way for addressing inequalities across all protected characteristics as reflected in the Equality Act 2010. But addressing inequalities and ensuring Equality and Diversity is reflected in all we do is not only a legal duty, but integral to promote equality on moral and democratic grounds.

2 WRES Metrics

In the previous year’s NHS England provided all Trusts with a standard submission template which once populated would be submitted through the NHS Digital's Strategic Data Collection Service (SDCS). This has now changed to an online submission. The collection period for the data has also been brought forward to the month of May to allow Trusts to check and validate the information collected. The submission of data is 31st August, and a narrative report published externally by 31st October.

According to an annual WRES report into race equality across the health service published in February 2023 indications are:

- *The NHS workforce is more diverse than at any other point in its history. The NHS Workforce Race Equality Standard (WRES) shows black and minority ethnic (BME) staff make up almost a quarter of the workforce overall (24.2% or 383,706 staff) - an increase of 27,500 people since 2021 (22.4% of staff).*

- *The analysis shows more than two fifths (42%) of doctors, dentists, and consultants, and almost a third (29.2%) of our nurses, midwives, and health visitors are from BME backgrounds.*

While the figures also show an increase in representation at board level:

- The number of BME board members across all NHS trusts has increased to 13.2% in 2022, up from 12.6% the year before, and almost double what it was in 2017 (7%) - BME staff still remain proportionally under-represented in senior positions, which is why the Long Term Plan has called on every NHS trust to set its own target for senior BME representation reflective of their overall workforce.

- In the past 12 months, BME very senior managers (VSMs) have increased from 9.2% to 10.3% (an increase of 51 – up from 290 in 2021 to 341 in 2022).

The National WRES report also shows:

- 29.2% of ethnic minority and 27.0% of white staff reported harassment, bullying or abuse from patients; an increase from 28.9% and 25.9% respectively.

- There was a modest reduction in staff bullying reported for both ethnic minority and white staff. A drop from 28.8% to 27.6% for ethnic minority staff and 23.2% to 22.5% for white staff.

- The percentage of staff believing their trusts provides equal opportunities for career progression and opportunities has fallen for white staff from 59.6% to 58.7%. There was a modest improvement for ethnic minority staff, to 44.4% from 44% in 2021.

- White shortlisted job applicants were 1.54 times more likely to be appointed from shortlisting than BME shortlisted applicants - an improvement from 1.61 in 2021. While data for BME staff entering formal disciplinary process remains unchanged from 2021 at 1.14 times, a vast improvement from its peak in 2016 at 1.56.

3 WRES data report for the Trust

The WRES was developed to help NHS organisations make a positive impact for staff from BME backgrounds working in the NHS. The WRES aims to inform year on year improvements in reducing those barriers that impact most on the career opportunities and workplace experiences of GEM staff - driving changes in attitudes, increasing employment and career opportunities, and implementing long-lasting change for BME staff.

Data in respect of the 9 indicators for the WRES data has been collected from the 2022 NHS Staff Survey and the a detailed action plan is a standing agenda item at the Human Rights Equality Diversity and Inclusion Programme Board. From previous discussions at the HREDI Board and with the GEM Staff Network an action plan was developed with colleagues within the Trust charged with specific actions monitored by the above group. Any revisions / additions to the action plan pay due regard to the internal GEM groups input including National discussions to future proof the action plan.

The POD Committee is responsible for governance and assurance.

4 Key indicators and way forward

The key WRES data across all of the metrics is indicated in Appendix 1.

Appendix 2 is the overarching HREDI action Plan.

5 Recommendation

Board are asked to note the content of this report and agree the HREDI action plan and key priorities.

Workforce Disability Equality Standard (WDES) - way forward

1.0 Summary and background

The purpose of this paper is to provide an update on progress against the Workforce Race Equality Standard indicators and propose future actions. These actions form part of the Trust's Equality Objectives and overarching Equality Diversity & Inclusion Work Plan started in 2021. **The HREDI action plan at Appendix 2 is also cross referenced to the EDI strategy that has been ratified at Board.**

The WDES was first mandated in July 2018 and it builds on the Workforce Race Equality Standard (WRES), which was introduced in 2015 however focuses on disability. The WDES seeks to promote the concept of disability as an asset, as research has found that disabled people have poorer experience of working in the NHS in England than non-disabled colleagues.

The WRES standard is also cross referenced to:

- the Equality Delivery System 2 (EDS2).
- the recently launched NHS Equality diversity and Inclusion Plan.

The above programmes of work should support performance review, set equality objectives and deliver on the Public Sector Equality Duty (PSED which sets out the **'general'** and **'specific'** duties on public authorities as indicted in the WRES section above.

To put the WDES into context the NHS People Plan states that in order…
'… to embed the important interventions that improve the experience of our people, we will develop a new offer with our people setting out explicitly the support they can expect from the NHS as a modern employer…'

This will be framed around the broad themes of:
'… creating a healthy, inclusive and compassionate culture, enabling great development and fulfilling careers, and ensuring everyone feels they have voice, control and influence…'

The interim plan then expands on 'Creating a healthy, inclusive and compassionate culture' by setting out 'action to improve equality will need to run through all elements of the work on this new offer. This will include further action to embed the Workforce Disability Equality Standard'.

2.0 Essentially implementing the WDES will help the Trust to:

- Improve understanding of inequalities experienced by disabled staff.

- Create fairer, more anti-discriminatory environments and culture which foster the engagement, involvement, inclusivity of disabled staff.

