MEETING OF THE BOARD OF DIRECTORS IN PUBLIC

Gateshead Health NHS Foundation Trust

Date: Wednesday 29th November 2023
Time: 9:30 am
Venue: Room 3, Education Centre/Teams

AGENDA

	TIME	ITEM	STATUS	PAPER
1.	9:30 am	**Welcome and Chair's Business**		
2.	9:33 am	**Declarations of Interest** To declare any pecuniary or non-pecuniary interests *Check – Attendees to declare any potential conflict of items listed on the agenda to the Company Secretary on receipt of agenda, prior to the meeting*	Declaration	Verbal
3.	9:34 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 27 September 2023** To be agreed as an accurate record	Agree	Enclosure 4
5.	9:40 am	**Matters Arising / Action Log** i. Band 2-3 HCA pay uplift scoping	Update	Enclosure 5
6.	9:45 am	**Patient & Staff Story**	Assurance	Presentation
		ITEMS FOR DECISION		
7.	10:00 am	**Calendar of Board Meetings 2024/25** To approve the dates presented by the Company Secretary	Approval	Enclosure 7
		ITEMS FOR ASSURANCE		
8.	10:05 am	**Chief Executive's Update Report** ii. **Thematic Review update** iii. **NENC Collaborative Governance update** To receive a briefing report from the Chief Executive	Assurance	Enclosure 8
9.	10:20 am	**Governance Reports** i. **Board Assurance Framework quarterly update** ii. **Trust Strategic Objectives quarterly update** iii. **Organisational Risk Register** To receive the reports presented by the Company Secretary, Director of Strategy, Planning and Partnerships and the Chief Nurse	Assurance	Enclosure 9
10.	10:35 am	**Assurance from Board Committees** i. Finance and Performance Committee – October 2023 and November 2023 ii. Quality Governance Committee – October 2023 iii. POD Committee – November 2023	Assurance	Enclosure 10
11.	10:55 am	**Finance Report** i. NHS England letter To receive the report, presented by the Group Director of Finance and Digital	Assurance	Enclosure 11
12.	11:05 am	**Integrated Oversight Report and Leading Indicators**	Assurance	Enclosure 12

		To receive the report, presented by the Group Director of Finance & Digital, Chief Nurse and Medical Director		
13.	11:20 am	**Nurse Staffing Update:** i. **Monthly Exception Report** ii. **Bi-annual Inpatient Safer Nursing Care Staffing Report** To receive the reports, presented by the Chief Nurse	Assurance	Enclosure 13
14.	11:35 am	**Maternity Update** i. **Maternity Integrated Oversight Report** To receive the report, presented by the Head of Midwifery	Assurance	Enclosure 14
15.	11.45 am	**Learning from Deaths Six Monthly Report** To receive the update, presented by the Medical Director	Assurance	Enclosure 15
16.	11:55 pm	**QE Facilities Six Monthly Report** To receive the report presented by Interim QE Facilities Managing Director	Assurance	Enclosure 16
		ITEMS FOR INFORMATION		
17.	12:05 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 17
18.	12:10 pm	**Questions from Governors in Attendance** To receive any questions from governors in attendance		Verbal
19.	12:20 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
20.	12:20 pm	**Chair Declares the Meeting Closed**		Verbal
21.	12:20 pm	**Exclusion of the Press and Public** To resolve to exclude the press and public from the remainder of the meeting, due to the confidential nature of the business to be discussed		Verbal

Gateshead Health NHS Foundation Trust

Trust Board

Minutes of a meeting of the Board of Directors
held at 9.30 am on Wednesday 27th September 2023, in
Rooms 9&10, Education Centre, Queen Elizabeth Hospital and via MS Teams

Present:	
Mr M Robson	Vice Chair / Non-Executive Director
Mr A Beeby	Medical Director
Mr A Crampsie	Non-Executive Director
Mrs T Davies	Chief Executive
Dr G Findley	Chief Nurse
Mr N Halford	Medical Director of Operations
Mrs J Halliwell	Interim Chief Operating Officer
Mr S Harrison	Interim Managing Director for QE Facilities
Mr M Hedley	Non-Executive Director
Mrs K Mackenzie	Group Director of Finance and Digital
Mrs M Pavlou	Non-Executive Director
Mrs A Stabler	Non-Executive Director
In Attendance:	
Mrs J Boyle	Company Secretary
Mrs A Harvey	Head of Research and Development (23/193)
Ms K Hooper	Lead Midwife for Risk, Safety & Quality (23/204)
Dr S Razvi	Associate Medical Director for Research and Development (23/193)
Mrs G Rutherford	Interim Deputy Director of People & Organisational Development
Ms D Waites	Corporate Services Assistant
Governors and Members of the Public:	
Mrs H Adams	Staff Governor
Mr S Connolly	Public Governor – Central
Mr R Dennis	Public Governor – Western
Mr M Learmouth	Public Governor – Central
Mr G Main	Public Governor – Western
Mr G Riddell	Public Governor – Western
Apologies:	
Mrs A Marshall	Chair
Mr A Moffat	Non-Executive Director
Mrs H Parker	Non-Executive Director
Mrs A Venner	Interim Director of People & Organisational Development

Agenda Item	Discussion and Action Points	Action By
23/188	**CHAIR'S BUSINESS:** The meeting being quorate, Mr M Robson, Vice 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. He welcomed those present including the Trust's Governors and welcomed Mrs J Halliwell, Interim Chief Operating Officer to her first meeting.	

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	Mr Robson wished to publicly offer the Trust's condolences to those affected by the Lucy Letby crimes and reported that the Board produced an immediate response to colleagues, providing assurance and encouragement that the Trust will always listen to concerns, anxieties and worries. The Board took time to consider the families and victims.	
23/189	**DECLARATIONS OF INTEREST:** Mr M Robson requested that Board members present report any revisions to their declared interests or any additional declaration of interest in any of the items on the agenda. Mrs J Boyle, Company Secretary, presented the Register of Board Members interests which has been updated to include Mrs J Halliwell as a new Board Member. 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 interest of Mrs Halliwell and note that the next annual review of the declaration of Board members' interests will take place in March 2024.	
23/190	**APOLOGIES FOR ABSENCE:** Apologies for absence were received from Mrs A Marshall, Mr A Moffat, Mrs H Parker and Mrs A Venner.	
23/191	**MINUTES OF THE PREVIOUS MEETING:** The minutes of the meeting of the Board of Directors held on Wednesday 26th July 2023 were approved as a correct record.	
23/192	**MATTERS ARISING FROM THE MINUTES:** The Board reviewed the action tracker as below: • Action 23/59 re. constitutional amendment. This was approved at the Annual General Meeting therefore action agreed for closure. • Action 23/64 re. committee review. The Good Governance Institute review conclusions are due to be discussed at the Board	

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	Development Day in October 2023 therefore will remain open until completed. • Action 23/156 re. Nursing apprenticeships 4-year programme. Has been added to the People & Organisational Development Committee cycle of business therefore action agreed for closure. • Action 23/157 re. slippage and escalating costs of Community Diagnostic Centre programme. Agenda item featured on Part 2 therefore action agreed for closure. • Action 23/157 re. leading indicators development. Proposal to include on Board Development Day agenda in October 2023. Action therefore agreed for closure. • Action 23/157 re. electronic patient record development. Mrs K Mackenzie, Group Director of Finance and Digital, reported that the engagement event has been postponed due to industrial action therefore is due to take place in December 2023. Mrs A Stabler, Non-Executive Director, felt that it was important to ensure that discussion took place around the impact of choice based on other local trusts and Mrs T Davies, Chief Executive, felt that this could be fed into discussions at the Board Development Day in October 2023 around strategic decision making criteria. Deadline date to be amended and action to remain open • Action 23/158 re. further clarification on contractual obligations in relation to mental health services overview. Mrs Davies reported that there is no update as yet therefore action to remain open. • Action 23/159 re. review of new operating model risk (2868) via the Executive Risk Management Group. The Board were informed that the risks have been reviewed therefore action agreed for closure. • Action 23/160 re. discussion of financial sustainability plans at the Board Development Day in August 2023. Discussions have taken place therefore action agreed for closure. • Action 23/161 re. the approval of the Patient Safety Incident Response Plan (PSIRP) at the Quality Governance Committee prior to ratification by Board. This has taken place and is on today's agenda therefore action agreed for closure. The Board reviewed the actions closed at the last meeting which ensures actions have been closed in line with expectations and the agreements made at the previous Board meeting. No further requirements were highlighted.	DW
23/193	**PATIENT STORY – RESEARCH AND DEVELOPMENT TEAM:** The Board welcomed Mrs Alison Harvey, Head of Research and Development and Dr Salmen Razvi, Associate Medical Director for Research and Development, who provided a presentation on the work of the Research and Development Team.	

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	She drew attention to some of the work undertaken by the team and encouraged the Board to review the Research and Development Annual Report which is included in the Board Reference Pack and demonstrates the good work undertaken and contribution of staff. Mrs Harvey highlighted the importance of engagement in relation to funding and health care improvements and felt that research should be incorporated into daily business. Mr Robson thanked Mrs Harvey for her positive feedback and following a query from Mrs A Stabler, Non-Executive Director, in relation to quantifying lost income, Mrs Harvey explained that a significant amount of funding has been turned down however research support is available within the organisation. She explained that greater awareness would be beneficial and a suggestion was made in relation to future recruitment processes. Mr A Beeby, Medical Director, felt that additional promotion work would be useful and Dr G Findley, Deputy Chief Executive and Chief Nurse, explained that all clinical roles should be involved. Mrs T Davies, Chief Executive, highlighted that research supports the improvement of patient outcomes and should be incorporated into normal practice. It was agreed that research would be referenced by Non-Executive Director representatives at consultant interview panels to support the cultural shift from research being seen as additional activity to business as usual. Mrs Harvey and Dr Razvi left the meeting.	
23/194	**WINTER PLAN SUBMISSION:** Mrs J Halliwell, Interim Chief Operating Officer, presented the draft Winter Plan Strategic Overview which provides assurance to support the work of the Trust during the winter period 2023/24. Mrs Halliwell reported that assurance can be provided that robust planning, mitigation and forecasting has taken place as well as considerations from lessons learnt from last year, business continuity and the impact of industrial action. She explained that a system approach has been undertaken via three groups including the system strategic group, system operational group and internal operational groups. A supporting Operational Trust Winter Plan has also been produced to provide specific guidance, information and instructions for teams to operationally respond during the winter period. Following a query from Mrs A Stabler, Non-Executive Director, in relation to system engagement and assurances for delivery, Mrs Halliwell explained that there have been some gaps in provision however this has already been highlighted and discussed to ensure early measures are taken around risk mitigation. Mr A Crampsie, Non-Executive Director, queried whether the current financial environment and impact of industrial action would contribute to a risk around delivery of the plan (particularly given reports that no additional winter monies would be made available to trusts) and Mrs K Mackenzie, Group	

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	Director of Finance and Digital, explained that winter monies are accounted for within financial plans however collective discussions are required to ensure funding is managed appropriately. Mr N Halford, Medical Director of Operations, highlighted that partnership working is moving positively and gaps are being identified whilst considering mutual aid. Mr M Hedley, Non-Executive Director, felt that the plan should be considered business as usual and Mrs Halliwell confirmed that the winter plan was aligned to the existing unscheduled care programme, with some already planned elements being accelerated for winter. Mrs T Davies, Chief Executive, highlighted that these plans have enabled the Trust to remain within funded bed bases with the support of clinicians ensuring that safe environments are maintained. Following further discussion, it was: **RESOLVED:** to ratify the submission of the Winter Plan 2023/24 Strategic Overview to NHS England.	
23/195	**PATIENT SAFETY INCIDENT RESPONSE PLAN (PSIRP):** Dr G Findley, Deputy Chief Executive and Chief Nurse, presented the Patient Safety Incident Response Plan (PSIRP) which sets out the Trust's 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). Dr Findley reported that the plan has been reviewed and approved by the Quality Governance Committee and provides detailed programmes of work to ensure patient safety. She drew attention to the focussed work plans which require Board approval and explained that they will be assessed throughout the year and reviewed by the Quality Governance Committee. A query was received in advance by Mr S Connolly, Deputy Lead Governor, in relation to services provided outside of the Trust and Dr Findley explained that the services are listed according to the Care Quality Commission requirements and includes all areas. Mrs J Halliwell, Interim Chief Operating Officer, felt that the programme of work includes key elements to system working and could provide shared learning, and Dr Findley confirmed that these key areas of work have already been agreed and shared with networks. Dr Findley also confirmed that the PSIRP plan has been shared with the QE Facilities Board as part of the engagement work. Mrs A Stabler, Non-Executive Director and Chair of the Quality Governance Committee, confirmed that the Committee approved the plan on behalf of the Board prior to submission and highlighted that the Integrated Care Board was impressed by the quality of the plan. She	

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	thanked Mrs Shelley Dyson, Head of Risk and Patient Safety, and the Patient Safety Team for their hard work. After consideration, it was: **RESOLVED:** to ratify the submission of the Patient Safety Incident Response Plan.	
23/196	**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 August 2023 meeting and provided a verbal update of the meeting held yesterday (26 September 2023). He highlighted that there was one item for escalation from the August meeting relating to the Community Diagnostics Centre however this is featured on the Part 2 board agenda. Mrs A Stabler, Non-Executive Director, raised a query in relation to the Month 4 Finance Report around unachieved cost reduction plans and the impact of industrial action and requested further assurance around the use of the orthopaedic ward and waiting list plans. Mr Robson highlighted that discussions took place at the Committee yesterday and an update will be provided. Key areas of discussion during the September meeting included: • Managed Laboratory Service Contract – discussion took place in relation to the procurement process and will to be presented to the Board in Part 2. • Quarterly QE Facilities' Report was received and good progress was noted. Standing Financial Instructions and Standing Orders are being redeveloped as a wraparound function and stretch targets have been provided. • Sustainability (Green Plan) update was provided and integrated reports are being developed. • Leading indicators and Integrated Oversight Report will be presented later in the meeting however discussion took place around trolley waits and referral to treatment (RTT) performance rates and it was felt that further control measures were required therefore this will be addressed via the performance meetings with a focus on pain, paediatrics and orthopaedics services. • Elective Recovery Programme – Mr Robson reported that a number of risks have been identified around year-end targets however assurance was provided around forecast assumptions and targeted approach. • NHS Impact Framework for continuous improvement was presented which is due for submission at the end of October	

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	2023 with any further amendments to be signed off by the Executive team. • Elective Recovery Board self-assessment was presented which is due for submission at the end of September 2023. The Committee approved this on behalf of the Board however there were some areas of partial assurance therefore an integrated report will be presented at the next Committee however Mr Robson felt that further discussion may be required around the implications of validation therefore could be discussed at a future Board Development Day. • Organisational Risk Register – Risk 3127 which relates to financial targets and the elective recovery fund was increased from 16 to 20 and it was felt that further risk assessment was required in relation to Risk 3186 relating to the maternity estate. • The Committee received an update on the Community Diagnostic Centre which has identified further delays therefore further work has been requested around this. A report will be presented to the Board in Part 2. • The strategic objective relating to the New Operating Model was agreed to be updated however this will require Board approval. Discussion took place in relation to agency use and it was felt that further control measures were required in relation to the financial position therefore action plans have been requested to be provided at the next meeting. An external meeting mapping exercise in relation to Objective 5.1 was being reviewed to assist in demonstrating delivery of this objective. **Quality Governance Committee (QGC):** Mrs A Stabler, Chair of QGC, provided a brief verbal overview to accompany the narrative report following the August 2023 meeting. She reported that there were three items for escalation: • Looked After Children service provision – Mrs Stabler reported that this was escalated to the Board last year and it was felt that a contract meeting with the Integrated Care Board would be helpful to review the increase in activity and deterioration in the delivery of the target. • Concerns were raised by the Committee in relation to the difficulty of tracking trauma patients resulting in the non-achievement of trauma rehabilitation standards identified in the Trauma Audit Research Network Report therefore actions have been identified • The Committee agreed that a QE Facilities report will be presented to outline quality assurances in relation to external contracts and Mrs M Pavlou, Non-Executive Director and QE Facilities Board Chair highlighted that the reports will be received for assurance (rather than approval) in future. • It was also noted that the Prevention Management of Violence and Aggression (PMVA) training figures require review and are being cross checked due to issues with reporting via the Electronic Staff Record (ESR) dashboard.	JH/JB

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	Digital Committee Mr Robson provided a brief verbal overview to accompany the narrative report following the August 2023 meeting on behalf of the Committee Chair and reported that there were no items for escalation however highlighted the following key points: • The Committee discussed the delay to the Electronic Patient Record plans with the engagement event being rearranged to 13th December 2023. • In relation to the Digital Key Performance Indicators (KPIs), the Committee acknowledged that work continues to refine the KPIs and escalation processes are in place. A further review will take place at the next Committee meeting. Mrs K Mackenzie, Group Director of Finance and Digital highlighted that an action plan is in place to manage this. **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 September 2023 meeting. She reported that there were two items for escalation which relate to concerns and plans around the recording of historic recruitment checks, and concerns around racism directed at staff. Mrs Pavlou highlighted that the Disclosure and Barring Service (DBS) report was on today's agenda and investigations are taking place in relation to the racism concerns in line with the recently approved Equality, Diversity and Inclusion Strategy. Other key points areas included: • A request for feedback on the Managing Well and Leading Well programmes and whether these have made an impact • A review of clinical appraisals which have not taken place and a request has been received for additional female appraisers. Mr N Halford, Medical Director of Operations, reported that clinicians undertake a five-year revalidation cycle however remedial work is being undertaken. • Further work to do around further development of the staff survey and Ms G Rutherford, Interim Deputy Director of People and Organisational Development reported that discussions are taking place via the Committee and a number of options are being explored. Dr G Findley, Deputy Chief Executive and Chief Nurse explained that further work is required around how the Pulse survey is received however a good response rate had been received from the Trust's Staff Survey. **Audit Committee:** Mr Robson provided a brief verbal overview to accompany the narrative report following the September 2023 meeting on behalf of the Committee Chair. He reported that there were no items for escalation however highlighted the following key points: • The Committee received good assurance and feedback from the effectiveness surveys for internal audit, external audit and counter fraud.	