- Provide better workplaces and services to patients and service users.

- Enable the Trusts commitment to meet the Equality Act's 'Public Sector Equality Duty'; and

- Help the NHS to deliver the government's pledge to increase the levels of disabled people in employment.

3.0 There are 10 WDES indicators which improvements are based on are:

- Workforce data (3 indicators)
- Questions from the NHS Staff Survey (5 indicators)
- Engagement and voices of disabled staff (1 indicator)
- Disability representation on Boards (1 indicator)

4.0 Recommendations

1. Continue to work on the actions as indicated within the WRES action plan across all of the ten WDES indicators.

2. Incorporate data from the WDES and continue to deliver on the actions indicated within the HREDI action plan.

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1 WDES Metrics

Data in respect of the 9 indicators for the WDES data has been collected from the 2022 NHS Staff Survey The results and associated action plan are a standing agenda item at the Human Rights Equality Diversity and Inclusion Programme Board (HREDIB). From previous discussions at the HREDI Board and with the D-Ability Staff Network an action plan was developed with colleagues within the Trust charged with specific actions monitored by the above group. Any revisions / additions to the action plan pay due regard to the internal D-Ability groups input including National discussions to future proof the action plan. This WDES action plan will enable us to measure our progress towards improving the experiences of our D-Ability employees.

Finally, the actions will be incorporated into the Trust's integrated work plans for equality, diversity and inclusion.

The POD Committee is responsible for governance and assurance.

2 WDES data report for the Trust

The WDES was developed to help NHS organisations make a positive impact for all disabled staff working in the NHS. The WDES aims to inform year on year improvements in reducing those barriers that impact most on the career opportunities and workplace experiences of Disabled staff - driving changes in attitudes, increasing employment and career opportunities, and implementing long-lasting change for Disabled staff.

The Trusts D-Ability Staff Network, Workforce Systems Manager helped in gathering information in respect of the 10 indicators. The collated information was discussed at the

Human Rights Diversity Inclusion Program Board (HREDIG).

The POD Committee is responsible for governance and oversight.

3 Key indicators and way forward

The key WDES data across all of the metrics is indicated in Appendix 1.

Appendix 2 is the overarching HREDI action plan.

4 Recommendation

The Board is asked to note the content of this report and agree the HREDI Action Plan.

Appendix 1

WRES Indicators

Key Findings: Red indicates less than good → Green indicates getting better → Amber indicates no movement →

WRES indicators for Gateshead Health NHS Foundation Trust

WRES Indicator			2019	2020	2021	2022	Trajectory		
1	Percentage of BME staff	Overall	5.4%	5.68%	6.05%	5.95%			
		VSM	0	0	0	0	↔		
2	Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME applicants		3.08%	1.8%	0.69%	4.5%	↗	**Overall considering that 3.7% of the demography of Gateshead comprises of BME groups, we seem to be on an upward Trajectory. Further detailed work is required to assess which areas show an increase or a decrease.** **.**	
3	Relative likelihood of BME staff entering the formal disciplinary process compared to white staff.		0.38	0.4*	0%	0%	↔	**Please see * below**	
4	Relative likelihood of white staff accessing non-mandatory training and CPD compared to BME staff		1.18	0.96	0	0	↔	**Detailed analysis required to understand where they may be blockages – both internally and externally**	
5	Percentage of staff experiencing harassment, bullying or abuse from patient's relatives or public in the last 12 months	BME	**29.5%** *(78 responses)*	**16.5%** *(85 responses)*	**21%** *(105 responses)*	**20.3%** *(133 response)*	↘	**Decrease**	**Better response from last year from BME as well as White respondents. Decrease for the BME Group, but an Increase for the White group.**
		White	**21.2%** *(1429 responses)*	**22.1%** *(1394 responses)*	**23.7%** *(1742 responses)*	**23.9%** *(1935 responses)*	↗	**Increase**	
6	Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	BME	**35.9%** *(78 responses)*	**32.9%** *(85 responses)*	**29.5%** *(105 responses)*	**19.1%** *(131 responses)*	↘	**Decrease**	**Whilst there has been a decrease in percentage terms, and that the number of responses has increased, further work is required to assess reasons why the decrease is not more significant.**
		White	**19.9%** *(1431 responses)*	**20.8%** *(1396 responses)*	**19.4%** *(1735 responses)*	**18.7%** *(1935 responses)*	↘	**Decrease**	

7	Percentage of staff experiencing discrimination at work from a manager / team leader or other colleagues	BME	**11.5%** *(78 responses)*	**17.1%** *(82 responses)*	**17.1%** *(105 responses)*	**11.4%** *(132 responses)*	↗	**Decrease**	**Whilst the response rate has increased the figure remains high and is virtually on par with the 2019 figure.** **The White group show an increase in both the responses and percentage**
		White	**4.2%** *(1418 responses)*	**4.7%** *(1393 responses)*	**6.2%** *(1733 responses)*	**4.7%** *(1937 responses)*	↗	**Increase**	
8	Percentage of staff believing that the trust provides equal opportunities for career progression or promotion	BME	**43.6%** *(78 responses)*	**44%** *(84 responses)*	**44.8%** *(105 responses)*	**47%** *(129 responses)*	↗	**Increase**	**Whilst there is an increase in the number of responses for both groups, the increase is not that significant - this could be due to post and pre COVID stages and work priorities.**
		White	**62.6%** *(1427 responses)*	**62.8%** *(1401 responses)*	**63%** *(1725 responses)*	**65.2%** *(1927 responses)*	↗	**Increase**	
9	BME Board membership		0	0	*1 Associated NED*	*0*			**No Change in figures to date**

Post and pre covid stages*This figure represents only 1 BME in respect of this indicator compared with 12 for the White category. Further investigation will be carried out to understand if data captured the first or final stage of a disciplinary process. This is also not reflective of the data that is coming through from the NMC and national data sets, as it shows that more BME colleagues are reprimanded which often leads to a formal disciplinary action.

WDES Indicators

Key Findings: **Red indicates not good** → **Green indicates getting better** → **Amber indicates no movement** →

	WDES Indicators		2018	2019	2020	2021	2022	Trajectory	
1	Percentage of Disabled staff in AfC paybands or medical and dental subgroups and VSM (including Executive Board members) compared with the percentage of staff in the overall workforce	Overall	**6.5%**	**5. 1%**	5.4%	5.6%	5.24%	↘	**Small Decrease**
		VSM	**0%**	**0%**	**0%**	**0%**	**7.7%**		
2	Relative likelihood of non-Disabled staff compared to Disabled staff being appointed from shortlisting across all posts.		**1.33**	**1.53**	**0.3***	**1.18**	**1.54**	↗	**Whilst this shows an increase, this is reflective of the number of candidates employed – which was small. (41 compared with 727)**
3	a) Relative likelihood of Disabled staff compared to non-Disabled staff entering the formal capability process, as measured by entry into the formal capability procedure		*	**0.0***	**0.01**	**8.34 (2 with disabilities)**	0	→	**Overall figures need to be reassessd as there may have been incidents which were not esclated into a formal process.**
4	Percentage of staff experiencing harassment, bullying or abuse from patients/service users, their relatives or the public in the last 12 months.								
	In the last 12 months, percentage of staff experiencing harassment, bullying or abuse from:		**2018**	**2019**	**2020**	**2021**	**2022**	**Trajectory**	
	a) Patients/service users, their relatives or other members of the public	Disabled (with LTC)	25% *(280 responses)*	23% *(320 responses)*	26% *(365 responses)*	31% *(504 responses)*	25.5% *(534 responses)*	↘	**Decrease. This however could be due to higher number of response.**
		Non Disabled (without LTC)	22% *(1096 responses)*	21% *(1195 responses)*	21% *(1123 responses)*	21% *(1339 responses)*	22.9% *(1529 responses)*	↗	**Increase of incidents. Whilst there were more responses worryingly this figure has become more negative**

	b) Managers	Disabled (with LTC)	18% *(28 responses)*	13% *(319 Responses)*	16% *(367 Responses)*	15% *(499 responses)*	11.7% *(532 responses)*		**An decrease of 3.3% ncrease. seems to be heading towards the 2019 figure. More work required to bring this down to 0%**
		Non Disabled (without LTC)	9% *(1090 responses)*	8% *(1191 Responses)*	8% *(1120 responses)*	6.5% *(1330 responses)*	6.1% *(1519 responses)*		**Small Decrease – but an increase in the number of responses**
	c) Colleagues	Disabled (with LTC)	24% *(280 responses)*	25% *(311 responses)*	24% *(360 responses)*	22% *(496 responses)*	23.9% *(527 responses)*		**Nearly a 2% increase –Further analysis will be undertaken as to reasons behind this**
		Non Disabled (without LTC)	15% *(1082 responses)*	14% *(1184 responses)*	14% *(1105 responses)*	14% *(1323 responses)*	12.2% *(1513 responses)*		**Whilst this figure has come down, proportionately, from responses this figure is still very high.**
	d) They or their colleague reported it	Disabled (with LTC)	37% *(101 responses)*	43% *(126 responses)*	41% *(148 responses)*	45% *(195 responses)*	43.5% *(193 responses)*		**Whilst there is a small decrease, comparativley the responses were also low.**
		Non Disabled (without LTC	30% *(299 responses)*	39% *(341 responses)*	42% *(310 responses)*	44% *(367 responses)*	45.3% *(419 responses)*		**A positive result and a slight decrease**
5	Percentage of disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.	Disabled (with LTC)	55% *(277 responses)*	54% *(322 responses)*	55% *(367 responses)*	57% *(500 responses)*	58.5% *(537 responses)*		**Slight Increase. Positive to see an increase in this KPI**
		Non Disabled (without LTC)	66% *(1092 responses)*	64% *(1191 responses)*	64% *(1127 responses)*	64% *(1328 responses)*	66.1% *(1515 responses)*		**A 2% rise and more responses from previous year**
6	Percentage of disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	Disabled (with LTC)	34 % *(199 responses)*	34% *(219 responses)*	34% *(228 responses)*	33% *(343 responses)*	28.2% *(397 responses)*		**Whilst the responses have gone up, the percentage shift is very small**
		Non Disabled (without LTC)	21% *(540 responses)*	19% *(610 responses)*	22% *(420 responses)*	21% *(633 responses)*	15% *(824 responses)*		**Whilst the responses have increased, he percentage shift is very small**