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	• Audit recommendation target dates were discussed and it was highlighted that some targets dates had been revised however Mrs Mackenzie highlighted that leads will be invited to attend the Committee to provide updates. Mr Robson thanked the Committee Chairs for their reports and after consideration, it was: **RESOLVED**: to receive the reports for assurance	
23/197	**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 in relation to Strategic Aim 2 - *we will be a great organisation with a highly engaged workforce* - and shared the sad news that one of our colleagues, Rodica Raican, a healthcare support worker from ward 8, unexpectedly passed away and wished to express that thoughts are with her beloved husband Mario, who is also a colleague on ward 9, her family, friends and colleagues. Another death of a colleague, Susan McGurk was not previously recognised at Board and Mrs Davies apologised for this and expressed her condolences to her family, friends and colleagues and highlighted a new process has been put in place whereby a Family Liaison Officer will be appointed for any staff member who dies in service. She emphasised that all colleagues within the organisation are respected and contributions are recognised. Mrs Davies provided further updates following the Lucy Letby case and highlighted that actions are being taken forward by all senior NHS leaders. The Trust's full time Freedom to Speak Up (FTSU) Guardian, Tracy Healy, commences in post in October, and alongside the FTSU Champions will strengthen our Freedom to Speak Up structures and capacity. Mrs Davies drew attention to the Strengthening the Clinical Voice report and explained that this has been undertaken as part of the thematic review which 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. The report briefly outlines the challenges and solutions that have been put in place or are in progress and is received for information only. Following discussion, it was: **RESOLVED:** to receive the report for assurance.	

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23/198	**DISCLOSURE AND BARRING SERVICE (DBS) UPDATE REPORT:** Dr G Findley, Deputy Chief Executive and Chief Nurse, provided an update on the work underway and the reducing risk in relation to historic DBS clearances formally recorded in the Electronic Staff Record. Dr Findley reported that some gaps were identified in historical DBS records following an internal review however assurance was gained that following the implementation of the recruitment system Trac in July 2021, all relevant DBS checks were in place. A task and finish group was established to review the gaps and a robust process was put in place to support identified staff to obtain new DBS clearance. She highlighted that a future process has been agreed with the Executive Management Team to move to the DBS update system and discussions have commenced with trade union colleagues on the most appropriate way to implement this. The DBS policy will also be updated incorporating new processes. Dr Findley drew attention to the progress made by the People and Organisational Development team and highlighted that 977 staff records were identified as having incomplete checks at the beginning of the process however 863 of these have now been completed and actions have been identified in relation to the remaining staff. The Board acknowledged the hard work undertaken by the teams around this and subsequent reduction in risk. Following a query, Mrs J Boyle, Company Secretary, confirmed that all new Governors undergo a DBS check on appointment. After consideration, it was: **RESOLVED:** to receive the report for assurance.	
23/199	**HEALTH CARE ASSISTANT PAY RATES:** Dr G Findley, Chief Executive and Chief Nurse, presented the report which provides 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. Mr M Robson, Vice Chair, informed the Board that 111 grievances were formally submitted by Trade union representatives at the beginning of the meeting and will be addressed by the People and Organisational Development Team. Mrs T Davies, Chief Executive, thanked colleagues for raising concerns and highlighted that it is important for the Trust to consider fair pay issues and will remain on the Board agenda via the People and Organisational Development Committee. Dr Findley reported that the national job profiles for band 2 and band 3 healthcare support workers were updated in July 2021 and it has	

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	become apparent that when matched against these job roles, some staff at band 2 within the organisation may be operating at band 3 level. There are 697 whole time equivalent (WTE) substantive staff and 179 bank staff who are potentially affected by this issue. Dr Findley highlighted that further work needs to be undertaken to review each Trust job description working in partnership with trade union colleagues and the approach in relation to back pay must also be agreed. It is anticipated that the job evaluation process will be completed by the end of November 2023. Ms G Rutherford, Interim Deputy Director of People and Organisational Development, highlighted that a regional task and finish group was being set up with HR Directors to undertake scoping work and provides assurance that other trusts are in a similar position. Dr Findley confirmed that the issue had been added to the Organisational Risk Register following a query from Mr A Crampsie and a further report will come back to the Board following the job evaluation exercise. Mrs K Mackenzie confirmed that this has not been included in the Trust's financial position as yet until further work has been completed and Dr Findley explained that the Trust will be working with the Integrated Care Board and other stakeholders. Mr Robson informed the Board that the People and Organisational Development Committee will oversee this piece of work and keep the Board informed of progress, recognising the importance of clearly communicating expected timescales for completion for affected colleagues. Following further discussion, it was: **RESOLVED:** to note the contents of the report and actions being undertaken to address the identified disparity in grades for staff.	AV/MP
23/200	**GOVERNANCE REPORTS** **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 July 2023 to 16th September 2023. Dr Findley reported that there are currently 16 risks on the ORR, one with a high score of 20, and 7 with a score of 16 agreed by the Executive Risk Management Group. There have been no additions to the ORR, although 2 risks have been increased which relate to financial risks, 4 risks have been removed and one risk relating to non-compliance with current legislation as a result of policies not being up to date, has been reduced from a risk score of 16 to 12 based on current mitigations. One	

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	risk has been closed in relation to the failure to meet the CQC Fundamental Standards as these are now being monitored in the quality improvement plan via the quality indicators. The Board noted the top 3 category of risks within the ORR agreed at the Executive Risk Management Group in September 2023 relating to finance, performance and workforce. After consideration, it was: **RESOLVED:** to receive the report for assurance.	
23/201	**FINANCE REPORT:** Mrs K Mackenzie, Group Director of Finance and Digital, provided the Board with 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). Mrs Mackenzie explained that the Trust has reported an actual deficit of £8.872m after adjustments for donated assets and gain & losses of asset disposal which is an adverse variance of £2.278m from the year-to-date target. The Trust is forecasting achievement of its planned deficit totalling £12.588m however Mrs Mackenzie drew attention to the financial risks which will include the additional costs in relation to the Health Care Assistants' pay rates. She reported that a Senior Management Team session is scheduled in relation to cost reduction plans and levels of control have been introduced to manage this. Communication plans are being considered and developed for dissemination across the organisation. Internal plans around the Capital Programme are on target however some delays have been identified in relation to external plans and plans around the Community Diagnostic Centre will be discussed in Part 2 of the Board. Mrs A Stabler, Non-Executive Director, queried the impact of Pillar 1 Covid testing. Mrs Mackenzie assured that this has a net neutral impact and therefore does not affect the deficit position. Mrs M Pavlou, Non-Executive Director, raised concerns in relation to decreased levels of income and Mrs Mackenzie explained that a culture change in approach was required across the organisation in relation to recovery plans and budget spend. Mrs T Davies, Chief Executive, reaffirmed the commitment to being clinically-led and management supported, identifying that clinical engagement would be key to ensuring that available resources are utilised on the right things for patients. It is noted that productivity and value for money would be key to utilising funds most effectively. Mr A Crampsie, Non-Executive Director, queried whether realistic programmes of work were in place to achieve the year-end plans at this point in the year. Mrs Mackenzie explained that achievement of the financial plan was not forecast to be in equal parts each month, with	

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	improvements expected during the second half of the year however there is a recognised risk hence the planned meetings with the management teams. Mrs T Davies concurred that there is not currently sufficient assurance over the plan, but noted the ongoing work and the need to risk assess efficiency plans without impacting upon patient safety. She reiterated that patient care must be safeguarded. Mr M Robson highlighted that additional funding may not be available this year however a 2-year plan report is expected to come back to the Finance and Performance Committee to consider recovery plans and undertake relevant risk assessments. Following consideration, it was: **RESOLVED:** to receive Month 5 financial position and note partial assurance for the achievement of the forecast 2023/24 planned deficit as a direct consequence of the reported year to date position and financial risks.	
23/202	**INTEGRATED OVERSIGHT REPORT AND LEADING INDICATORS:** Mrs K Mackenzie, Group Director of Finance and Digital, introduced the Integrated Oversight Report (IOR) for July and August 2023. She drew attention to the Leading Indicators report which sets out progress in relation to the development of reporting and provides an overview of performance against the measures for August 2023. Development work is still being undertaken and a session will take place at the October 2023 Board Development Day to strengthen areas of focus with a view to replacing the Integrated Oversight Report in the future. Mrs Mackenzie provided the following key messages by exception from the Integrated Oversight Report: **Caring Domain:** • There has been a positive increase in Patient Friends and Family Testing and the Trust remains above the national average for this. • The number of overdue complaints at the end of August continues to demonstrate significant improvement from previous months **Safe Domain:** • Two serious incidents were reported in August however the number of reported serious incidents continue to be lower than the same period last year • Patient safety incidents have reduced during August however patient falls are consistently the top reason for incidents of this nature therefore reducing harm from falls has been identified as a Trust Leading Indicator.	

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	• The Trust has recorded 9 cases of Chloridoids Difficile infection against the national objective of 23 cases and this measure has also been identified as a Trust Leading Indicator. **Effective Domain:** • There were on average 46 patients who no longer met the criteria to reside in a hospital bed each day in August 2023 however there is a local ambition to reduce this to no more than 18 patients per day and the Trust continues to work with partners around this. **Responsive Domain:** • There have been high numbers of Emergency Care attendances which has resulted in an increase in ambulance handovers however there have been zero 12 hour wait breaches within the month. • Cancer performance targets remain a challenge however the Trust was above the national average in relation to 2 week waits. • Challenges remain in achieving planned activity levels and continues to place pressures on the Trust's waiting lists however the Trust has no patients waiting more than 78 weeks and plans are in place to manage the risk around patients waiting more than 52 weeks. **Well Led Domain:** • The number of staff in contracted posts increased slightly in August, and the gap between planned and contracted staffing levels have narrowed. • Sickness rates have increased along with an increase in agency requests therefore further discussions will be taking place around this at the Finance and Performance Committee. After consideration, it was: **RESOLVED:** to receive the report for assurance, noting the improvements and ongoing challenges in key areas.	
23/203	**NURSE STAFFING EXCEPTION REPORT:** Dr G Findley, Deputy Chief Executive & Chief Nurse, presented the report for August 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. Dr Findley reported that August has demonstrated some staffing challenges relating to vacancies and short-term sickness absence alongside ward movements to accommodate maintenance across the Trust. The Trust has continued to experience periods of increased patient activity with surge pressure resulting in escalation areas which	

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Agenda Item	Discussion and Action Points	Action By
	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. Dr Findley drew attention to the recorded red flags however highlighted that reports will change following the introduction of the new incident reporting system In-Phase. Mrs A Stabler, raised a query in relation to the triangulation of the report with patient experience and complaints information and Dr Findley explained that further data is required to enable a full review however will be picked up via the Quality Governance Committee. Following discussion, it was: **RESOLVED:** to receive the report for assurance.	
23/204	**MATERNITY UPDATE:** **Maternity Integrated Oversight Report:** Mrs K Hooper, Lead Midwife for Risk, Safety & Quality, presented a summary of the maternity indicators for the Trust for July 2023. She reported that the national targets for Carbon Monoxide monitoring have now been confirmed which is showing a current achievement below the target therefore this has been placed on the risk register however mitigations are in place around additional training and audits. The reporting of targets against the Continuity of Care pathway has been paused following the Ockenden Report in September 2022 and Mrs A Stabler, Non-Executive Director, explained that a letter received from the NHS England Chief Nurse states that this measure does not need to be delivered if the maternity unit is fully staffed. A listening event and dedicated model for the delivery of services has been introduced. Given that the unit is fully staffed the Board confirmed its support for the current model and approved the removal of Continuity of Care from the dashboard. Mrs Hooper drew attention to the response of the unit following the Lucy Letby trial and reported that the senior midwifery team has been present on the Special Care Baby Unit to listen to staff thoughts and provide support and detailed Perinatal Mortality Review Tool (PMRT) reports are presented on a quarterly basis to the Mortality and Morbidity Steering Group and a summary will be provided within the next report. Following a query from Mrs J Halliwell, Interim Chief Operating Officer, in relation to midwifery staff data sets, Mrs Hooper reported that there are new staff in post therefore the fill rates require updating. After consideration, it was:	GF

UNCONFIRMED

Agenda Item	Discussion and Action Points	Action By
	RESOLVED: to receive the report for assurance. Mrs Hooper left the meeting.	
23/205	**STAFF SURVEY RESULTS ACTION PLAN UPDATE:** Mrs G Rutherford, Interim Deputy Director of People and Organisational Development, presented the report which highlights themes and progress on actions which have emerged from the business unit People Action Plans. Mrs Rutherford highlighted that detailed discussions have taken place at the People and Organisational Development Committee however drew attention to identified common themes which include behaviour, relationships and team dynamics. A key area of focus has been identified around management development and work is being undertaken to increase engagement around the Pulse staff survey. Following a query from Mrs A Stabler, Non-Executive Director, in relation to the low response rates for the Pulse survey and whether there were any potential financial savings around this, Dr G Findley, Deputy Chief Executive and Chief Nurse, reported that this was a national requirement, and the Trust is not a significant outlier in terms of response rates. Following discussion, it was: **RESOLVED:** to receive the report for assurance and information.	
23/206	**FREEDOM TO SPEAK UP (FTSU) GUARDIAN REPORT:** Mr A Beeby, Medical Director and Ms T Healy, newly appointed Freedom to Speak Up (FTSU) Guardian, provided a Quarter 1 update on FTSU activity for the period April to June 2023. Mr Beeby reported that there have been seven concerns raised during the reporting period, all of which are now closed and explained that where concerns have been raised, these are being managed in a variety of ways with those of greater significance and/or risk being raised with the Executive Management Team. Further reports will also highlight themes raised. He introduced Ms T Healy, the newly appointed Freedom to Speak Up Guardian, and also reported that nine FTSU champions have been appointed. The Board noted that completion of the FTSU training was previously agreed, and Mrs G Rutherford, Interim Deputy Director of People and Organisational Development will provide details to Board members around this. Mrs T Davies, Chief Executive, acknowledged that improvements around freedom to speak up were required prior to the Lucy Letby case however was assured that progress was being made and themes	GR

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Agenda Item	Discussion and Action Points	Action By
	around cases will be aligned to the Reportable Issues Report within Part 2 of the Board. Following a query from Mrs M Pavlou, Non-Executive Director, in relation to staff feedback around grievance processes and whether additional questions could be included within the staff survey, Mrs Rutherford reported that this was being looked via local surveys as well as an extensive engagement process and Ms Healy highlighted that staff could be provided with a survey after using the service. Mrs J Halliwell, Interim Chief Operating Officer, felt that it would also be beneficial to share intelligence with line managers to ensure themes were captured and discussed. The importance of triangulating FTSU themes with the information collected from other areas / sources was acknowledged. Dr G Findley, Chief Nurse, explained that discussions are also required around where the report will be presented in future and will discuss with Mrs A Venner, Interim Director of People and Organisational Development. After consideration, it was: **RESOLVED:** to receive the report for assurance and information.	
23/207	**WORKFORCE RACE EQUALITY STANDARD (WRES) AND WORKFORCE DISABILITY EQUALITY STANDARD (WDES) REPORT:** Mrs G Rutherford, Interim Deputy Director of People and Organisational Development, provided an update on progress against the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) indicators and proposed future actions which form part of the Trust's equality objectives and overarching Equality Diversity and Inclusion Work Plan. Mrs Rutherford reported that the overall rating for both the WRES and the WDES indicators is partially compliant and the associated action plans for both reports identify actions required to move the ratings to fully compliant. She highlighted that further work is required in relation to BME and disabled staff experiencing harassment, bullying or abuse and she reminded the Board that the Trust has recently signed up to the anti-racism charter and will be managed via the Human Rights and Equality, Diversity and Inclusion Board. Further work is also required in relation to declaration rates around disability and requires continued promotion to staff to declare their disability status to improve the reliability of equalities monitoring. Mrs Rutherford explained that there is a lot of work required to achieve full compliance and felt that it would be beneficial to provide focussed communication throughout the year. Discussion also took place in relation to bullying and harassment and Dr G Findley, Deputy Chief	

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Agenda Item	Discussion and Action Points	Action By
	Executive and Chief Nurse, will discuss options around sharing information with the violence and aggression group further with Mrs Rutherford. Mr A Crampsie, Non-Executive Director, felt that it was important to provide transparent information across all networks and Mrs Rutherford highlighted that teams are working collaboratively with the Staff Networks to ensure actions are addressed and moved forward. Following further discussion, it was: **RESOLVED:** to receive the report for assurance and information.	GF/GR
23/208	**REGISTER OF OFFICAL SEAL:** Mrs J Boyle, Company Secretary, provided the Board with details of the use of the official seal between 1 September 2022 and 31 August 2023. Mrs Boyle reported that 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. She therefore confirmed that the official seal has not required to have been used within the last 12 months. After consideration, it was: **RESOLVED**: to formally note that the official seal has not been used during this current year (September 2022-2023).	
23/209	**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 November 2023 and it was: **RESOLVED:** to receive the cycle of business for 2023/24.	
23/210	**QUESTIONS FROM GOVERNORS IN ATTENDANCE:** There were no further questions received from Governors.	

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Agenda Item	Discussion and Action Points	Action By
23/211	**DATE AND TIME OF THE NEXT MEETING:** The next meeting of the Board of Directors will be held at 9:30am on Wednesday 29th November 2023.	
23/212	**CLOSURE OF THE MEETING:** Mr Robson declared the meeting closed.	
23/213	**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	

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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
23/64	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	This has been reviewed - neither claims info or GIRFT data give specific information that link to mortality and are not thought to add anything in terms of interpreting mortality data. **Recommended for closure**	
23/157		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.	18/10/2023	Kmac	**Sept 23** - Discussion to take place at the October Board Development Day in relation to strategic decision making **Nov 23** – wider strategic discussion held and EPR engagement day scheduled for 13 December. **Action recommended for closure.**	
23/158	23/07/2023	CEO update	Mental Health Services overview – to request further clarification re. contractual obligations	27/09/2023	TD	**Sept 23 –** no further information received following request.	