7	Percentage of disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which the organisation values their work.	Disabled (with LTC)	42% *(282 responses)*	42% *(323 responses)*	38% *(364 responses)*	36% *(506 responses)*	39.1% (*537 responses)*		**Whilst the responses are higher, it is dissapointing to see that the percentage shift taking place is very small**
		Non Disabled (without LTC)	53% *(1089 responses)*	54 % *(1191 responses)*	51% *(1120 responses)*	45% *(1333 responses)*	45% *(1528 responses)*		**Whilst the responses are higher, it is dissapointing to see that the percentage shift taking place remains as last year**
8	Percentage of disabled staff saying that their employer has made adequate adjustments to enable them to carry out their role.	Disabled (with LTC)	81% *(171 responses)*	85% *(179 responses)*	75% *(221 responses)*	78% *(290 responses)*	78.8%		**Very small Increase.**
		Non Disabled (without LTC)	0%	0 %	0%	0%	71.8%		
9	Staff engagement score for disabled staff compared to non-disabled staff and the overall engagement for the organisation (out of 10).	Disabled (with LTC)	6.9% *(283 responses)*	6.9% *(324 responses)*	6.9% *(367 responses)*	7% *(508 responses)*	6.5% *(539 rersponses)*		**Whilst the responses have gone up, the percentage shift is very small and 7% is seen as an average score. Further work is required to understand why this figure has not increassed**
		Non Disabled (without LTC)	7.3% *(1102 responses)*	7.3 % *(1201 responses)*	7.3% *(1130 responses)*	7% *(1341 responses)*	7.1% *(1532 responses)*		**Very little movement**

For question 4 - Whilst the figures show either an increase or a decrease, the figures are still high, our aim should be a zero%

For question 5 - There is a positive increase across the Disabled group, (57% up from 55%) the Non-Disabled group has remained at the same level (60%) for the last few years.

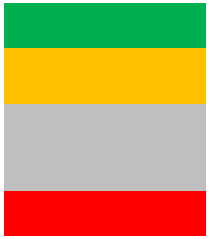
For question 7 – Data across both Disabled and Non-Disabled groups shows a decrease in respect of this KPI. Anecdotal conversations have indicated that the impact of COVID / flexi working has not really helped in staff feeling motivated in the work undertaken. This potentially could be reflected within these figures.

10	Percentage difference between the organisation's Board voting membership and the organisation's overall workforce	2019			2020			2021		
		Disabled	**Non-Disabled**	**Disability unknown or Null**	**Disabled**	**Non-Disabled**	**Disability unknown or Null**	**Disabled**	**Non-Disabled**	**Disability unknown or Null**
	Total Board	0%	100%	0%	0%	100%	0%	7.7%	92.3%	0%
	Voting Board	0%	100%	0%	0%	100%	0%	7.7%	92.3%	0%
	Non Voting Board	0%	0%	0%	0%	0%	0%	0%	0%	0%
	Executive Board Member	0%	100%	0%	0%	100%	0%	20%	80%	0%
	Non Executive Board Member	0%	100%	0%	0%	100%	0%	0%	100%	0%

Waiting for confirmation – but initial indicators are that the figures for 2022 have not changed.

Appendix 2

Gateshead Health NHS Foundation Trust Equality and Diversity Objectives and Action Plan 2020 – 2024

Acronyms used	
WRES - Workforce Race Equality Standard *WDES - Workforce Disability Equality Standard* *GPG - Gender Pay Gap* *PSED - Public Sector Equality Duty* *EDS - Equality Delivery System* *GEM – Global Ethnic Majority (previously BAME)*	 Complete In progress /Partially Complete/Minor Risk of delay Stood down Not started/Major risks or delays

OVERALL RAG Rating

Overarching EDI Aims	Outline of supporting actions	Summary of Progress - 2023	Cross reference indicators	Diversity Inclusion KPI	Time Frame	Supported / Advised by
	Ensure Human Rights Equality, Diversity and Inclusion (HREDI) are integrated within the provision of care	• EDI Board development session undertaken for Board. Further development sessions planned in respect of each of the PC's	WRES / WDES indicators 1 and 2	All KPIs applicable	**Apr-23**	EDI Manager with support from the Network Chairs Resourcing Manager
		• Women's Network established. • A separate Network already exists for the Armed forces and the Resourcing			**Ongoing** **Ongoing**	

Empowering our People in investing time in engaging with one another through inclusive networks, communities and forums	*and employment practices*	Manager has ongoing meetings re recruitment into the workforce • HREDI strategy has been approved at board • Three months reporting cycle on progress and activity to the People and Organisational Development Committee (a sub-committee of the Board) • Quarterly updates to the Senior Management Team			**Complete** **Beginning in Dec 23/Jan 24**	
	Recruitment and selection *Ensuring that EDI is embedded in our recruitment processes.*	Detailed action plan developed in respect of this KPI. Aspects of work being carried out are as follows: • Undertaking an audit around inclusive recruitment • monitoring the outcome of the engagement sessions • understanding the barriers to accessing recruitment • undertake a deep dive on those who have not been successful and offer of feedback and support • coaching opportunities - for internal applicants • Ensure that People are aware of Conscious and Unconscious bias that can impact upon the delivery of care. • Undertake a data analysis of who applied • Involve people with lived experience in interview panels and People	WRES / WDES indicators 1 and 2 NHS EDI improvement Plan – High Impact A	Provide appropriate Recruitment and Selection Training Provide appropriate and targeted training around Values and Inclusion Have a Zero tolerance Policy around behaviours that lead to bullying and harassment	**Aug-23** **Oct 23 onwards for the duration of the plan**	Resourcing Manager, EDI manager and Head of People