Agenda Item Number	Date of Meeting	Agenda Item Name	Action	Deadline	Lead	Progress	RAG-rating
23/196	27/09/2023	F&P Committee Assurance Report	Discussions re. implications of validation in relation to elective recovery board self-assessment to take place at future Board Development Day	31/12/2023	JH / JB	**Oct 23** – scheduled for the Dec 23 Board development day	
23/199	27/09/2023	HCA pay rates	The Board to be kept informed of progress in the HCA pay rate review via the People and OD Committee update reports	31/12/2023	GF/AV	**Nov 23 –** coversheet enclosed to provide update	
23/204	27/09/2023	Maternity IOR	To include summary of perinatal mortality review tool reports in next report	29/11/2023	GF		
23/206	27/09/2023	FTSU Guardian Report	To provide details to Board members re. FTSU training	29/11/2023	GR		
23/207	27/09/2023	WRES and WDES report	To discuss options around sharing information with the violence and aggression group in relation to bullying and harassment	29/11/2023	GF/GR		

Closed Actions from last meeting

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 agreed as closed.	
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 agreed as closed.	
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 discussion following review at QEF Board	27/09/2023	JB	**Sept 23** – extraordinary Board was not required. Item features on Part 2. Action agreed as closed.	
			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 agreed as closed. ***Post-Board note*** *– this has been deferred to Dec 23 Board development day.*	
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 agreed as closed.	
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 agreed as closed.	
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 and featured on September's Board agenda. Action agreed as closed.	

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 5i

Report Title:	**Band 2-3 HCA pay uplift scoping**			
Name of Meeting:	Board of Directors			
Date of Meeting:	29/11/23			
Author:	Sarah Neilson, Head of Education, Learning and Development Gemma Rutherford Interim Deputy Director of People and OD			
Executive Sponsor:	Gill Findley, Chief Nurse Amanda Venner, Group Director of People and OD			
Report presented by:	Amanda Venner, Group Director of People and OD			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☐	**Information:** ☒
	To provide an update on the updated national profiles for Healthcare Support workers from their current Band 2 to Band 3, based on their current role and responsibilities. Currently 612 Healthcare Assistant posts are in scope including bank as at 16th November 2023.			
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*	Discussed at Trust Board in September 2023 and at the Joint Consultative Committee in October 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*	This is a follow on from a previous report presented at Board of Directors on 27th September 2023. A collective grievance was submitted on 27th September 2023 and agreement was made with Unison that work was to continue as planned and responding to grievance would delay this work. The Healthcare Assistant post job description was evaluated via Agenda for Change panel on **Friday 10th November 2023.** Regional unison and staff side have been updated with outcome.			

	A freedom of Information request was received from Unison on 17th October, this is in the process of being responded to. Regional meetings continue across People profession, Directors of Finance and with Directors and Deputy Directors of Nursing. Gateshead is keen to continue to work collaboratively with regional partner Trusts on this complex workforce agenda. Neighbouring Trust positions remain similar to Gateshead with Newcastle Trust being the only Trust that has already reached local agreements and commenced implementation. Key, joint decisions to be made regionally are currently under discussion and are as follows: 1. Back pay date 2. Spine point position i.e. top to top 3. Implementation no later than March 2023 4. Band 2 roles to be retained as 'entry' level post to NHS. 5. No detriment to individuals from their Trust pay We are in agreement with these principles and the work that underpins them. Gateshead are currently developing a full Project Initiation Document (PID), supported by the Deputy Director of Transformation. The senior responsible officers for this project will be Andrew Rayner, Deputy Director of Nursing and Gemma Rutherford, Interim Deputy Director of People and OD, with the Executive Director of People & OD and Chief Nurse as shared Executive leads. Governance and assurance will be provided via the People and OD Committee, with updates to the Board as necessary. Close working with staffside colleagues will be imperative to the implementation of this work. Board to note that this is an extremely challenging and complex issue; nationally Cheshire and Mersey are having to deal with a major dispute with Unison members on this matter. Warrington and Halton Hospitals have had a two-day healthcare assistants strike as a result of this work. The next steps to be taken are as follows: Full project scoping. Clarification on what this means for individuals. Communication plan.

	Working Group to be established. Detailed paper into POD committee January 2023.				
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	Receive paper by way of update.				
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 strategic objectives that the report relates to:	SA2: We will be a great organisation with a highly engaged workforce. SA2.2: Growing and developing our workforce				
Links to CQC Key Lines of Enquiry (KLOE):	Caring ☐	Responsive ☐	Well-led ☒	Effective ☐	Safe ☐
Risks / implications from this report (positive or negative):					
Links to risks (identify significant risks – new risks, or those already recognised on our risk management system with risk reference number):	TBC				
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒		

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 7

Report Title:	**Calendar of Board Meetings 2024/25**			
Name of Meeting:	Board of Directors – Part 1			
Date of Meeting:	29 November 2023			
Author:	Diane Waites, Corporate Services Assistant			
Executive Sponsor:	Alison Marshall, Chair			
Report presented by:	Jennifer Boyle, Company Secretary			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☒	**Discussion:** ☐	**Assurance:** ☐	**Information:** ☒
	To inform the Board of the planned Board meeting dates for 2024/25.			
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 – 30 October 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*				
Recommended actions for this meeting:	The Board is asked to approve and receive the dates of the Board of Directors' meetings to be held in 2024/25.			

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** ☒

Board of Directors' Meetings 2024/25

During 2024/25 the Board of Directors will hold 9 public meetings including the Annual General Meeting.

Date	Time	Venue
31 January 2024	9.30am	Room 3, Education Centre
27 March 2024	9.30am	Room 3, Education Centre
5 June 2024	9.30am	Room 3, Education Centre
31 July 2024	9.30am	Room 3, Education Centre
24 September 2024 (Tuesday)	9.30am	Room 3, Education Centre
25 September 2024 Annual General Meeting	9.30am	Lecture Theatre, Education Centre
27 November 2024	9.30am	Room 3, Education Centre
29 January 2025	9.30am	Room 3, Education Centre
26 March 2025	9.30am	Room 3, Education Centre

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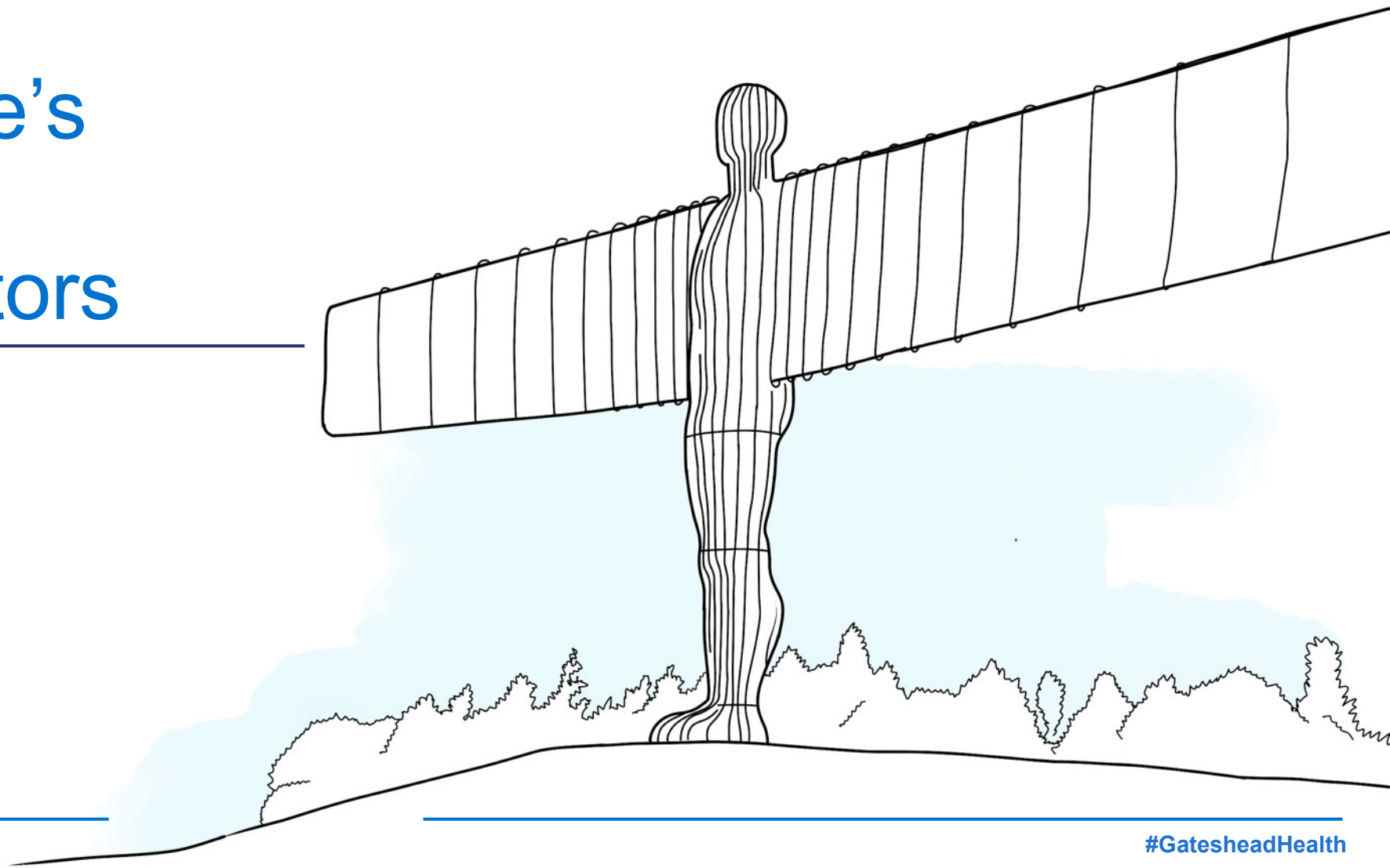
Chief Executive's Update to the Board of Directors



Trudie Davies, Chief Executive

29 November 2023

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

NHS Gateshead Health NHS Foundation Trust

Engagement, involvement and visits:

- Clinical Strategy Group
- Visits to services across the Trust

- Our **Gastro team** received some excellent feedback as part of a recent IQILS (Improving Quality in Liver Services) visit. The team demonstrated clinical and managerial commitment to improvement and innovation in care delivery.
- Our **flu and Covid vaccination programmes** are in full swing and we are encouraging all colleagues to be vaccinated to protect themselves, their loved ones and our patients.
- The number of **overdue complaints continued to fall**, demonstrating significant improvement from the previous year. Being more responsive helps us to learn and improve our services to patients.
- The **Endoscopy** unit has once again been JAG-accredited for the next 5 years. This means the service is meeting best practice quality standards and is a fantastic achievement for the team and for our patients.
- Our **Enabling Effective Learning Environments (EELE)** team won the Nursing in Primary Care award at the Nursing Times Awards for their work with the Newcastle GP service. The team has been hosted by Gateshead Health since June 2020 and has developed a scheme to support student nurse training and improve care in GP surgeries.
- The **Thirlwall Public Enquiry**, which was commissioned following the conviction of Lucy Letby, has published its terms of reference. We have received notification that all trusts with neonatal units will receive requests for evidence.
- **Leading indicators** (October 2023):
  - We are reporting positive progress in respect of the proportion of closed actions on our **CQC action plan**.
  - Our year-to-date **healthcare associated C-Diff infection numbers** increased to 20 against a threshold of 23, slightly above the trajectory for this point in the year. A ten point action plan has been developed by the Infection, Prevention and Control team

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

NHS Gateshead Health NHS Foundation Trust

- We are delighted to announce a number of new **substantive appointments** have been made across the Group. Amanda Venner has been appointed as Group Executive Director of People and OD and Joanne Halliwell as Group Chief Operating Officer. Gavin Evans has been appointed as Managing Director of QE Facilities and will join us in early 2024.
- Significant focus on our **culture** as an organisation – listening to those who have spoken up to tell us when things aren't right. We need to hear these messages in order to help us to act and make Gateshead a great place to work and be cared for in the NHS. We are committed to a **zero-tolerance approach** to discrimination for our colleagues and our patients and there is a focussed piece of work ongoing to embed this within the Group.
- We celebrated signing our **anti-racism charter with Unison colleagues,** which is really important in signalling our commitment to abolishing discriminatory behaviours.
- Our new full-time **Freedom to Speak Up Guardian, Tracy Healy**, delivered a presentation to our Board, with each Board Member making a pledge as part of Freedom to Speak Up Month.
- We celebrated **Black History Month** during October, culminating in an excellent webinar which we held in conjunction with the Integrated Care Board which highlighted the role that black women have played in shaping history, inspiring change and building communities.
- Our **catering team** have achieved a five star hygiene rating in a recent Food Standards Agency inspection. This is an outstanding accomplishment recognising the achievement of the highest standards for cleanliness, safety and hygiene.

Engagement, involvement and visits:

- LGBTQ+ network
- FTSU stall
- Star Awards
- Black History Month webinar
- Facebook Live events for colleagues

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

- In line with recent communications from NHS England, our key focus as a Trust and across the region is on productivity, financial recovery and delivery of the elective recovery programme.
- There were significant front-of-house pressures in October, with a year-on-year increase of 3.2% in A&E attendances – an additional 10 attendances per day more than the previous year. Significant ambulance handover pressures were felt in October, although there was an improvement in 30-60 minute handovers compared to the previous month.
- **Leading indicators** (October 2023 data):
  - The target of 60% of patients being admitted to a bed in 1 hour of decision to admit is not being met (9.11% in October). A formal review of patient flow is underway and the winter ward was opened at the start of November to increase capacity.
  - The target of zero 12-hour decision to admit breaches has not been met with 90 recorded between April and the end of October, of which 74 (82%) were in the months of September and October. We are reviewing our internal escalation processes and patient flow.
  - We are aiming to reduce our overall length of stay to less than 4 days. Whilst there have been some improvements, the October figure increased to 5.52 (4.47 in September). We are reviewing our clinical pathways, developing our front of house frailty model to prevent avoidable admissions, as well as working across the system to seek system-wide solutions.
  - We are aiming to reduce to zero the number of 52-week waiters by the year end. At the end of October the Trust had 274 patients who had been waiting more than 52 weeks. The largest pressure specialities are Paediatrics, Pain, Trauma and Orthopaedics and General Surgery. Recovery plans and waiting list validation exercises are in place.
- Note that full information on the leading indicator performance is included in the dedicated Board agenda item.

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

NHS Gateshead Health NHS Foundation Trust

- Our **diabetes team** won an award for their innovative work in a joint project to support children and young people to access new diabetes technologies. The project seeks to support children from low-income families maximise their diabetes management. The project involves working in collaboration with the North East and North Cumbria Children and Young Persons' Diabetes Network.
- The Trust donated mobile phones and laptops, that had come to the end of their life within the NHS, to be repurposed for use by children and young people living with Type 1 Diabetes in the NENC region. As of August 2023, six months into the project, 160 families had been provided with a suitable device, with 70% of these families living in areas that are ranked as being in the top 30% of the most deprived areas in the country. Feedback on the scheme has been overwhelmingly positive and it has been recognised by NHS Providers as a best practice case study for addressing health inequalities.
- The **maternity team** were commended by the Director for Public Health in Gateshead for their continued work to reduce smoking at the time of delivery. There has been a reduction across the North East and North Cumbria, with Newcastle and Gateshead reporting to be at 9.7%, which is below the regional average.
- **Dr Karen Franks**, Clinical lead for Older People's Mental Health and Dementia has been commended for her contributions to the NHS England regional clinical network for mental health. The clinical network held a celebration event prior to be subsumed into a wider regional function in November. This demonstrated the value of working outside of organisational boundaries to deliver better outcomes for people.

Engagement, involvement and visits:

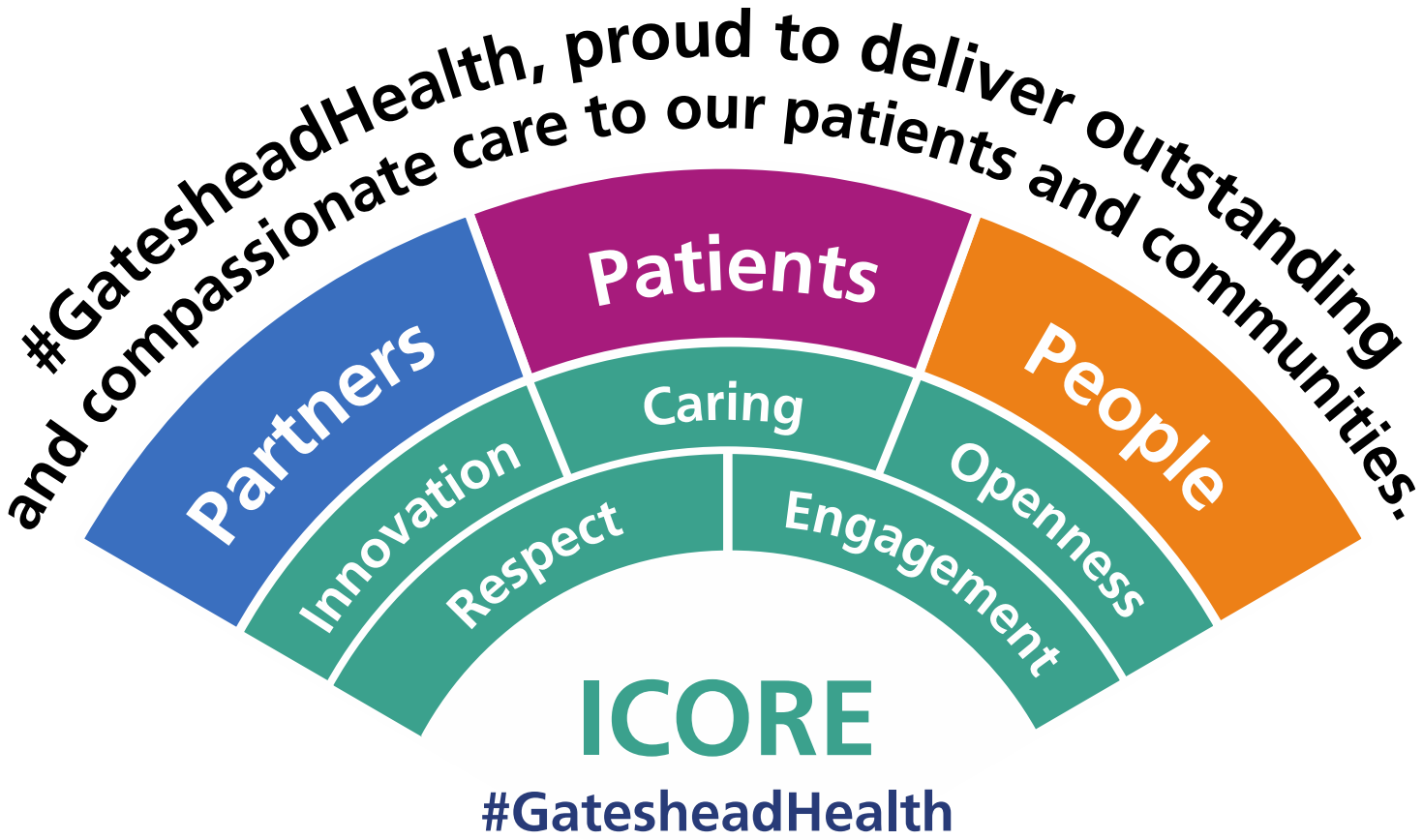
- North East Women's Health Conference
- Meeting with the Gateshead Council Leader and Chief Executive.
- Meeting with local MPs.
- Provider Collaborative meetings.
- Pathology Board meetings.