		inductions (dependent upon the level of job being recruited to). • Empowering and upskilling our people		of our people.		
	Ensure Equality Diversity and Inclusive practices are mainstreamed	• Agenda items circulated to all members of the Panel are referenced to the WDES / WRES KPI's. • All external EDI related information is discussed and actions agreed • Links to culture programme around the vision, values and behaviours	All WRES and WDES indicators	All KPIs applicable	**Ongoing for the duration of the plan**	EDI Manager/ DD Corporate Services and Transformation/ Head of Workforce
	Board development around HREDI. Specifically this includes: • *Executive sponsor for EDI* • *Board development sessions for EDI across all PC's* *- Board attendance at visibility at network events* *- Board development plan to ensure*	• Executive sponsor identified and potential chair for HREDI programme board • EDI metrics are on board agenda's • Monthly reporting on progress and activity to the People and Organisational Development Committee (a sub-committee of the Board) Quarterly updates to the Senior Management Team • I session around EDI board development has taken place, further sessions being planned. • External consultant engaged in NED recruitment.	All WRES and WDES indicators NHS Improvement Plan High Impact Action 2	All KPIs applicable	**Sept 2023** **Ongoing Starting Dec/23 / Jan 24** **Jan 24** **July 23**	Company secretary, EDI Manager and Executive Sponsor (Director of People and Organisational Development)

	future inclusivity - Visibility of board to ward eg Board Members and Governors take a proactive approach toward Inclusive behaviour. • *Board engagement with People, patients, public and community* • *Utilising the Inclusive leadership Framework* • *Individual anonymised staff stories at board* • *Work towards ensuring we are representative of the population we serve, including an increase in Board BME membership*	• Offer support to BAME individuals who were shortlisted but were unsuccessful for future appointments • EDI Governor session delivered			**NOT YET STARTED** **July 23**	

	Freedom to Speak Up	• Developing the capabilities around the Freedom to Speak up particularly around BAME staff • Full time Freedom to speak up Guardian appointed • Work very closely with EDI manager – issues where inequalities have been perceived are discussed and potential resolution methods are looked at • Work with network chairs and participate in meetings when time permits • FTSU champions- diverse and reflect the trust, however there is still more work to do. • Protected characteristics recorded on FTSU database. • FTSU induction and ongoing training for Internationally Educated Nurses (conscious of their vulnerability) • The possible barriers to speaking up for staff with protected characteristics to managers is covered on the Managing Well course	Cross reference to all WRES and WDES indicators	All KPIs applicable	**Oct 2023 for the duration of the Plan** **July 2023** **Ongoing** **Ongoing**	Freedom to Speak Up Guardian

	Health inequalities *- Be proactive by taking positive action for inclusive access* *- Supporting Digital Inclusion* *- Positive action for retention and recruitment* *-Collaboration and co-design* *- Exploiting our data and analysis* *- Ensure equality of outcomes.* *- Maximising our social value* *- Intelligence led preventive programmes* *- Targeting long term health condition diagnosis and management*	• 4 Workstream areas identified. 1. Removing access to barriers (What are the inequalities in our workforce across health outcomes & health determinants - What are the inequalities in the patient population as they arrive into our services?) 2. Focus on Experience of Care (Services and pathways to improve inclusivity) 3. Improving outcomes for everyone (Focusing our population health impact using Core 20 plus 5 principles) 4.Workforce ((Maximising our social value As an anchor institution we will also make choices aimed at reducing inequalities with particular focus on purchasing locally and employing inclusively.)	Detailed Action plan produced in respect of the workstreams and work is underway	All KPIs applicable	**Ongoing programme**	Deputy Director of Transformation and Corporate Services

	Awareness training programmes	See section on core training	All WRES and WDES indicators NHS Equality Diversity and Inclusion Improvement Plan High Impact Action 4	All KPIs applicable	**Ongoing programme**	Head of Learning and Development and EDI Manager

	Calendar of events for the Trust *- Ensure that world faith days / customs are celebrated* *- Ensure cognisance is paid around cultural and religious practices impacting upon holidays and food* *- Enabling people to attend, and be involved in regular meetings about programmes impacting upon provision of service, this will include assessing recruitment, promotion , leadership*	• Linking into regional EDI programme • Engagement with the international nurses to help facilitate forthcoming days of faith • South Asian History Month – celebrated within the HUB – with traditional food • Planning ongoing in terms of celebrating Black History Month	WRES /WDES indicators and GPG	Ensure ongoing conversations value diversity, inclusion and belonging, and liaise with stakeholders to identify the teams that need priority focus.	Ongoing programme	Head of Communications and Engagement and EDI manager

Holding one another to account in living our values, by incorporating EDI into our core values, challenging unconscious bias and fostering diverse thinking	**Ensure mandatory reporting is completed.** - *Workforce Race Equality Standard (WRES)* - *Workforce Disability Equality Standard (WDES)* - *Gender Pay Gap*	• The HREDIG programme Board has concentrated on the WRES / WDES action plans. • Network Chairs concerns have also been tabled within this group and appropriate actions have been undertaken. • Two sessions around Cultural Competency Training have been delivered. More dates being assessed. • POD leads have contributed in providing R and S info, however further work is required. • E and D continues to be delivered as part of the Managing Well programme	WRES / WDES / GPG across all indicators (high priority area for improvement)	All KPIs	**Ongoing updates to HREDIG. Board update due Sep / Oct 23** **Aug 23** **July 23** **Ongoing**	EDI Manager/ All Head of Services for POD
	Local Champions Embed equality and diversity by identifying local champions and ensuring that services have a local reference point as well as a corporate service.	Still to begin	WRES / PSED (high priority area for improvement)	All KPIs	Jan/ Feb 24	EDI Manager/ Head of People / Head of Learning and Development
	Staff Networks *Help readdress any detrimental impact as well as progressing the EDI agenda*	• Network Review undertaken - waiting ratification • Developmental session agreed with the Head of Equity and Equality ICB Lead • Specific areas of work identified by Network members being assessed. E.g • Leadership and OD	WRES / PSED	Network members will develop and grow in their own right as well as helping	Oct 23 Nov 23	EDI Manager/ DD Corporate Services and Transformation/ Head of People / Head of Learning and Development