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

Gateshead Health NHS Foundation Trust

- We continue to share our strategy and strategic intent around being a **Centre of Excellence for Women's Health.** We attended the first North East Women's Health Conference with our place partners in the local authority and primary care. Our IVF team provided one of the showcase presentations for the day, outlining how they have improved accessibility and engagement with different groups across our community.
- We will be holding a Gateshead-based Women's Health Conference in the future as part of our intent to become a Northern Centre of Excellence for Women's Health.
- We submitted a bid for funding to the ICB to support a Women's Health Hub. The value of the funding is £250k with an additional £40k for the delivery of regional training. Our aim would be to provide a multi-disciplinary approach to care, with a one-stop approach using digital to support this wherever possible. We have received notification that our bid has been shortlisted and are awaiting the final outcome. This would be a fantastic opportunity for Gateshead, aligning with our strategic intent to become a Centre of Excellence for Women's Health.

Gateshead Health
NHS Foundation Trust



Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 8i

<table>
<tr><td>Report Title:</td><td colspan="4">Thematic Review Delivery Plan Update</td></tr>
<tr><td>Name of Meeting:</td><td colspan="4">Board of Directors</td></tr>
<tr><td>Date of Meeting:</td><td colspan="4">29 November 2023</td></tr>
<tr><td>Author:</td><td colspan="4">Trudie Davies, Group Chief Executive</td></tr>
<tr><td>Executive Sponsor:</td><td colspan="4">Trudie Davies, Group Chief Executive</td></tr>
<tr><td>Report presented by:</td><td colspan="4">Trudie Davies, Group Chief Executive</td></tr>
<tr><td rowspan="2">Purpose of Report
Briefly describe why this report is being presented at this meeting</td><td>Decision: ☐</td><td>Discussion: ☐</td><td>Assurance: ☒</td><td>Information: ☐</td></tr>
<tr><td colspan="4">To provide the Board with assurance over the progress made in respect of the Thematic Review Delivery Plan</td></tr>
<tr><td>Proposed level of assurance – to be completed by paper sponsor:</td><td>Fully assured
☐
No gaps in assurance</td><td>Partially assured
☒
Some gaps identified</td><td>Not assured
☐
Significant assurance gaps</td><td>Not applicable
☐</td></tr>
<tr><td>Paper previously considered by:
State where this paper (or a version of it) has been considered prior to this point if applicable</td><td colspan="4">Executive Team – the Executive Team review the delivery plan for assurance and approve any recommendations to move an action to ‘complete’ or adjust target dates.</td></tr>
<tr><td>Key issues:
Briefly outline what the top 3-5 key points are from the paper in bullet point format

Consider key implications e.g.
• Finance
• Patient outcomes / experience
• Quality and safety
• People and organisational development
• Governance and legal
• Equality, diversity and inclusion</td><td colspan="4">• The Thematic Review Delivery Plan was presented to Board in May 2023 for approval.
• Progress has been monitored through the Executive Management Team meetings, noting that a number of the actions will also have been visible to Board Members through committees, Board development and the Board itself.
• The current position is:

<table>
<tr><th>Action status at last formal review</th><th>Actions</th><th>Of which are recommended for closure:</th></tr>
<tr><td>Not yet started</td><td>0</td><td>-</td></tr>
<tr><td>Started and on track</td><td>15</td><td>10</td></tr>
<tr><td>Plan in place with some risk</td><td>4</td><td>0</td></tr>
<tr><td>Off track</td><td>4</td><td>1</td></tr>
<tr><td>Complete</td><td>21</td><td>-</td></tr>
<tr><td>Total number of actions</td><td>40</td><td>11</td></tr>
</table>
</td></tr>
</table>

	This means that 52.5% of actions are confirmed as being completed, which would rise to 80%, should the actions recommended for closure be approved. Key risk areas (i.e those actions which have exceeded their target dates and are marked as off track) are: • Action 4 - addressing the backlog of complaints, although noting a plan is in place; • Action 13 – development of digital displays to support key communication and promotion; and • Action 31 – promotion of a zero-tolerance approach to bullying and harassment, although it is noted that this is a priority area and there has been a significant focus on this over the last couple of months. The commitment and action here continues. It is recommended that three target dates are revised: • Actions 4 and 11 – extension of the date to 31 March 2024 recognising that the original review of clinical leadership and time allocation has been expanded beyond its original scope; and • Action 29 – extension of the date for the implementation of the risk management system in line with the implementation plan for the new software to 29 February 2024. Recommendations regarding action closures and adjusted target dates will be considered when the plan is reviewed by the Executive Team, although Board Member views on the appropriateness of the recommendations outlined the latest version of the plan would be welcomed as part of the discussion at Board.	
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	The Board is recommended to note the latest update in relation to the Thematic Review Delivery Plan for assurance. Assurance is provided that areas off-track or at risk are receiving additional focus to ensure that plans are in place. The Board is asked to note that the Executive Team will continue to routinely monitor progress against the plan and escalate areas of concern to the Board via the Board committees.	
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 strategic objectives that the report relates to:	Links to the strategic objectives are shown for each individual action on the delivery plan itself.				
Links to CQC Key Lines of Enquiry (KLOE):	Caring ☐	Responsive ☐	Well-led ☒	Effective ☐	Safe ☐
Risks / implications from this report (positive or negative):					
Links to risks (identify significant risks – new risks, or those already recognised on our risk management system with risk reference number):	POD 3298 - Increase in incivility and disrespectful behaviours being reported (12) COO 3186 - There is a risk to ongoing business continuity of service provision due to ageing trust estate (12) 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) CEOL2 3255 - People may lose trust an confidence in our services (16) CEOL2 2993 - Risk of potential non-compliance with current legislation and guidance as a result of policies not being up to date. (12)				
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒		

Gateshead Health NHS Foundation Trust

Thematic Review Delivery Plan

	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

No.	Theme	Action	Link to strategic objectives / key indicators	Deadline	Workstream Lead	Board Sponsor	Progress	RAG-rating
1	Strategy, planning and performance	Final enabling strategies to be completed and ratification at the May 2023 Board meeting	All	24/05/23	N Bruce	T Davies	May 23 – clinical strategy to be presented to CSG on 10 May. EDI, clinical and finance strategies scheduled for May Board. Estates strategy is covered as part of action 40. July 23 – action completed, strategies ratified and published. Action agreed as complete.	
2	Strategy, planning and performance	Refinement of the IOR at Board and Committee level to provide ward to Board exception reporting	All	30/09/23	D Renwick	K Mackenzie	May 23 – work is progressing. Business intelligence function is now within the Director of Finance portfolio which will support close working with the digital teams to deliver the IOR functionality. July 23 - IOR refreshed and leading indicators agreed and in use. Action agreed as complete.	
3	Strategy, planning and performance	Address the backlog of complaints within an agreed timescale	SA1.2	30/06/23	A Rayner	G Findley	May 23 - Progress has already started with a 50% reduction in the number of overdue complaints. Additional clinical resource has been added into the corporate complaints team. July 23 – 9 overdue complaints remaining, all in medicine BU	

No.	Theme	Action	Link to strategic objectives / key indicators	Deadline	Workstream Lead	Board Sponsor	Progress	RAG-rating
							November 23 – position has deteriorated with 17 overdue complaints (14 in medicine and 3 in surgery). Meetings held with the Chief Matrons. Plan in place for each of the complaints. Member of staff on redeployment is assisting in the complaints team.	
4	Strategy, planning and performance	Assessment of leadership resource across operational business units and corporate functions	SA2.1 SA2.2 SA2.3	31/07/23	N Halford G Findley J Halliwell	T Davies	May 23 – Heads of Clinical Service meeting to make assessment. Nov 23 – work is ongoing but has been extended to include a wider review across management. This is anticipated to be completed by 31 March 2023. *A deadline extension to 31 March 2023 is therefore requested.*	
5	Strategy, planning and performance / clinical engagement	Review of Director portfolios, including strategy, planning and business intelligence (including the capacity of this function)	SA2.2 SA2.3 SA4.1 SA4.2 SA5.1	31/05/23	T Davies	A Marshall	May 23 – the Group Director of Finance and Chief Operating Officer portfolios have been reconfigured to move the business intelligence function to the DoF. N Bruce has been appointed as Interim Director of Strategy, Planning and Partnerships. Medical Director of Operations appointed. Action agreed as complete.	
6	Strategy, planning and performance	Development of key indicators to support performance visibility and alignment to the	All	30/06/23	D Renwick	K Mackenzie	May 23 – draft indicators developed and to be shared with Clinical Strategy Group for comment and input ahead of launch in June. Key indicators have been referenced throughout the strategic objective to provide clear linkage. Initial reporting of the key indicators will occur in July 23.	

No.	Theme	Action	Link to strategic objectives / key indicators	Deadline	Workstream Lead	Board Sponsor	Progress	RAG-rating
		strategic objectives					July 23 – leading indicators completed and are in use. Action agreed as complete.	
7	Clinical engagement	Review decision-making at senior level to support appropriate prioritisation and ensure decisions are made at the right level based on the right information	All	31/05/23	T Davies A Beeby J Boyle	T Davies	May 23 – membership of EMT expanded and new chairs of EMT and SMT established. Work is ongoing re: aligning the cycles of business to support effective decision-making. Action agreed as complete. July 23. Action completed. New style meetings in operation and functioning well. Action agreed as complete.	
8	Clinical engagement	To increase the face-to-face visibility of the senior team	SA2.3	31/05/23	Executives SMT	T Davies	May 23 – a dedicated weekly drop-in is in the planning stages. Tea and chat in the hub established along with executive walkabouts and Facebook live sessions. Action agreed as complete.	
9	Clinical engagement	To develop a Trust core narrative to support collective understanding and purpose	SA2.2 SA2.3	31/05/23	H Fox	T Davies	May 23 – this is under development Nov 23 – full communications review to be presented at Trust Board by Claire Riley. *This will determine whether the action is to be considered as complete.*	
10	Clinical engagement / understanding sustainable and	Review of service vulnerability and sustainability	SA3.1 SA3.2 SA4.2	31/05/23 for initial templates	N Bruce	T Davies	May 23 – discussed at CSG in May and template issued for return by 31/05/23 to inform initial outputs.	

No.	Theme	Action	Link to strategic objectives / key indicators	Deadline	Workstream Lead	Board Sponsor	Progress	RAG-rating
	vulnerable services			30/09/23 for full review completion			Oct 23 – Clinical assessment complete, economic assessment underway. Trust Board updated 27/9/23. Outputs will link into 24/25 planning work. *Action recommended for closure given assessment is complete.*	
11	Clinical engagement	Review clinical leadership time allocation to ensure clinicians are supported to attend and contribute to key strategic decision making	SA2.2 SA2.3	30/06/23	N Halford	A Beeby	May 23 – initial discussions commenced as part of the Clinical Strategy Group in May. Nov 23 – work is ongoing but has been extended to include a wider review across management. This is anticipated to be completed by 31 March 2023. *A deadline extension to 31 March 2023 is therefore requested.*	
12	Board visibility	Share outcomes of visibility initiatives - observations, successes, learnings, you said, we did	SA2.3	30/06/23	H Fox	T Davies	May 23 – Facebook Live launched which can be used to share updates and outcomes. July 23 - Tea and chat in the hub established along with executive walkabouts and Facebook live sessions also available as options for sharing information. Communications arrangements reviewed. Action agreed as complete.	
13	Board visibility	Promotion of Board visibility and other key information such as CQC ratings through noticeboards and interactive displays	SA2.3	30/06/23	H Fox	T Davies	Aug 23 - posters featuring pictures of the executive team are now up throughout the Trust. QEF report that CQC ratings are displayed at the entrances to our buildings. Further discussion taking place in relation to the use of interactive TV screens Nov 23 - The posters for the executive team will be updated following the new appointments.	

No.	Theme	Action	Link to strategic objectives / key indicators	Deadline	Workstream Lead	Board Sponsor	Progress	RAG-rating
							There are ongoing discussions with software providers for TV screens but costs are currently prohibitive. Therefore, the following is/has been actioned: • QR codes are being included with direct links to board of directors on the 'Welcome to Gateshead posters' • A link to the new signage for safer staffing will be included to increase board visibility • A dedicated page has been created on the intranet with board and SMT members that all staff can access on their own devices	
14	Board visibility	Implementation of the 15 Steps Programme	SA1.2 SA2.3	30/06/23	A Rayner	G Findley	July 23 – principles of 15 steps are included in the NED walkabouts and PLACE – further work to be done to include the governors in this work. Nov 23 – 15 Steps Programme is now being launched and will be reported to the Patient Experience Meeting. *Action recommended for closure.*	
15	Unitary Board / governance	Provide further BAF training to Board Members	All	30/06/23	J Boyle	G Findley	May 23 – training date to be identified July 23 – action completed. Training sessions delivered. Action agreed as complete.	
16	Unitary Board / governance	Delivery of training on Board and committee paper development	All	31/07/23	J Boyle	T Davies	May 23 – guidance to be revised and circulated with opportunities to attend workshops. July 23 - request extension to October 23	

No.	Theme	Action	Link to strategic objectives / key indicators	Deadline	Workstream Lead	Board Sponsor	Progress	RAG-rating
		and presentation					Oct 23 – training material updated and 2 workshops in the diaries to be held before the end of October, with an offer of holding additional mop-up / one-to-one sessions. Nov 23 – 2 workshops held in October with good attendance and refresher material made available on the intranet for all staff. *Action recommended for closure.*	
17	Unitary Board / governance	Identify informal opportunities to develop Board relationships	SA2.3	31/05/23	T Davies	A Marshall	May 23 – informal post-Board events commenced in April 23 with a plan to continue. July 23 Board development sessions in place with opportunity for informal networking after each session. Action agreed as complete.	
18	Unitary Board / governance	To increase the frequency of review and focus on top organisational risks	All	31/05/23	G Findley	T Davies	May 23 – Executive Risk Management Group moved to monthly and now chaired by the Chief Executive July 23 – action completed given the increased frequency of the Group. Action agreed as complete.	
19	Unitary Board / governance	To provide additional focus on Board development, including effective Board challenges	All	31/12/23	T Davies	A Marshall	May 23 – development work to be commissioned in the coming months July 23 –board development to be offered as a tender. Specification in development Oct 23 – plans paused given the SOF 3 rating and the discussion held at the August 23 Board development, which indicated that there was not	

No.	Theme	Action	Link to strategic objectives / key indicators	Deadline	Workstream Lead	Board Sponsor	Progress	RAG-rating
							a collective agreement to proceed with an externally commissioned development plan Nov 23 – further discussions planned for December's development session.	
20	Unitary Board / governance	Increase the visibility and understanding of complaints responses, themes and trends with Executive Directors	SA1.2	30/06/23	G Findley	T Davies	July23 – reportable issues log developed which includes any high profile complaints. Themes and trends are discussed at the quality governance committee. Action agreed as complete.	
21	Unitary Board / governance	Consider the option of recruiting associate Non-Executive Directors to support succession planning, coaching and Board diversity	SA3.2	31/05/23	-	A Marshall	May 23 – discussion to be held as part of the May 23 Board meeting. July23 – reengaged with NHSE next scheme and we are hopeful of getting placement through that scheme. Encouraged aspiring NEDS to register with the scheme. Action completed as far as we are able to	
22	Unitary Board / governance	Ensure consistent and effective clinical governance structures are in place at	All	31/12/23	Heads of Clinical Service	G Findley	May 23 – review commissioned and to be led by the Clinical Head of Service for Medicine, utilising outputs from recent review of business unit governance. Outputs to be in place and embedded by December 23. Further action Trust-wide to be developed.	

No.	Theme	Action	Link to strategic objectives / key indicators	Deadline	Workstream Lead	Board Sponsor	Progress	RAG-rating
		operational business unit level					Nov 23 – Medicine have an agreed way of working that ensures they are reviewing incidents, risks and complaints at divisional level. Review of governance structures has been completed by the GGI. Awaiting feedback meeting with the Chief Executive and Deputy Chief Executive.	
23	Unitary Board / governance	Review governance structures at operational business unit level and those groups reporting into Board committees to support effective assurance and escalation to Board committees and Board	All	31/12/23	G Findley	T Davies	May 23 – the Good Governance Institute have been commissioned to lead on this review and make recommendations to the Trust. July23 GGI are starting interviews with staff and observation of key meetings in August. Due to completed first week in September Nov 23 – review and report complete – to share with CEO and Deputy CEO in December	
24	Unitary Board / governance	To reduce the backlog of out-of-date policies	All	31/07/23	J Boyle	T Davies	May 23 – weekly reports being prepared for SMT and demonstrating steady progress to date July 23 policy compliance is still at 70%. Small improvements, but still needs further work. Oct 23 – significant improvement made over the last few months, with 16% of policies now overdue.	

No.	Theme	Action	Link to strategic objectives / key indicators	Deadline	Workstream Lead	Board Sponsor	Progress	RAG-rating
							Nov 23 - continued improvement with 12% of policies now overdue. Regular reporting continues, with a number of policies expected to be reviewed in the next few months. Recommended to retain amber rating, but note the reduction in backlog since the development of the thematic review delivery plan.	
25	Unitary Board / governance	To review historic DBS process and seek assurance over completeness	SA1.2 SA2.3	30/09/23	G Rutherford	A Venner	May 23 – review is underway with an update to be provided to Board. July 23 – current position is one DBS outstanding and 13 people who have partially completed their applications Oct 23 – one DBS outstanding – volunteer, plan to address. Action agreed as completed.	
26	FTSU / organisational culture	Review of FTSU function required	SA1.1 SA1.2 SA2.1 SA2.2 SA2.3	31/5/23	G Rutherford	A Venner	May 23 – review complete and currently advertising for a full time FTSU Guardian to increase the resource in this area July 23 – Full time FTSUG appointed. Awaiting start date Nov 23 – FTSUG in post and launched organisation wide. Action agreed as complete.	
27	FTSU / organisational culture	To ensure greater triangulation of	SA2.3	31/07/23	G Rutherford	A Venner	May 23 – the output of the initial review will be shared at the July People and OD Committee	

No.	Theme	Action	Link to strategic objectives / key indicators	Deadline	Workstream Lead	Board Sponsor	Progress	RAG-rating
		learnings, themes and trends (including from incident reporting) and share widely to provide confidence in raising concerns					July 23 – updated report produced and shared with the POD committee Oct 23 – work on Zero Tolerance ongoing with launch in Nov. Collaborating with networks. Board development session held in October 23. Action agreed as complete, recognising that the new FTSU Guardian will continue to develop the triangulation.	
28	FTSU / organisational culture	Develop a just and restorative culture, including embedding a learning approach to incidents	SA2.3	31/12/23	S Dyson L Farrington	G Findley A Venner	May 23 – launched at the Patient Safety Conference in March 23. To agree the milestones as this programme spans across years. July 23 – new policy is in draft for consultation. New learning tools have been introduced	
29	FTSU / organisational culture	Ensure risk management system is effective, accessible and fit for purpose	All	31/07/23	S Dyson	G Findley	May 23 – InPhase procured as the new risk management system with a lead in time. Training will be provided. Colleagues encouraged to review and cleanse data in current system prior to data transfer. To align to the review of clinical governance in business units. July 23 – timeline has slipped by 1 month November 23- Inphase in now operational for incidents and alerts in line with agreed plan. Next phase in the risk management module.	

No.	Theme	Action	Link to strategic objectives / key indicators	Deadline	Workstream Lead	Board Sponsor	Progress	RAG-rating
							Recommended to adjust the deadline to 29 February in line with the implementation plan.	
30	FTSU / organisational culture	Further development of an improvement culture including increased capacity and training for certified leaders	All	30/09/23	K Roberton	T Davies	May 23 – portfolio of the transformation lead has been refined to increase leadership capacity in this area to develop an embedded improvement culture Nov 23 – *recommend action to be considered complete based on increased capacity being secured.*	
31	FTSU / organisational culture	Promote a zero-tolerance approach to bullying and harassment	SA2.3	31/07/23	L Farrington	A Venner	July 23 – one of the priority areas in the culture programme. Request change of deadline to December 23 Oct 23 – as above (27) work ongoing Nov 23 – work continues with recent Board development sessions and updates through staff communication channels. A Zero-Tolerance engagement event is scheduled for 27 November for colleagues.	
32	FTSU / organisational culture	Cultural shift to encouraging a greater focus on positive achievements, striking a realistic balance with our challenges	SA2.3	30/06/23	All Executives H Fox	T Davies	May 23 – aligning communications to the Trust core narrative Nov 23 – positive achievements now being regularly promoted through communications, including the CEO weekly bulletin and Team Brief. *Recommended that this action is considered complete.*	

No.	Theme	Action	Link to strategic objectives / key indicators	Deadline	Workstream Lead	Board Sponsor	Progress	RAG-rating
33	Comms / stakeholder engagement / understanding sustainable and vulnerable services	Continued development of relationships at place and within the system and a need to define strategic intent	SA4.1 SA4.2 SA5.1	30/09/23	N Bruce A Beeby	T Davies	May 23 – redefined portfolios increased Medical Director capacity to work with the Chief Executive to develop these relationships. Director of Strategy post supporting development of our strategic intent. Key partners invited to join Executive Team and SMT for producing discussions on collaboration and joint working. Oct 23 – Gateshead Place reps attended CoG on 20/9/23 and SMT on 28/9/23. Ongoing discussions regarding key meetings and interactions Nov 23 – this will continue to evolve and develop as part of business as usual arrangements, with place interactions being built into the regular business of key governance meetings. *Recommended that this action is considered complete, notwithstanding the ongoing need to develop and maintain strong relationships.*	
34	Comms / stakeholder engagement	Review of senior communications capacity and resource to support external communications and promotion	All	30/09/23	K Roberton	T Davies	July 23 – review of communications function has been commissioned from NHSE. Terms of reference have been agreed Nov 23 – output to be presented at Trust Board part 2. *Recommended that this action is considered complete.*	

No.	Theme	Action	Link to strategic objectives / key indicators	Deadline	Workstream Lead	Board Sponsor	Progress	RAG-rating
35	Comms / stakeholder engagement	Explore and enhance communication channels that extend beyond digital	SA2.3	31/05/23	H Fox	T Davies	Nov 23 – a number of initiatives have been implemented, including Tea and Chat and regular walkarounds. Membership engagement has also restarted, with members invited to attend the relaunched Medicine for Members events in the Trust. The external communications review may provide additional recommendations here. *Recommended that this action is considered complete, notwithstanding further recommendations may arise from the communications review.*	
36	Comms / stakeholder engagement / understanding sustainable and vulnerable services	Develop appropriate data, actions and resource to drive the health inequalities agenda. This includes building connectivity to place-based inequalities work and the joint strategic needs assessment	SA4.1	30/09/23	K Roberton J Clark	A Beeby	May 23 – the reprofiling of the Medical Director portfolio provides additional leadership capacity here with a clear focus on developing relationships at place. Nov 23 - *Recommended that this action is considered complete given previous update.*	
37	Comms / stakeholder engagement	Develop links with the local community and continue the	SA1.2 SA2.2 SA4.1	31/07/23	H Fox	G Findley	May 23 – Open Day arranged for 8 July. Volunteer recruitment included in the Quality Account as a quality priority for 23/24.	

No.	Theme	Action	Link to strategic objectives / key indicators	Deadline	Workstream Lead	Board Sponsor	Progress	RAG-rating
		focus on volunteer recruitment					August 23 – action completed. Open Day event held. Action agreed as complete.	
38	Equality, diversity and inclusion	Increase the profile, commitment and focus on the EDI agenda at Board and within the Trust – develop a clear ambition with timeframes for improvement	SA2.3	31/07/23	K Sohanpal	A Venner	May 23 – NED recruitment includes significant focus on seeking a diverse range of candidates. Gen Equity and reverse mentoring programmes continue. July 23 new guidance from NHSE – will be presented at SMT by end August. Oct 23 – Board dev session 18.10.23. CoG session on 22.11.23. Work ongoing overseen by POD. Action agreed as complete, recognising that there continues to be a significant focus here as reflected in other actions.	
39	Equality, diversity and inclusion	Restructure EDI into the People and OD business unit	SA2.3	30/06/23	K Sohanpal	A Venner	Completed. Staff now moved. Action agreed as complete.	
40	Understanding sustainable & vulnerable services	Full estates review to be conducted to inform future options to maximise estates spaces for clinical services	SA1.1 SA1.2 SA3.1 SA3.2 SA2.1 SA2.2	30/06/23 for initial assessment 31/03/24 for full delivery	N Bruce S Harrison	K Mackenzie	May 23 – agreed initial scope to conclude by 30/06. Oct 23 – review of estates complete. Long list of priorities agreed along with criteria for shortlisting. Proposed shortlist of schemes discussed and agreed at Trust Board 27/9/23. Nov 23 – further update on the November Board agenda.	
41	Understanding sustainable &	To develop a clear understanding	SA3.1 SA4.2 SA5.1	31/05/23 for initial input re:	N Bruce	A Beeby	May 23 – Director of Strategy appointed with this action in the remit of the role. Linked to action 10.	

No.	Theme	Action	Link to strategic objectives / key indicators	Deadline	Workstream Lead	Board Sponsor	Progress	RAG-rating
	vulnerable services	of our USP and associated campaigns to deliver this vision		sustainable services templates 30/09/23 for full review completion			Oct 23 – strategic intent developed and shared internally and externally inc. letter to ICB on women's health. Ongoing work in relation to delivery. Nov 23 – achieved national financial support for womens hub. To develop delivery plan by Jan 2024. *Action recommended for closure as original action has been completed.*	
42	QE Facilities	Commission independent review of governance	SA1.2 SA3.1 SA5.1	30/06/23	T Davies	A Marshall	May 23 – Deloitte LLP contracted to deliver independent governance review. July 23 – Deloitte review has concluded. Feedback to board in July 23 Nov 23 – review and report agreed and actions in progress as per separate plan. Action agreed as complete.	
43	QE Facilities	Ensure interim leadership arrangements are in place	SA2.1 SA2.3 SA5.1	31/05/23	T Davies	A Marshall	May 23 – interim Managing Director appointed for a six-month period. Action agreed as complete.	
44	QE Facilities	Develop a shared vision and understanding to inform the future leadership and governance of QEF	SA2.3 SA5.1	31/05/23	S Harrison	T Davies	May 23 – collective QEF senior team and Board session held in April 23 to agree principles and risk appetite. Action agreed as complete.	

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 8ii

Report Title:	**North East and North Cumbria Provider Collaborative Governance Update**			
Name of Meeting:	Board of Directors			
Date of Meeting:	29 November 2023			
Author:	Matt Brown, Managing Director, NENC Provider Collaborative			
Executive Sponsor:	Trudie Davies, Group Chief Executive			
Report presented by:	Trudie Davies, Group Chief Executive			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☐	**Information:** ☒
	To note the latest formal documentation from the Provider Collaboration in relation to the Responsibility Agreement and the strategic partnership between the Collaborative and NECS (North of England Care System).			
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*	NENC Provider Collaborative			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	• The paper has been prepared directly by the Provider Collaborative Managing Director to provide an update to all NHS Foundation Trust Boards in the Integrated Care System. • The paper is for noting rather than decision-making.			
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	The FT Boards of the 11 NENC Provider Collaborative members are asked to: • Note the Responsibility Agreement between the ICB and the Collaborative; and • Note the strategic partnership between the			

	Collaborative and NECS.	
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 strategic objectives that the report relates to:	SA4.2: Work collaboratively as part of Gateshead Cares system to improve health and care outcomes to the Gateshead population SA5.1: We will look to utilise our skills and expertise beyond Gateshead in order to ensure organisational sustainability and contribute towards innovative care and provision within 2023/24	

Links to CQC Key Lines of Enquiry (KLOE):	Caring ☐	Responsive ☐	Well-led ☒	Effective ☐	Safe ☐

Risks / implications from this report (positive or negative):			
Links to risks (identify significant risks – new risks, or those already recognised on our risk management system with risk reference number):	-		
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒

North East and North Cumbria
Provider Collaborative

North East and North Cumbria Provider Collaborative Governance

Update for NHS Foundation Trust Boards

October 2023

1. Purpose

1.1. The purpose of this note is to update Boards on the governance arrangements for the NENC Provider Collaborative (the Collaborative) specifically focusing on the responsibility agreement (RA) with the ICB and the strategic partnership agreed with NECs.

1.2. Trust Boards are asked to note progress in these areas.

2. Context

2.1. In July 2022 the Collaborative provided an update to Trust Boards noting the agreement for the 11 Foundation Trust's in NENC to formally work together set out in the 'Collaboration Agreement'. This agreement was supported by an aims and aspirations document as well as an operating model. All Trust Boards approved these by September 2022.

2.2. In presenting the formal collaborative approach it was noted that the final element of these arrangements was a responsibility agreement (RA) with the ICB which was under discussion at that point in time. That agreement is now in place for 2022/3, with the following summarising the requirements and the full RA attached at appendix A.

3. Responsibility Agreement

3.1. NHSE guidance on the functions and governance of the integrated care board (August 2021) stated that:

> *Provider collaboratives will agree specific objectives with one or more ICBs, to contribute to the delivery of that system's strategic priorities. The members of the collaborative will agree together how this contribution will be achieved.*
>
> *The ICB and provider collaboratives must define their working relationship, including participation in committees via partner members and any supporting local arrangements, to facilitate the contribution of the provider collaborative to agreed ICB objectives.*

3.2. To meet this requirement the Collaborative and ICB have established a responsibility agreement (RA) which defines and describes the working relationship between the ICB and the Collaborative. It provides a framework for building an ongoing relationship recognising that:

- The ICB and the Collaborative share a vision and purpose, with common aims and objectives to improve the health and wellbeing of the people of the North East and North Cumbria.
- This is a supportive relationship which will evolve over time.
- The agreement sets out the agreed remit of the Collaborative in relation to the delivery of the NENC Integrated Care Strategy.

3.3. The RA also covers ways of working both in terms both formal and informal and how resources will be secured both to undertake programmes of improvement and for investments. It is an annual arrangement that will be reviewed and refreshed in year, with an agreement for 24/5 to be in place for 1st April 2024.

3.4. The RA recognises that the Collaborative's Provider Leadership Board will determine programme governance structures required to deliver the agreed work programme, ensuing where appropriate links are made with the relevant NHS England regional and national programme teams. Where agreed programmes of work are mapped to the delivery of ICB goals and objectives within the Integrated Care Strategy and when complete, the Five Year Forward Plan, the Collaborative will report progress through to the ICB via the ICB programme management system.

3.5. The RA recognises that areas of work will evolve over time and there will be a need to respond to emerging and ad hoc requirements. However it does set out the specific work programmes agreed between the ICB and the Collaborative for 2023/4, which are summarised below:

i. Delivery of a comprehensive elective recovery plan and programme, including leading the work of the ICS with the Getting It Right First Time Programme.

ii. Delivery of a diagnostics plan and programme.

iii. Support the development of the overarching ICB clinical strategy, as part of which, taking a lead on the strategic approach to secondary and tertiary clinical services to address quality and sustainability issues across the sector. This will include ad hoc clinical service improvement work and the oversight of relevant clinical networks.

iv. Continued implementation of the aseptic manufacturing hub.

v. Leadership of the FT capital programme, supported by agreed capital priorities and goals for estates, equipment and digital.

vi. Delivery of a strategic workforce programme on behalf of the FT providers, linking to the ICB programme and to include action on agency spend and bank arrangements.

3.6. The RA established a Collaborative operational budget of £1.3m for 2023/4. This is comprised of:

- £600K contribution from the NECS (on behalf of ICB)
- £200K roll over of underspend from previous years
- £500K contribution from Trusts.

4. Strategic Partnership with NECS

4.1. As part of evolving working arrangements the Collaborative has agreed to form a strategic partnership with NECS. This recognises the role and support which NECS has offered in the establishment of the Collaborative and the ongoing alignment of priorities and work areas for the Collaborative and NECS focusing on, specifically:

- The deployment of resources and support across system programmes and areas, covering people, digital and analytical requirements;
- The identification of economies of scope and scale in corporate, clinical and clinical support services;
- The delivery of system priorities where there is appropriate congruence (e.g. elective recovery);
- The building of capacity and capability to ensure future resilience through the identification, development and deployment of digital tools and AI to the mutual benefit of the partners;
- Developing population-based approaches to the management of patients to facilitate better care, outcomes and utilisation of resources;
- Mutual development of skills, leadership and associated development for clinical and non-clinical staff.

4.2. This relationship will enable the Collaborative to draw upon the capabilities of NECS and its wider expertise and experience via its comprehensive supply chain as well as being able to shape the direction and development of NECS' strategic direction and priorities.

5. Recommendation

5.1. The FT Boards of the eleven NENC Provider Collaborative members are asked to:

i. Note the Responsibility Agreement between the ICB and Collaborative
ii. Note the strategic partnership between the Collaborative and NECS

Matt Brown
Managing Director
North East and North Cumbria Provider Collaborative
26th September 2023

Appendix A: Responsibility Agreement

Appendix A

North East and North Cumbria Provider Collaborative

North East and North Cumbria

PROVIDER COLLABORATIVE RESPONSIBILITY AGREEMENT

2023/24

1 PURPOSE

This Responsibility Agreement defines and describes the working relationship between the North East and North Cumbria (NENC) Integrated Care Board (ICB) and the NENC Foundation Trust Provider Collaborative (the Collaborative). It provides a framework for building an ongoing relationship and collaboration, which recognises that:

- The ICB and the Collaborative share a vision and purpose, with common aims and objectives to improve the health and wellbeing of the people of the North East and North Cumbria.
- This is a supportive relationship which will evolve over time.
- The agreement sets out the agreed remit of the Collaborative in relation to the delivery of the NENC Integrated Care Strategy.
- It also covers ways of working both in terms both formal and informal and how resources will be secured both to undertake programmes of improvement and for investments.

2 BACKGROUND

The Provider Collaborative provides a formal mechanism for collective decision making across all 11 FTs on important 'whole system' issues in NENC. The Collaborative will act on behalf of and take decisions representing the collective view of our 11 FTs, through an approach that will be additive, tackle unwarranted variation and enhance working at Place.

The Collaborative began working together in 2019 with

arrangements formally endorsed by Trust Boards over the summer of 2022.