	Network review to be undertaken	• Career pathways • Highlight EDI issues from Network members to Board • Work with Allies to readdress change		deliver effective patient care Address culture change required based on allyship and a greater appreciation of the different cultural norms that can cause misunderstandings and miscommunication.	NOT YET BEGUN	

Holding one another to account in living our values, by incorporating EDI into our core values, challenging unconscious bias and fostering diverse thinking	**Work place adjustments** *Develop managers understanding of reasonable adjustments and the AIS and develop a process by which we can collate the information and have an overview of RAs across the Trust*	• Ongoing - however detailed analysis to be undertaken to assess how often reasonable adjustments are put into place. • Level 2 Disability Compliant Leader	WDES / WRES (high priority area for improvement)	Change the working culture and move to a more compassionate and inclusive environment	Information for L3 being complied - for submission end of March 2023	EDI Manager/ Head of Workforce
	Equality Data *Improve Equality Data for service users, addressing data gaps.*	• EDI dashboard updated on a quarterly basis and intelligence shared with key members of the HREDI programme board Information is used to sense check WRES, WDES, GPG reports and recommendations	WRES / WDES	All KPIs	**Refresh information gathered on a quarterly basis Jan 24**	EDI Manager/ Head of People / People & Information Systems Team Manager

	Sexual orientation monitoring and transgender monitoring *Equity for service users as well as incorporating data collection in Systems used by the Trust*	• Initial meetings arranged with Stonewall • Regional EDI leads approached to assess positive outcomes of using Stonewall equality index • Sexual orientation training with external provider being assessed	PSED and EDS indicator 1 and 2	Change the working culture and move to a more compassionate and inclusive environment	Commencing in Sept 23 Sept 23 NOT YET STARTED	Head of People
	Recruitment and selection *Ensuring that EDI is embedded in our recruitment processes. This includes reviewing:* *- audit around inclusive recruitment* *- monitoring the outcome of the engagement sessions* *- understanding where the barriers to accessing*	• Bite sized R and S programme on offer • Unconcious and conscious bias addressed with training • Re assessing where inequalities within the process take place	WRES / WDES indicators 1 and 2	Provide appropriate Recruitment and Selection Training Provide appropriate and targeted training around Values and Inclusion Have a Zero tolerance Policy around	Aug-23 NOT YET STARTED	Resourcing Manager, EDI manager and Head of People

	recruitment *- undertake a deep dive on those who have not been successful* *- feedback and support/coaching opportunities - for internal applicants* *- Ensure that People are aware of Conscious and Unconscious bias that can impact upon the delivery of care.* *- undertake a data analysis of who applied* *- Involve people with lived experience in interview panels and People inductions (dependent upon the level of job being recruited to).* *- Empowering and upskilling our people*			behaviours that lead to bullying and harassment of our people.		

	Increased use of social media to engage directly with patients / families / carers	• Ongoing use of social media to engage with patients, families and carers	WRES / WDES	Have a clearer understanding of our people, patients and communities served	Ongoing	Head of Communications and engagement

Increasing opportunities for our people to have their voices heard.	**Equality Delivery system 2 (EDS) Qualitative and Quantitative measurements around EDI and direction of travel**	• A proroforma produced by the NHS patient and Engagement Lead was sent to Trust - This was populated and used as part of the EDI discussions. • Ongoing discussions as to how the EDS will be used, next year (cross referenced to the WRES/WDES / and the NHS Inclusion Plan) around next steps for 2024 • In essence 3 working groups were tasked to assess ways forward. Further discussions to be held in the next 2 months to agree priory actions and ways forward.	WRES / WDES indicators 1 and 2 and EDS indicator 3	All KPIs	**Feb 23** **Dec 23/Jan 24**	EDI Manager/ Head of POD services / Trust Secretary / Patient Experience Manager
	Faith Considerations *- Meet the spiritual needs of patients and staff* *- Ensure that all patients, families and carers can utilise the chaplaincy services across all faith groups;* *- Work towards an*	• The Chapel and Faith room are available for all faith groups. Updated literature is being sourced and will be made available within the prayer rooms.	EDS indicator 2 (potential change in this indicator)	Cultural competency is an integrated within our everyday understandin g Change the working culture and move to a	Head of Chaplaincy and EDI Manager Report to HREDI **April 2023** ngoing for the duration of the plan	EDI Manager/ DD Corporate Services and Transformation / Finance Director and Head of Chaplaincy

	inclusive provision for contemplation /prayer for non-faith groups	• Meetings arranged with Head of Estates to scope both the Chapel and prayer room as Muslim members of staff have indicated that the space has outgrown its usage	EDS indicator 2	more compassionate and inclusive environment	Head of Chaplaincy and EDI Manager Report to HREDI April 2023	EDI Manager/ DD Corporate Services and Transformation / Finance Director and Head of Chaplaincy
		• 2 sessions around Cultural Competency delivered. Further training sessions being planned to roll out to the Trust.	EDS indicator 2		From June 2023	EDI manager and the Head of Learning and Development