3 MEMBERSHIP OF THE PROVIDER COLLABORATIVE

The Members of the Collaborative are all of the foundation trusts (FTs) within NENC:

- County Durham and Darlington NHS FT
- Cumbria, Northumberland, Tyne and Wear NHS FT
- Gateshead Health NHS FT
- Newcastle Upon Tyne Hospitals NHS FT
- North Cumbria Integrated Care NHS FT
- North East Ambulance Service NHS FT
- North Tees and Hartlepool NHS FT
- Northumbria Healthcare NHS FT
- South Tees Hospitals NHS FT
- South Tyneside and Sunderland NHS FT
- Tees, Esk and Wear Valleys NHS FT

3 REMIT

3.1 General

The Collaborative will identify and deliver a programme of mutual benefit and that:

- Contributes to the delivery of the NENC Integrated Care Strategy, in particular its long term goal of 'Better Health and Care Services' by identifying opportunities to improve the quality and sustainability of the health services in the Region, towards a goal of all statutory organisations regulated by the Care Quality Commission being rated either 'Good' or 'Outstanding'.

- Supports the efficient and effective use of resources within its member organisations, with a focus on opportunities to collaborate and/or share resources and to identify and reduce unwarranted variation

- Undertakes collective strategic workforce planning in collaboration with national and regional teams

- Develops opportunities to act as 'anchor institutions', including supporting economic development by leveraging their power as large employers and purchasers.

- Supports the achievement of the integrated care strategy goals of 'longer, healthier life expectancy' 'fairer outcomes'.

3.2 Specific work programmes agreed between the ICB and the Collaborative for 2023/24

- Delivery of a comprehensive elective recovery plan and programme, including leading the work of the ICS with the Getting It Right First Time Programme.
- Delivery of a diagnostics plan and programme
- Support the development of the overarching ICB clinical strategy, as part of which, taking a lead on the strategic approach to secondary and tertiary clinical services to address quality and sustainability issues across the sector. This will include ad hoc clinical service improvement work and the oversight of relevant clinical networks.
- Continued implementation of the aseptic manufacturing hub
- Leadership of the FT capital programme, supported by agreed capital priorities and goals for estates, equipment and digital
- Delivery of a strategic workforce programme on behalf of the FT providers, linking to the ICB programme and to include action on agency spend and bank arrangements

3.3 As appropriate the Provider Collaborative and the ICB will identify in issues and opportunities where a collective provider response is required. This could include specific service issues (for example development and deployment of response to CMDU) to cross cutting issues (e.g. developing an approach to repatriations).

3.4 The ICB will support the Collaborative in its work which will include access to appropriate resourcing for system objectives as well access to appropriate data and analytics to inform work, where the ICB holds this information, on the principle of 'do it once'. The ICB will also ensure appropriate officer involvement in Collaborative work programmes as agreed with the Collaborative.

4 GOVERNANCE ARRANGEMENTS

It is recognised that these arrangements may evolve over time.

The Provider Collaborative operates as a formal partnership of all 11 NHS Foundation Trusts (FTs) in NENC. It is a whole system collaborative acting, at scale across multiple FTs with individual FTs continuing to work with each other in collaborative arrangements on a geographical or sectoral basis and play full roles within their relevant place-based partnerships, working closely with local communities and partner organisations.

It is underpinned by a formal collaboration agreement, operating under a provider leadership model, with formal mechanisms for collective decision making across all FTs on important 'whole system' issues. The Collaborative will act on behalf of and take decisions representing the collective view of our 11 FTs, rather than being a separate formal entity. Individual organisations remain accountable in line with NHS governance and regulatory requirements.

The PLB will determine the programme governance structure required to deliver the agreed work programme, ensuing where appropriate links are made with the relevant NHS England regional and national programme teams.

Where agreed programmes of work are mapped to the delivery of ICB goals and objectives within the Integrated Care Strategy and when complete, the Five Year Forward Plan, the Collaborative will report progress through to the ICB via the ICB programme management system.

5 RESOURCES

Based on the work programme contained within this agreement, the resources for 23/24 are set out below in summary, together with the funding sources. A programme staff organisation chart is provided as appendix 1

Costs banded at top of grade, or actual where available.

Post	WTE	Band	Annual cost £k	23/24 cost £k
Managing Director (hosted by NUTH)	1.0	VSM	130	130
Director of Elective Recovery & Transformation (NHSE)	0.4	VSM	60	60
Elective Programme Director (NECS)	1.0	8D	605	605
Corporate Programme Director (NECS)	1.0	8D		
Senior Development Lead (NECS)	1.0	8D		
Senior Project Manager (NECS)	1.0	8A		
Programme Support Officer (NECS)	1.0	5		
Mutual Aid Lead (STSFT)	0.4	8A	30	30
Project Support Officer (NECS)	1.0	5	60	60
Senior Programme Support Officer (Gateshead)	1.0	6	55	30
Subtotal (filled)			***940***	***915***
Vacant				
Clinical Programme Lead	1.0	8C	95	70
Project Manager	4.0	7	240	180
Performance & Intelligence Lead	0.6	8A	45	30
Finance Lead	0.2	8A	15	10
Comms Lead	1.0	6	60	45
Administrative Assistant	1.0	3	30	20
Clinical Leadership & Backfill			30	30
Subtotal (vacant)			***515***	***385***
Non pay (inc corporate support eg HR, finance)			30	30
Total Costs			**1,485**	**1,330**
Income				
Carry over from 22/23				180
NECS contribution				500
ICB contribution				100
FT contribution (£550k/11 = **c£50k per FT**)				550
Total Income				**1,330**

Note – the right-hand column, denoted 23/24 cost (£k), takes account of likely actual in-year costs, for example due to recruitment taking place mid-year

Separate funding streams are in place in 23/24 for:

- Aseptics Project Director

- Aseptics Project Manager
- Cancer Programme Manager
- Diagnostics Programme

There will be other potential posts through the Provider Collaborative, such the Digital Diagnostics Implementation Leads, pharmacy and procurement opportunities e.g., diabetic devices.

In addition, the ICB and will support the Collaborative in the following ways:

- A shared approach to the use of BI resources, including a commitment to 'do once and share'
- Support from the ICB Programme Management Office, and access to a suite of project management and quality improvement tools
- Support for the team, with a link executive and team (the Chief of Strategy and Operations)

6 AGREEMENT

Insert signature	Insert Signature
Ken Bremner	Sam Allen
Chair, Provider Collaborative	CEO, Integrated Care Board
Insert Date	Insert Date

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 9i

Report Title:	**Board Assurance Framework Update**			
Name of Meeting:	Board of Directors			
Date of Meeting:	29 November 2023			
Author:	Jennifer Boyle, Company Secretary			
Executive Sponsor:	Dr Gillian Findley, Chief Nurse and Deputy Chief Executive			
Report presented by:	Dr Gillian Findley, Chief Nurse and Deputy Chief Executive			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
	This report provides the Board with the current Board Assurance Framework 2023/24 for review and assurance, following scrutiny by each of the mapped Board committees.			
Proposed level of assurance *– 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*	Board Committees			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	• Extracts of the BAF have been reviewed and updated at each Board committee meeting since the full BAF was presented to Board in July 2023. • The BAF key is as follows: Key / Description 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 Current risk scores compared to target are as follows:			

This demonstrates that 3 risks have been managed effectively to achieve the target risk score. The BAF demonstrates that active updates are being made to the BAF at each committee to reflect to identification of new controls or assurances and any gaps.

Areas with the highest current scores relate to performance, finance and our people (culture and health and wellbeing). This triangulates with the information reported to Board as part of other formal reports on the agenda.

A further update will be provided at the January 2024 Board meeting as the year-end approaches.

Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	The Board is requested to review the BAF, noting that it is under continuous review and update at the relevant Board committees.

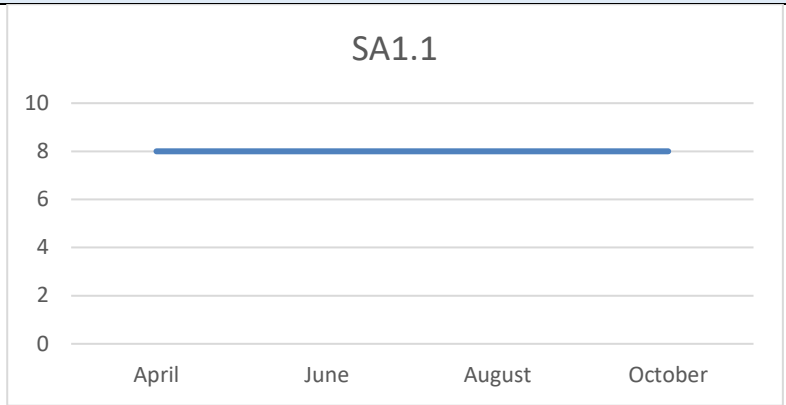
Trust Strategic Aims that the report relates to:	**Aim 1** ☒	We will continuously improve the quality and safety of our services for our patients
	Aim 2 ☒	We will be a great organisation with a highly engaged workforce
	Aim 3 ☒	We will enhance our productivity and efficiency to make the best use of resources
	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 strategic objectives that the report relates to:	This relates to all corporate objectives, assisting in the management and mitigation of risks which may pose a risk to delivery.	

Links to CQC Key Lines of Enquiry (KLOE):	Caring ☐	Responsive ☐	Well-led ☒	Effective ☐	Safe ☐
Risks / implications from this report (positive or negative):					
Links to risks (identify significant risks – new risks, or those already recognised on our risk management system with risk reference number):	Risks identified on the BAF itself.				
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐		**No** ☐		**Not applicable** ☒

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

Strategic objective:	SA1.1 Continue to improve our maternity services in order to improve performance against key indicators and ensure improved patient outcomes by March 2024.
Executive Owner:	Chief Nurse
Board Committee Oversight:	**Quality Governance Committee**
Date of Last Review:	October 23 Quality Governance Committee
Summary risk	

This is a risk that the Trust is unable to maintain the level of improvements required to enhance maternity services due to resource capacity (finance, staffing and estates for example), impacting upon the quality of maternity services and a decline in performance against the maternity metrics and patient outcomes.



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

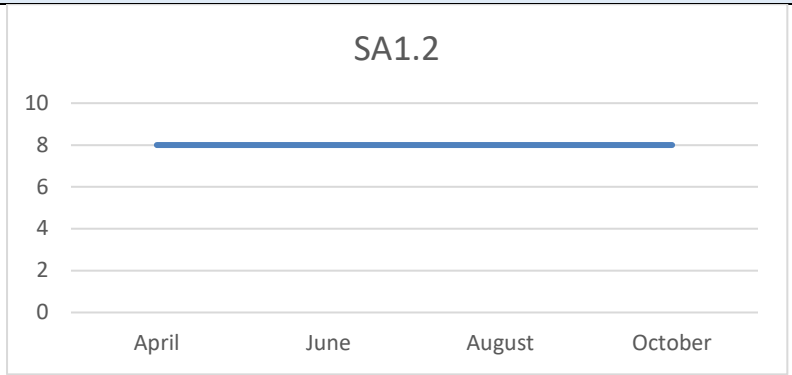
Links to risks on the ORR (scores as at June 23):	POD 2764 - Workforce - Risk of not having a clearly agreed workforce plan for the next 3, 5 and 10 years. (16) SURGE 2398 - Risk that MDT are delayed to a maternity emergency/delayed CCU transfers for maternity patients due to separate buildings (15) COO 3186 - There is a risk to ongoing business continuity of service provision due to ageing trust estate (12)

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

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

Maternity assurance report presented at every Quality Governance Committee meeting						
Ockenden assurance report to Board in May 2022						
Patient safety walkabouts with Executive Directors and Non- Executive Director held monthly						
Assurance (Level 3 – external)						
Feedback received from regional team regarding Ockenden evidence submission						
Maternity Voices Partnership provide regular feedback to the unit on patient experience						
Friends and Family test score results are positive and provide good assurance over the quality of care						
Chief Midwifery Officer visit to the Trust. Awards presented to colleagues in Maternity for the provision of excellent care, leadership and inspiration to colleagues and patients.						
CQC maternity survey ranked the Trust as 8th in England for its maternity services						
CQC report received – 'good' rating for maternity						

Strategic objective:	SA1.2 Develop and implement a continuous Quality improvement plan that enables the delivery of improved performance against key indicators by March 2024
Executive Owner:	Chief Nurse
Board Committee Oversight:	Quality Governance Committee
Date of Last Review:	October 23 Quality Governance Committee
Summary risk	

Pressures on performance, people and finance coupled with external influences may place significant risk on the ability of the Trust to achieve national quality standards and deliver the quality improvement plan		**CURRENT RISK SCORE**			**TARGET RISK SCORE**		
		Likelihood	Impact	Score	Likelihood	Impact	Score
		2	4	8	2	4	8

Links to risks on the ORR (scores as at June 23):	MEDIC 2982 - Risk of delayed transfers of care and increased hospital lengths of stay (16) POD 2764 - Workforce - Risk of not having a clearly agreed workforce plan for the next 3, 5 and 10 years. (16) NMQ 3089 - Quality - Risk of quality failures in patient care due to external causes such as delayed discharges and external pressures. (12) POD 3095 - Risk of Significant, unprecedented service disruption due to industrial action (20)

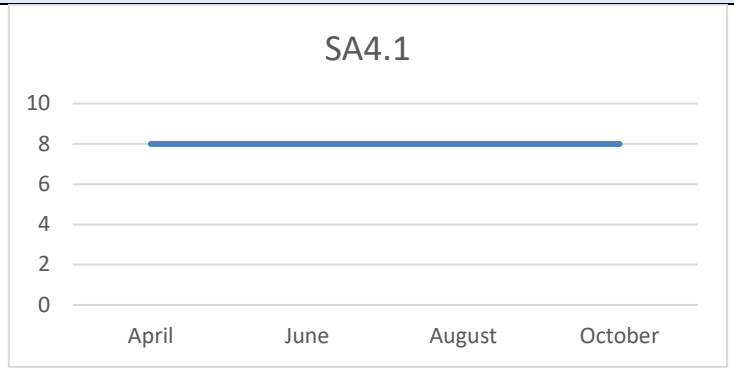
Controls	**Gap in controls and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Gap analysis undertaken against CQC standards	Query raised regarding whether health and safety inspections are taking place in line with requirements	GF	Oct 23		
Core standards action plan has been developed					
Clinical audit programme in place					
Quality Governance Committee and sub-groups in place					
Equality and Quality Impact Assessment (EQIA) programme in place					
Transformation and Quality Improvement Programme in place					

Datix and incident reporting systems in place to record risks and incidents and capture learnings						
Nursing strategy in place						
Good Governance Institute work completed re: assessment of compliance and controls regarding well-led.						
CQC task and finish group established						
New Compliance Group established						
Quality Strategy ratified at Board in March 2023 and now live						
Good Governance Institute undertaking a review of meetings to ensure appropriate coverage, escalation, assurance etc.						
Continuous improvement framework in development						
PSIRF plan and policy developed						
Assurance (Level 1: Operational Oversight)		**Gaps in assurance and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
SafeCare meetings in each operational business unit		Leading indicator report continues to develop and training planned for the Board	Exec Directors	December 2023	Oct – Scheduled for Board development in December	
Quality is a key component of the Quarterly Oversight meetings		Gap in assurance relating to the quality and safety aspects of QEF's work outside of the core contract with the Trust. A report is being developed by QEF for presentation to QGC.	SH (QEF)	December 2023		
Compliance Manager is in post and has action plan for compliance		Northern Trauma Network Peer Review completed and identified some priority actions, particularly tracking trauma patients and meeting the rehabilitation standards. Plans are being developed to address the findings	AB	Update at Oct 23		
CQC task and finish group in place to provide oversight of CQC action plan						
Assurance (Level 2: Reports / metrics seen by Board / committee etc)						
IOR includes quality metrics mapped to the key lines of enquiry – reviewed by the Quality						

Governance Committee and Board bi-monthly						
Patient and staff stories presented to Board at every meeting						
Clinical audit outcomes reported to Quality Governance Committee						
Complaint triangulation report presented to Quality Governance Committee						
Safer staffing report now including red flag data						
Cancer services annual report received						
Assurance (Level 3 – external)						
CQC process audit by AuditOne – outcome awaited						
AuditOne audits from 2021/22 – NICE Guidance (good) and Duty of Candour (good)						
Medicines optimisation service received 'good' rating from CQC						
Screening Quality Assurance Service (SQAS) visit to colposcopy with positive feedback						
GGI well-led governance report completed						
Northern Trauma Network Peer Review (note that this has identified some gaps in assurance)						

Strategic objective:	SA4.1 Identify key local health inequalities challenges and ensure improvement plans are in place by March 2024
Executive Owner:	Medical Director
Board Committee Oversight:	Quality Governance Committee
Date of Last Review:	October 23 Quality Governance Committee
Summary risk	

There is a risk that due to competing pressures (such as financial constraints and the need to meet national operational targets) the Trust does not deliver on its health inequalities action plan, resulting in continued decline in health within the local population



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

Links to risks on the ORR (scores as at June 23):	COO 2945 - Risk of ineffective and inefficient management of services due to availability and access to appropriate and timely BI. (12)

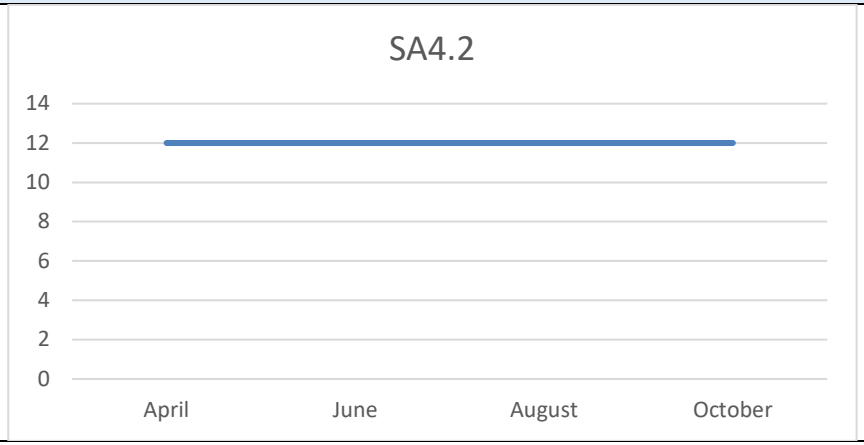
Controls	Gap in controls and corrective action	Owner	Timescale	Update	Action status
Health Inequalities Lead and SRO identified	Lack of knowledge and expertise – resource to be identified internally. Maintain strong links with ICS team and Gateshead Director of Public Health	Medical Director	December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

					cover sheets.	
Health Inequalities Board established with members including the Director of Public Health for Gateshead						
Waiting lists record deprivation score index and data sets also record ethnicity						
Trust engagement in Making Every Contact Count						
Engagement in Gateshead Cares System Board						
Engagement with Gateshead Citizens' Advice to provide support to patients and staff						
Quality Governance Committee established as the reporting line for Health Inequalities Board						
Health Inequalities action plan in place						
Increased capacity to develop strategic relationships at pace due to the appointment of the Medical Director of Operations freeing up capacity for the Medical Director to lead in this with the CEO						
Assurance (Level 1: Operational Oversight)		**Gaps in assurance and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
		Gap in assurance linked to lack of dedicated resource, meaning assurance flows are not functioning as effectively as they should	Medical Director	December 23		
Assurance (Level 2: Reports / metrics seen by Board / committee etc)						
Presentations to the Board of Directors on health inequalities by						

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

Strategic objective:	SA4.2 Work collaboratively as part of Gateshead Cares system to improve health and care outcomes to the Gateshead population
Executive Owner:	Chief Operating Officer
Board Committee Oversight:	Quality Governance Committee
Date of Last Review:	October 23 Quality Governance Committee
Summary risk	

There is a risk that health and care outcomes for the population of Gateshead are not improved, so the Gateshead Care priorities and action plan fail to collectively deliver and the health and care outcomes at place-level are not delivered



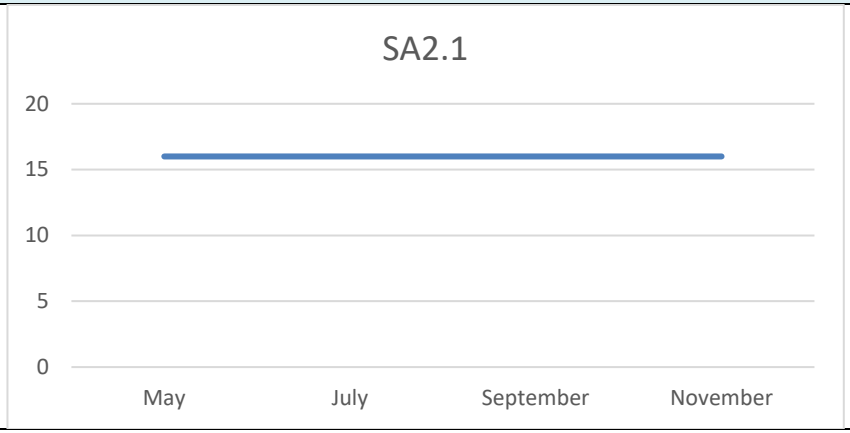
CURRENT RISK SCORE			TARGET RISK SCORE		
Likelihood	Impact	Score	Likelihood	Impact	Score
4	3	12	2	3	6

Links to risks on the ORR (as at April 23):	MEDIC 2982 - Risk of delayed transfers of care and increased hospital lengths of stay (16) NMQ 3089 - Quality - Risk of quality failures in patient care due to external causes such as delayed discharges and external pressures. (12)

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

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

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

Strategic objective:	SA2.1 Caring for our people in order to achieve improved compliance to leading indicators by March 2024
Executive Owner:	Executive Director of People and OD
Board Committee Oversight:	People and OD Committee
Date of Last Review:	November 2023 POD Committee
Summary risk	
There is a risk that the Trust is unable to provide appropriate levels of support to staff from a health and wellbeing perspective due to resource and capacity constraints and an increase in activity as part of our operational recovery. This may result in increases in sickness, reductions in morale, reduced retention rates and ultimately impact negatively on our ability to deliver high quality care to our patients.	

CURRENT RISK SCORE			TARGET RISK SCORE		
Likelihood	Impact	Score	Likelihood	Impact	Score
4	4	16	2	5	10

Links to risks on the ORR:	POD 3095 - Risk of significant, unprecedented service disruption due to industrial action (20)

Controls	**Gap in controls and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Health and wellbeing funding secured for 23/24 in form of B7 role, 12m Band 5 and B3 for 3 months.	Delivery of the HWB Strategy.	AV	Mar 23	Complete and added to controls	
Health and wellbeing team established (funding expires June 23).	Deliver a sustainable annual vaccination campaign that improves vaccination uptake, ensuring 85% of staff are vaccinated.	LF	January 24	July 23 – planning for this has commenced	
Clear progress in reducing outstanding historic DBS	Reduction in sickness absence – training to be rolled out and new absence management approach embedded.	DB	Oct 23	Professional Absence Management training remains ongoing, robust absence	

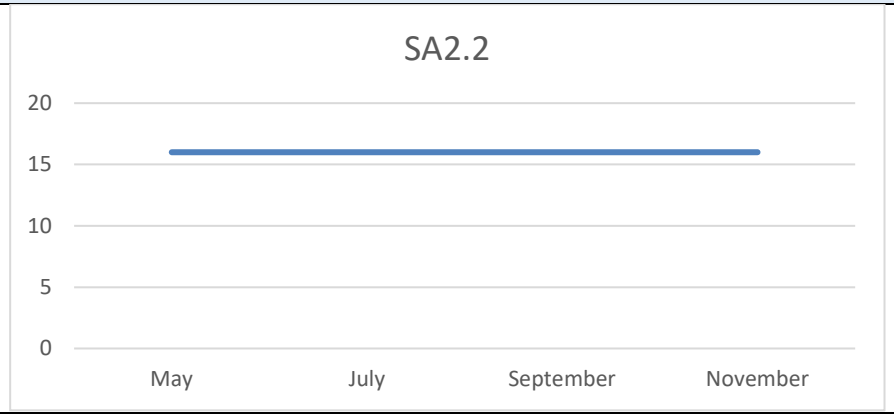
					management process embedding, focused approach reviewed and well received by SMT, further focused approached required and to be reviewed in 6 months	
Partnership with Gateshead Citizen's Advice to provide additional support to staff.		Health and wellbeing team funding due to expire in June 23 and finance to extend not yet agreed. Charitable funds currently explored.	LF	Jun 23	Funding has been secured for a B7 Health & Wellbeing Manager role, which will go out to advert this month. Charitable Funds request submitted to fund B5 for another 12 months and work underway to scope options around B3 position. July 23 – B7 successfully appointed. Charitable Funds were secured to extend the Band 5 Health & Wellbeing Advisor position for a further 12 months. The B3 role has been extended for 3 months to cover a planned Occupational Health & Wellbeing Team restructure.	
Listening Space now launched and in operation.		Implementation of rolling DBS programme to be completed.	DB	Timescale TBC	July 23 – this work has commenced	
Plans in place to prepare and mitigate risks as much as possible in respect of		Flu and covid vaccination programme 23/24 ongoing although uptake needs improved.	LF	Jan 24	Campaign is ongoing but needs further	

forthcoming industrial action.					focus	
Flu and Covid vaccination programme delivered to colleagues.						
Health and Wellbeing ambassador network established.						
Improved catering provision in place, with medium term actions on track.						
Positive impact of focused sickness absence management approach from both management and POD teams.						
HWB strategy in place						
Planning in place for Covid, flu, whooping cough vaccinations						
Progress being made to close any gaps in recruitment check documentation						
Assurance (Level 1: Operational Oversight)		**Gaps in assurance and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
POD Quality Meeting, Management Meeting and People Portfolio Board.		Compliance with health and wellbeing conversations unknown.	DJ	Dec 22 To be reviewed Feb 23	Reportable from ESR from appraisals completed since November 22	
Assurance (Level 2: Reports / metrics seen by Board / committee etc)						
Health and wellbeing metrics reported to POD Committee, including vaccination uptake and actions to support financial wellbeing						
Health and wellbeing metrics reported in IOR at Board.						
Strategic objective update reported for Q1						
Assurance (Level 3 – external)						
Staff feedback on HWB in 2022 survey results.						
International recruitment team has been awarded the NHS Pastoral Care						

Quality Award - recognises commitment to providing high-quality pastoral care and the positive impact this has on staff wellbeing.						

Strategic objective:	SA2.2 Growing and developing our people in order to improve patient outcomes and reduce reliance on high cost agency staff by March 2024
Executive Owner:	Executive Director of People and OD
Board Committee Oversight:	People and OD Committee
Date of Last Review:	November 2023 POD Committee
Summary risk	

Risk of not having the right people in the right place at the right time with the right skills due to lack of workforce capacity, resources and expertise across the organisation, ultimately impacting negatively on our patient outcomes and financial outcomes.



CURRENT RISK SCORE			TARGET RISK SCORE		
Likelihood	Impact	Score	Likelihood	Impact	Score
4	4	16	2	5	10

Links to risks on the ORR:	2764 - Risk of not having clearly agreed workforce plans for the next 3, 5 and 10 years (16) POD 3095 - Risk of significant, unprecedented service disruption due to industrial action (20)

Controls		**Gap in controls and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Planning and co-ordination process in place for industrial action		People Strategy has been developed and is due to be presented at March Board.	AV	New approved timescale – March 23	People Strategy timeline in Trac. Jan 23 – People Strategy to be presented at 9 Feb Board strategy day with ratification planned for March Board. April 23 - People Strategy signed off and agreed at March 2023 Board. Verbal update to be given and final	

					version shared at PODC in May 2023.	
International recruitment – programme well established.		Further development of people metrics; nursing dashboard further developed, medical staffing and AHP designed and tested. People Analyst to look to triangulate bank and agency spend, sickness absence and vacancy rates and include in the narrative.	LH	Feb 23	April 23 - AHP dashboard developed and updated monthly. Initial Medical Dashboard developed – pending feedback from Medical Workforce Group. Nursing Dashboard not yet developed and reached a position where it was agreed with the Head of Nursing that the Nursing workforce information (whilst in various places) was sufficient. Bank, agency, sickness and vacancy rates triangulated via the inpatient workforce report summary with has been developed.	
Recruitment process streamlined (RPIW).		Comprehensive Workforce Plans – paper to be brought back to May Committee, writing up work to date, next actions and potential risks.	NB	Mar 23	Meetings scheduled throughout January 2023 with Business units and The Whole System Partnership to gather intelligence to support workforce planning looking at skill requirements. April 23 - Paper listed to be presented at	

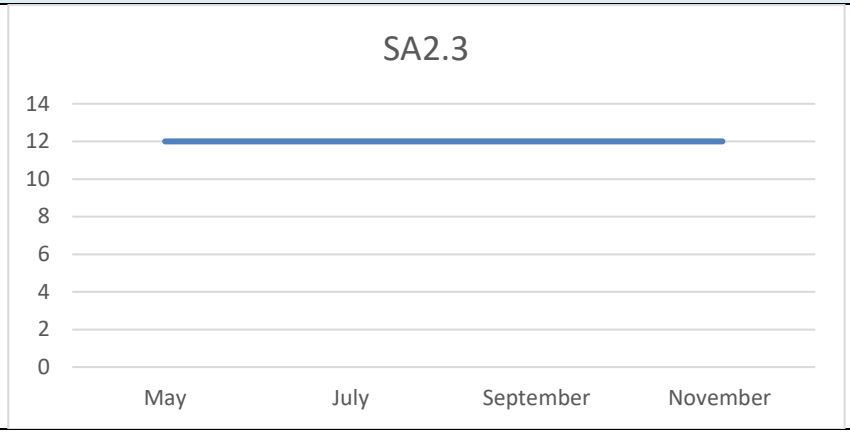
					PODC in May 2023.	
Managing Well and Leading Well programmes fully operational.		E-Rostering for Medical Workforce. Medical staffing task and finish group agreeing future medical staffing service with scoping of potential new e-rostering system to follow given the current system has expired. Current controls in place to effectively manage the rostering in the interim, and good clinical engagement.	BO	Proposed new date Feb 24	Zebra Project manager in post regular meetings in diary with Medical Staffing Manager. Implementation plan under review. New system to be scoped	
New absence management policy in place.		Securing funding to progress the RNDA apprenticeship programme – Gateshead Apprenticeship into Nursing GAiN	SN	Proposed new date June 23	Presented to SMT but further work required. April 23 - Agreed in principle at SMT with planning to commence. As investment needed exceeds £1m in total, this requires board approval. July 23 – on July 23 Board agenda for decision Aug 23 – approved at July Board – recommend the closure of this gap.	
People analyst in post and initial reports developed; nursing dashboard in place with benchmarking and trajectories.		Exit interview process to be embedded and work to be undertaken to increase completion rates	NB	Proposed New date Feb 24	April 23 - Exit interview process reviewed and revisions suggested, however still requires roll out, comms and embedding. July 23 – agreed to review as part of wider retention work – to be considered at Sept POD Committee. Nov 23- Lack of	

					capacity to progress this work. Discussed at Nov committee with revised date proposed	
Retention initiatives in place to support and encourage colleagues to remain with the Trust.		NHS Long Term Workforce Plan released – internal scoping for the Trust and wider ICS to be undertaken	AV / GR	Jan 24	Aug 23 – briefing delivered to Board as part of Board development	
School and local community supply initiatives in place to attract the Trust's future workforce.		Medical Staffing task and finish group actions to be formulated into an action plan with target dates identified.	AV / GR	Jan 24		
Agency group in place to provide greater controls over the usage of agency staff.						
Healthcare Academy Approach in Development supporting Health Care Careers across Gateshead.						
KPI report developed around Theatre's initiatives and progress reports provided.						
Workforce plan in place						
People Strategy 2023-25 in place						
GAiN apprenticeship programme approved by Board						
Medical Staffing task and finish group has been set up, good progress being made						
Assurance (Level 1: Operational Oversight)		**Gaps in assurance and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Staffing Task and Finish Group.		BU Dashboard.	LH	~~Feb 23~~ Proposed new date July 23	April 23 - Business unit level workforce information is available via BI reporting but is currently being redeveloped by the BI	

					team, co-ordinated by the People & Information Systems Manager.	
Nursing Workforce Group (People Portfolio Board approach).		Medical Staffing Dashboard.	LH	Feb 23	April 23 - Initial Medical Dashboard developed – pending feedback from Medical Workforce Group.	
POD Management Meeting and SMT.		Further POD metrics being developed.	LH	Mar 23	April 23 - our People Analyst is always looking at ways to analyse and present current metrics differently. Looking at change over time, variations and data points that stand out.	
Medical staffing dashboard developed in draft		Consideration how we are able to report on the overall training picture for the Trust.	NH/CB	TBC		
Strategic objective update reported for Q1.						
Assurance (Level 2: Reports / metrics seen by Board / committee etc)						
POD Metrics to POD Committee.						
POD Portfolio Board.						
Nurse/HCSW Dashboard now in place to monitor vacancies and presented to formal groups for assurance and review.						
Assurance (Level 3 – external)						
Returns to NHSE.						

Strategic objective:	SA2.3 Being a great place to work in order to improve staff survey outcomes and impact upon patient outcomes within 2 years.
Executive Owner:	Executive Director of People and OD
Board Committee Oversight:	People and OD Committee
Date of Last Review:	November 2023 POD Committee
Summary risk	

There is a risk that the Trust's culture does not reflect the organisational values due to resourcing pressures and a lack of focus on organisational development, training and development, resulting in reduced retention, vacancies, poor staff survey results and ultimately impacting on patient outcomes.



CURRENT RISK SCORE			TARGET RISK SCORE		
Likelihood	Impact	Score	Likelihood	Impact	Score
3	4	12	2	5	10

Links to risks on the ORR:	2764 -Risk of not having clearly agreed workforce plans for the next 3, 5 and 10 years (16) POD 3095 - Risk of significant, unprecedented service disruption due to industrial action (20)

Controls	**Gap in controls and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Trust-wide engagement programme that resulted in the launch of a new vision and behaviour framework.	Engagement approach for the culture programme not yet fully defined.	LF	~~March 23~~ June 2023	April 23 - Culture Programme launched w/c 24 April 2023, with initial communications underway. Culture Board to be established May 2023, with a programme scoping session to	

					follow, when a full engagement approach will be agreed.	
Trust values have been reviewed as part of the wider engagement programme and remain the same.		Culture Programme approach agreed, with a structure built around 6 workstream SRO's and supporting Programme Managers.	LF	March 2023	April 23 - 6 SROs and 6 Programme Managers confirmed.	
Culture Programme has been established overseen by the Transformation Board and sponsored by the CEO.		Engagement plan for EDS2.	KS	~~May 2023~~ Nov 23	April 23 - Verbal update to be given at PODC in May 2023. July 23 – written update requested for Sept 23 Nov 23- agreed T&F group to be set up reporting to the HREDI group	
Overarching Programme SRO agreed and confirmed.		Freedom to Speak Up – more information to be included on themes, trends and closing dates. People analyst to support future developments of the report.	GR	July 2023	April 23 – action plan in place to review Freedom to Speak Up more widely. Included in thematic review. June 23 – interviews scheduled for a dedicated FTSU Guardian role. Nov 23- Complete, new Guardian in post and data reporting confirmed	
Freedom to Speak Up report received for Q1		Low completion rates for Pulse survey – action to increase the Pulse survey rates in line with the leading indicator work	LF	Jan 24		
Existing team of Cultural Ambassadors that can support the programme.		Increase Board-level compliance for FTSU training	AV / SN / JB	Sept 23	July 23 – reminder sent to Board August 23 reminder sent to Board 12/13 completed all staff mandated training.	