	Accessible Standard *- Gather comprehensive demography data to assess the makeup of the communities broken down via the Protected characteristics.* *- Assess the access needs of groups served* *- Ensure that the Patient Public Engagement and Experience (PPEE) is sustained for full involvement.* *- Ensure that there is on-going support for and provision of the service user, young people and carers.* *- Work towards developing innovative peers support – a listening service that develops*	• Detailed actions in the WDES action plan • AIS Policy being refreshed • Utilising the Big word and their services for equitable interpretation across all of our services • 2 Cultural competency training delivered. Further session being explored.	WDES	Cultural competency is an integrated within our everyday understandin g	Ongoing **Oct 23** **Ongoing** **July 23**	Patient Experience Lead, Head of Communications and Engagement and EDI Manager

	service users and carers as volunteers (help in evaluating elements of services to ensure due diligence has been paid in respect of service delivery for all our users and carers). *- Ensure that adequate provision is there for patients where English may not be their first language.* *- Use the NHS Accessible Standard and work to ensure that all letters are jargon free and user friendly.* *- Ensure that inclusive imagery and gender free terminology is used*					

	Development of an engagement programme from June 2023 for 12 months. The aims is to involve and empower people from the communities served. To include engagement with:
	- communities
	- established networks (internal and external)
	- staff
	- stakeholders
	
	To involve partners at place (Gateshead) and regionally. We will:
	- Proactively engage with communities served to understand issues
	- Continually welcomes comments, compliments, complaints and
		• Communication with the following groups has been undertaken
		  • Connected Voice
		  • Haref
		  • Gateshead Council
		  • Mosques
		  • Sikh and Hindu Temples
		  • Jewish Community group
		
		For all faiths served, calendar days and dates have been identified celebrations of faith around EID - Diwalli, Bashaki, Rosh Hashanan and Yom Kippur be integrated within the existing Trust celebrations
		
		• Calendar of important faith days being produced
		
		• Calendar of dates pertinent to celebration
		
		• PALS – to ensure that information be provided in an appropriate manner across faith.
			WRES / WDES / GPG /EDS	Change the working culture and move to a more compassionate and inclusive environment
				
				Have a clearer understanding of our people, patients and communities served
				
				Have a clearer understanding of our patients groups.
				
				Engagement with other Health partners within the ICB region
					NOT YET STARTED
					
					Provisional dates for information to be completed by end of October 2023
						EDI manager, Heads of Services for POD, Patient Experience Manager

	concerns *- listen and respond effectively to complaints and concerns* *- Continue to use a variety of modes to capture the experience of patients* *- collect Equality data in line with the current protected characteristics* *- Continue to utilise the Patient Advice and Liaison Service (PALS) service*			will give a wider understandin g across the region around Health inequalities based upon different communities accessing our services Cultural competency is integrated within our everyday provision of care		

	Clinical Service *Continuous improvement in clinical services and identification of how EDI will be addressed in services*	• EDS goals have changed - One of the Domains is around Inclusive leadership . There is detailed actions around Recruitment and Selection as part of the delivery of EDS. The goals and ways forward are a standing agenda item on the HREDI Programme Board Agenda	WRES / WDES indicators 1 and 2 and EDS indicator 3 High Impact Action 3	Change the working culture and move to a more compassionate and inclusive environment	December 23 / Jan 24	EDI Manager/ Head of People / Patient Experience Manager
	Utilise local population information on equality characteristics to identify service usage and develop plans with partners and external stakeholders, including service users from the communities served.	• The work around this agenda is still in its infancy. However we are looking at how we can integrate work streams and cross reference pieces of work that other trusts are undertaking within the region.	NA	Change the working culture and move to a more compassionate and inclusive environment	NOT YET STARTED Discussions with regional EDI and ICB Lead	EDI Manager/ Head of People / Patient Experience Manager

	Estates strategy *Assess current provision of facilities, equipment that aid and support the 9 protected characteristics (e.g. Access, loop induction, prayer facilities and equipment)*	• Clinical estates strategy being developed	WDES indicator 8 and EDS (high priority area for improvement)	Engagement with other Health partners within the ICB region will give a wider understandin g across the region around Health inequalities based upon different communities accessing our services		EDI Manager/Head of Workforce

CORE and Essential Training:	**Continued provision and monitoring of core/essential EDI training**	• Training programme has been developed - specific training is listed below as part of the core and essential training for EDI	WRES / WDES / PSED	All KPIs	Ongoing	EDI Manager / Head of Learning and Development
	Neurodiversity training	• Ongoing	WDES	Change the working culture and move to a more compassionate and inclusive environment	Ongoing	EDI Manager / Head of Learning and Development
	Cultural competency training	• Ongoing - Training is being provided by HAREF and started in June 2023. • Further sessions being assessed for roll out	PSED	Cultural competency is an integrated within our everyday understanding Address culture change required based on allyship and a greater appreciation	June 23	EDI Manager / Head of Learning and Development

				of the different cultural norms that can cause misunderstandings and miscommunication.		
	Reverse and Reciprocal Mentoring	• Due to a lack of take up the Reciprocal mentoring programme, the programme is being re-assed and will be offered in a different format linked to Leadership. • External NHS provision Around developing leaders is also being assessed. • The bite size R and S packages have been reassessed and conscious and unconscious bias aspects integrated into the training	WRES Indicator 1 and 2 (high priority area for improvement)	Change the working culture and move to a more compassionate and inclusive environment	POD colleagues to report to HREDIG - **June 2023** **Ongoing**	Head of Leadership, OD and Staff Experience

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 21

Report Title:	**Register of Official Seal**			
Name of Meeting:	Board of Directors			
Date of Meeting:	27th September 2023			
Author:	Diane Waites, Corporate Services Assistant			
Executive Sponsor:	Trudie Davies, Chief Executive			
Report presented by:	Jennifer Boyle, Company Secretary			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
	To receive details of the use of the official seal between 1 September 2022 and 31 August 2023.			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☒ *No gaps in assurance*	**Partially assured** ☐ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	-			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	In accordance with the Board's Standing Orders paragraph 12.3 the Board must receive an annual report documenting when the official Trust seal has been used throughout the year. This report is presented to Board each September in accordance with the cycle of business. The official seal has not required to have been used during this current year. This report formally documents this in accordance with Standing Order paragraph 12.3.			
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	The Board is asked to formally note that the official seal has not been used during this current year (September 2022-2023).			

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

Meeting:	Trust Board
Chair:	Alison Marshall
Financial year:	2023/24

	Lead	Type of item	Public/Private	Sep-23	Nov-23	Jan-24	Mar-24
Standing Items			Part 1 & Part 2				
Apologies	Chair	Standing Item	Part 1 & Part 2	√	√	√	√
Declaration of interests	Chair	Standing Item	Part 1 & Part 2	√	√	√	√
Minutes	Chair	Standing Item	Part 1 & Part 2	√	√	√	√
Action log	Chair	Standing Item	Part 1 & Part 2	√	√	√	√
Matters arising	Chair	Standing Item	Part 1 & Part 2	√	√	√	√
Chair's Report	Chair	Standing Item	Part 1		√	√	√
Chief Executive's Update Report	Chief Executive	Standing Item	Part 1 & Part 2	√	√	√	√
Cycle of Business	Company Secretary	Standing Item	Part 1 & Part 2	√	√	√	√
Patient & Staff Story	Company Secretary	Standing Item	Part 1	√	√	√	√
Questions from Governors	Chair	Standing Item	Part 1	√	√	√	√
Items for Decision			Part 1 & Part 2				
Annual Declarations of Interest	Company Secretary	Item for Decision	Part 1				√
Approval of new Strategic Objectives	Deputy Director of Corporate Services & Transformation	Item for Decision	Part 1				
Board Assurance Framework - quarterly updates	Company Secretary	Item for Assurance	Part 1		√		
Board Assurance Framework - approval of closing and opening position	Company Secretary	Item for Decision	Part 1				√
Standing Financial Instructions, Delegation of Powers, Constitution and Standing Orders - annual review	Company Secretary / Group Director of Finance	Item for Decision	Part 1	√			
Calendar of Board Meetings	Company Secretary	Item for Decision	Part 1		√		
Winter Plan	Chief Operating Officer	Item for Decision	Part 1	√			
Board Committee Annual Reviews of Effectiveness and Terms of Reference Update	Company Secretary	Item for Decision	Part 1				
CQC Statement of Purpose and Registration	Chief Nurse	Item for Decision	Part 1			√	
Items for Assurance			Part 1 & Part 2				
Board Committee Assurance Reports	Committee Chairs	Item for Assurance	Part 1	√	√	√	√
Trust Strategic Objectives - quarterly updates	Director of Strategy, Planning and Partnerships	Item for Decision	Part 1		√		√
Board Assurance Framework - quarterly updates	Company Secretary	Item for Assurance	Part 1		√		
Organisational Risk Register	Chief Nurse	Item for Assurance	Part 1	√	√	√	√
Annual Staff Survey Results	Exec Director of People & OD	Item for Assurance	Part 1				√
Finance Report	Group Director of Finance	Item for Assurance	Part 1	√	√	√	√
Integrated Oversight Report	Chief Operating Officer	Item for Assurance	Part 1	√	√	√	√
Maternity Integrated Oversight Report	Chief Nurse	Item for Assurance	Part 1	√	√	√	√
Nurse Staffing Exception Report	Chief Nurse	Item for Assurance	Part 1	√	√	√	√
Nurse Staffing Annual Capacity & Capability Report	Chief Nurse	Item for Assurance	Part 1				
Learning from Deaths (6 monthly report)	Medical Director	Item for Assurance	Part 1		√		

SIRO Report & Digital Update	Group Director of Finance	Item for Assurance	Part 1		√		
EPRR Core Standards Self-Assessment Report	Chief Operating Officer	Item for Assurance	Part 1		√		
CNST Maternity Compliance Report	Chief Nurse	Item for Assurance	Part 1			√	
Green Plan (formally Sustainable Development Management Plan)	QEF Managing Director	Item for Assurance	Part 1	defer to Nov	√		√
QEF 6 monthly update report	QEF Managing Director	Item for Assurance	Part 1		√		
Freedom to Speak Up Guardian Report	Exec Director of People & OD	Item for Assurance	Part 1	√			√
WRES and WDES Report	Exec Director of People & OD	Item for Assurance	Part 1	√			√
Quality Accounts Priorities 6 monthly update	Chief Nurse	Item for Assurance	Part 1		√		
Items for Information			Part 1 & Part 2				
Register of Official Seal	Company Secretary	Item for Information	Part 1	√			
Ad Hoc Items (i.e. items emerging during the year)			Part 1 & Part 2				
Staff survey results action plan update	Exec Director of People & OD	Item for Assurance	Part 1	√			
Thematic review updates	Chief Executive	Item for Assurance	Part 1		√		