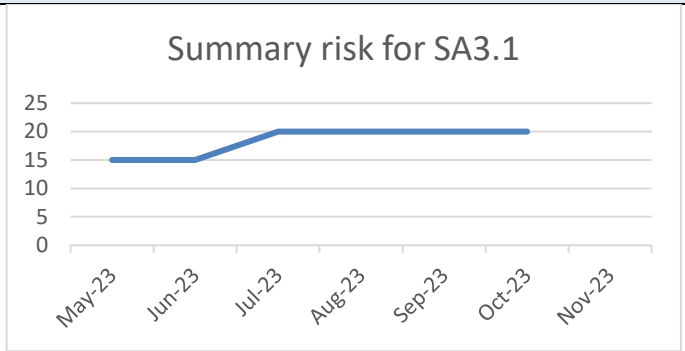
					5/13 have completed the board level training. Nov 23- compliance rates are	
2022 Annual Staff Survey results received, analysed and communication campaign underway.		Develop zero-tolerance time to stop campaign Good engagement with staffside and networks	AV/LF	Nov 23	Nov 23- Launch date of 24th November with team working on intranet site and support materials	
EDS2 update received.		Work on robust comms and engagement on the 2023 staff survey	LF	Nov 23	Nov 23- campaign launched and current response rate is 35.1%	
Culture programme resource and staffing now in place		Staff networks to be 're-launched' along with Zero tolerance campaign	AV/KS	Nov 23		
Professional Nurse Advocates in place						
Legacy Nurses recruited						
Staff survey launched for 2023						
9 FTSU Champions and full-time Guardian appointed						
Corporate induction programme in place						
Anti-racism charter signed with Unison						
Assurance (Level 1: Operational Oversight)		**Gaps in assurance and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
POD Management Team.						
Assurance (Level 2: Reports / metrics seen by Board / committee etc)						
Transformation Board.						
POD Portfolio Board.						

POD Committee in place with regular reporting						
Corporate objective update for Q1 to POD						
Assurance (Level 3 – external)						
Staff survey 2022 provides good assurance						

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

Strategic objective:	SA3.1 Ensure that there is a strong focus on improving productivity and efficiency and best use of resources in everything that we do to meet the required performance standards/recovery requirements by March 2024.
Executive Owner:	Chief Operating Officer
Board Committee Oversight:	Finance and Performance Committee
Date of Last Review:	October 2023 – F&P Committee
Summary risk	

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



CURRENT RISK SCORE			TARGET RISK SCORE		
Likelihood	Impact	Score	Likelihood	Impact	Score
4	5	20	3	3	9

Links to risks on the ORR (as at July 23):	MEDIC 2982 – risk of delayed transfers of care and increased hospital lengths of stay (16) POD 2764 - Workforce - Risk of not having clearly agreed workforce plans for the next 3, 5 and 10 years. (16) POD 3095 - Risk of significant, unprecedented service disruption due to industrial action (was 20 now 16) ~~FIN 3128 - Risk that the capital cost of delivery of the new operating model continues to increase resulting in revenue implications. (16)~~ Risk closed from ORR. FIN 3102 - Activity is not delivered in line with planned trajectories, leading to reduction in income (16)

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

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

					May 23 – collaborative work will continue, but the specific work referenced here is complete. Discharges currently within tolerable limits.	
Winter Plan in place and signed off by Board and submitted to ICB for winter 22/23		A need to develop a collective understanding of the sustainability, vulnerabilities and strengths of our service offering. The Trust Board has commissioned a review to inform this.	Executive Directors	~~September 2023~~ March 24	May 23 – incorporated into thematic review delivery plan. Engagement underway with full review expected to be completed by September 23. Sept 23 – an update is included on the Sept Board agenda. Oct 23 – follow-up discussion scheduled for Oct Board development. Proposal to revise deadline date in line with financial year. Proposal for target date change approved at F&P Committee.	**On track**
Estates plan for the New Operating Model in place and being delivered						
Productive relationship with local authority on discharges – collaboration will continue as business as usual						

Development of a focussed length of stay project to support a reduction in the duration of hospital stays						
Annual plan submitted for 23/24 covering operational delivery, finance and workforce						
Delivery Oversight Group established to oversee the delivery of the sustainability workstreams.						
Assurance (Level 1: Operational Oversight)		**Gaps in assurance and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Chief Operating Officer meets with senior team on a weekly basis to oversee performance delivery		NO workforce or Quality data in the IOR that enables triangulation with performance information	~~Chief Operating Officer~~ Group Director of Finance and Digital	March 23	March 23 – work being undertaken to refine the IOR with exception reporting at Board and increased granularity at operational tiers May 23 – this work is now complete and changes have been made to the IOR.	**Complete**
Escalation into BU monthly monitoring outcome of Q2 QOM re: Assurance Framework.		Benefits realisation process for elective and scheduled care transformation programmes not clear. Outcomes to be clearly defined so that they can be measured.	Chief Operating Officer	~~December 2022~~ April 2023	March 23 – action reopened to reflect benefits realisation exercise reporting to April F&P Committee. May 23 – paper was presented to April's meeting in line with timescale. Follow-up paper presented to the May 23 meeting.	**Complete**

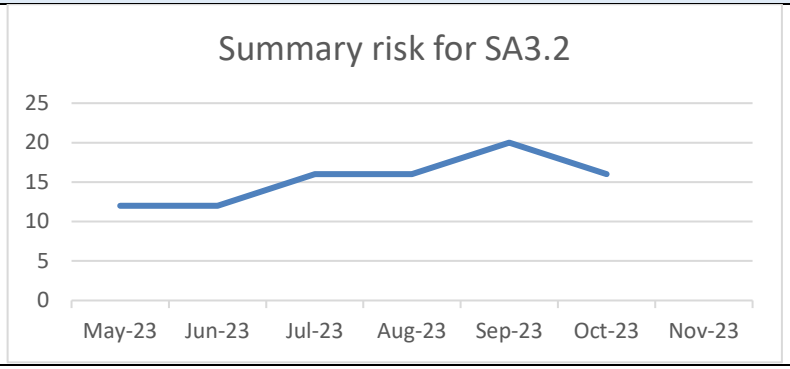
					Action considered complete.	
Elective and Planned Care Recovery project Board in place to monitor delivery of the transformation programme		Committee not sighted on the themes and trends from the weekly performance clinics – identified as a gap in assurance. Agreed to bring a summary back to the Committee along with the impact on the activity trajectory	Deputy Director of Planning and Performance	August 2023	Oct – note these are now entitled the Access and Performance Clinics. Elective Recovery Board Assessment presented and agreed action to bring to the Committee a single elective recovery report. On agenda for Oct meeting. Confirmed that this addresses gap in assurance and agreed to close.	
Unscheduled Care Programme Board in place to monitor oversight and delivery of the transformation programme		Gap in assurance relating to understanding the impact of the New Operating Model. A further report to come back to Committee to articulate performance metrics and mitigations.	Group Director of Finance / Deputy Director of Planning and Performance	July 2023	July 23 – on agenda Oct 23 – learning report is included on the agenda. Review and determine whether this address the gap in assurance here. Nov 23 – note that the paper was deferred to the Nov F&P meeting and therefore will be considered this month to determine if the report closes the gap in assurance	
Weekly performance clinics in place						
Assurance (Level 2: Reports / metrics seen by Board /						

committee etc)						
Quarterly Oversight Meetings in place -Executive led to meet on performance of all business units chaired by the CEO						
Integrated Oversight Report reviewed at Board and Board committees, and undertaking deep dives where required for extra assurance e.g. discharges.						
~~Transformation Board meets monthly with a suite of project update reports to provide assurance over key related workstreams feed into F&P Committee~~						
Operational Business Unit governance review completed and shared with the OBUs and Chief Operating Officer. Model documents developed to aid implementation.						
Quarterly Oversight meeting outputs on F&P cycle of business to provide assurance bi-monthly						
IOR contains quality and workforce data to support triangulation with operational performance						
Elective recovery report now presented regularly at F&P Committee.						
Leading indicators developed and reported to F&P Committee for assurance						
Assurance (Level 3 – external)						

External review of discharges underway – outcome not yet available	[redacted]					
ECIST review undertaken – confirmed all transformation plans appropriate and identified areas of good practice						
External review of waiting list integrity provided good assurance						
Monthly regional performance report – benchmarking provided as part of IOR						

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

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



CURRENT RISK SCORE			TARGET RISK SCORE		
Likelihood	Impact	Score	Likelihood	Impact	Score
4	4	16	2	4	8

Links to risks on the ORR:

~~FIN 3128 - Risk that the capital cost of delivery of the new operating model continues to increase resulting in revenue implications. (16)~~ Risk closed from ORR.
FIN 3103 - operational pressures result in non-achievement of CRP (16)
FIN 3127 - There is a considerable risk that the Trust is unable to meet the financial projections included in its plan. (was 20 now 16 in line with Committee decision in October)
FIN 3102 - Activity is not delivered in line with planned trajectories, leading to reduction in income (16)

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

					May 23 – new structures are now in place and all core roles recruited to.	
Financial accountability framework in place		SFIs and scheme of delegation require updating to reflect changes in the governance structure and decision-making	Group Director of Finance / Company Secretary	2023/24	March 23 – note this work will now take place in 23/24. May 23 – Deloitte review due for completion end of June with delivery plan to be agreed once findings known July 23 – Deloitte report anticipated by the end of the month August 23 – report received and to be considered at an extraordinary Board. Sept 23 – this features as part of the actions agreed at the extraordinary Board in Sept. Agreed as a priority action with a confirmed deadline of December 2023.	**On track**
Regular meetings with ICS to discuss system position, required actions and inflationary pressures		Trust moved into SOF Segment 3. Immediate actions to be identified and developed with reporting to the Delivery Oversight Group.	Group Director of Finance	Sept 23	Oct 23 – DOG report on the agenda. Review and determine whether this closes gap in control.	
New business case process launched in April 22.		Business planning process for the Trust to be fully reviewed and refreshed to strengthen the controls in place and bring forward the planning to	Interim Director of	Oct 23	Sept 23 – update paper provided to	

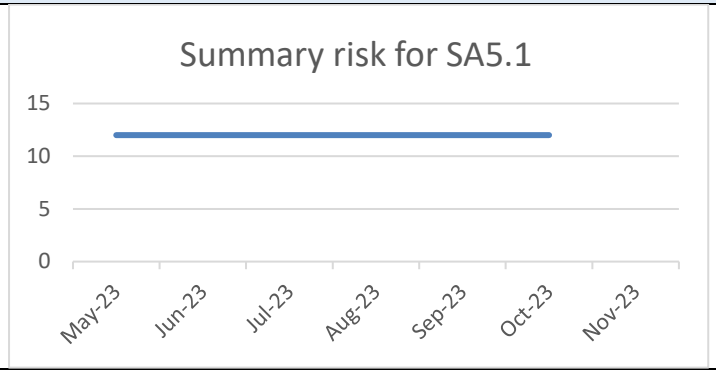
		commence earlier and encompass a longer time period	Strategy, Planning and Partnerships		SMT to outline proposed process.	
Oversight meetings in place with each business unit to hold to account, CRP and accountability framework key item						
Capital plan in place with monthly reporting to F&P						
Close monitoring of the Elective recovery programme to ensure delivery of ERF						
CRP framework in place for 23/24						
Core finance roles recruited to, strengthening the capability and capacity of the team						
Delivery Oversight Group established to oversee the delivery of the sustainability workstreams						
Assurance (Level 1: Operational Oversight)		**Gaps in assurance and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Month end finance closure and related procedures		System Oversight Framework external monitoring and assurance arrangements not yet defined	Group Director of Finance	March 23	Dependent upon external developments – will be kept under review Jan – the forecasting protocol document has previously been presented to committee. SOF reporting and monitoring still to be confirmed. Feb 23 – no change March 23 – monitoring by NHSE has not yet restarted.	**Complete**

					The monitoring arrangements for 23/24 are yet to be communicated. May 23 – ICB meeting held to confirm SOF rating with further meeting in June. June 23 – meeting arranged for 21 June.	
Monthly budget meetings held between business units and assigned financial management support leads						
Oversight / hold to account meetings						
Regional DoF ICS meetings now happening 4 times per month, accompanied by a monthly triangulation meeting between the Trust, the ICB and NHSE.						
SMT planning sessions held to develop a robust and realistic CRP plan for 23/24						
Assurance (Level 2: Reports / metrics seen by Board / committee etc)						
Achievement against revenue and capital plan reviewed for assurance at Finance and Performance Committee, including agency spend, CRP detail and forecasting.						
Revenue and capital report received for assurance at Board of Directors						
HFMA action plan in place and presented to the Committee.						
Assurance paper received on CRP plans and delivery						
CRP reporting and assurance defined as via SMT, Transformation Board and then Finance and Performance						

Committee.						
Supply and Procurement Committee oversight routinely reported to Finance and Performance Committee						
QEF Finance Report routinely presented to Finance and Performance Committee for assurance						
Leading indicators developed and reported to F&P Committee for assurance						
Assurance (Level 3 – external)						
Internal audits provide assurance over financial systems and controls – accounts receivable (good), accounts payable (reasonable), capital planning and monitoring (good), waivers (reasonable).						
ICB oversight meetings in place						
Unqualified audit opinion issued for 22/23						
'Good' Head of Internal Audit opinion issued for 22/23 – provides external assurance over control environment						

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

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



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

Links to risks on the ORR:	FIN 3127 - There is a considerable risk that the Trust is unable to meet the financial projections included in its plan. (was 20 now 16 in line with Committee decision in October)

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

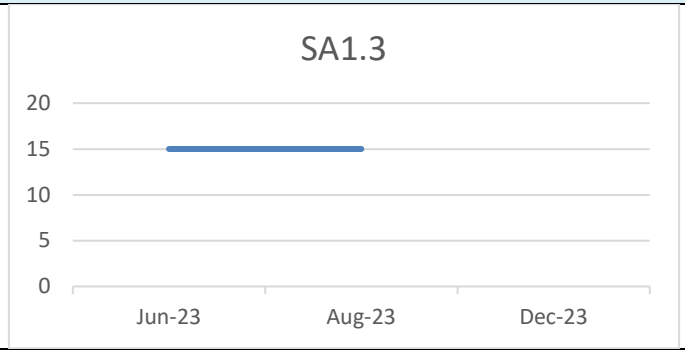
QEF commercial strategy in place		A need to ensure the appropriate governance structure is in place to support the delivery of the collective vision for QEF and provide assurances back to the Trust Board and F&P Committee. Independent governance review to be commissioned to inform this.	CEO	~~June 2023~~ July 2023 December 2023	May 23 – review commenced and due to report at the end of June 23. June 23 – verbal feedback to be provided 28 June with the written report to follow in July 23. Oct 23 - action log developed following time-out session and consideration of report. Priority actions identified. Proposed date for completion of priority actions Dec 23 – date change requested.	**On track**
Strategy session between the Board and QEF held – shared vision now in place.						
QEF Strategy agreed at extraordinary Board – 4 Sept						
Assurance (Level 1: Operational Oversight)		**Gaps in assurance and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Weekly senior management meetings in QEF with reporting to QEF Board						
Commercial divisions within QEF report to QEF Board on progress made						
Assurance (Level 2: Reports / metrics seen by Board / committee etc)						
QEF quarterly reporting to F&P Committee						
QEF reporting to Board twice per year						

Assurance (Level 3 – external)	[redacted]					
	[redacted]					

Digital Committee (SA1.3)

Strategic objective:	SA1.3 Ensure that there is a Digital first and data led approach to transformation and improvement across all domains of activity in order to contribute to delivery of the key indicators by March 2024
Executive Owner:	Group Director of Finance and Digital
Board Committee Oversight:	Digital Committee
Date of Last Review:	August 23 Digital Committee
Summary risk	

There is a risk that the Trust is not able to access / utilise digital technologies to greatest effect, impacting upon the ability to drive improvements in service provision and deliver against the leading indicators as well as increasing the risk of critical system failure.



CURRENT RISK SCORE			TARGET RISK SCORE		
Likelihood	Impact	Score	Likelihood	Impact	Score
3	5	15	2	5	10

Links to risks on the ORR (as at June 23):	COO 2945 - Risk of ineffective and inefficient management of services due to availability and access to appropriate and timely BI. (12) IMT 1797 - Risk of failure to review appropriate information across multiple sources of clinical records stored in both system and paper format leading to potential patient harm. (was 16 now 12)

Controls	Gap in controls and corrective action	Owner	Timescale	Update	Action status
Digital re-prioritisation and engagement exercise completed to ensure digital delivery plan is realistic based on current resource.	Digital Strategy delivery plan to be developed.	Nick Black, CIO	Sep 23	Gap assessment underway.	**Started and on track**
Digital Transformation and Digital Assurance Groups in place.	Agree OBC for Electronic Patient Record system	Nick Black, CIO	Oct 23	OBC for EPR agreed by Execs in February 23. Asked to be re-validated following market engagement.	

					Nov 23 – new market engagement event arranged for 13 Dec. Revised deadline required to be agreed for closure of this gap.	
Significant stakeholder engagement to seek views on digital aspirations and challenges within the Trust to inform future developments.		Agree FBC for Electronic Patient Record system	Nick Black, CIO	Oct 24	Follows OBC review Nov 23 – as above. A revised deadline will need to be agreed here to enable appropriate monitoring.	
Engagement of Channel 3 Consulting to lead options appraisal, outline business case development and requirements specification work on the electronic patient record (EPR) plan.		Implementation of additional layer of project governance to provide control, ownership and assurance on the delivery of digital programmes.	Adam Charlton	Jun 23	Nov 23 – update to be provided at the December meeting.	
Systems management audit programme.						
Structured project management and change control procedures						
Clinical Safety resource in place to oversee and manage best practice process.						
Board approved Digital strategy in place						
Qualified Cyber security specialist in place						
Prioritisation matrix in place to support the management of risks to the digital delivery plan						

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

		identified EPR solution is required to ensure the Trust is ready to benefit from funding should / when it becomes available.			Channel 3 and is currently with key stakeholders for review. Meeting held with CEO and Group Director of Finance & Digital to verify approach 4th May Next steps - develop RFI/market engagement document and have a showcasing day to view the possibilities of the suppliers on the patch (ICS/national requirement) It has been confirmed regionally that no known funding is available. June 23 – EPR outline business case approval now anticipated for Nov 23 following clinical review. Nov 23 – new market engagement event arranged for 13 Dec. Revised deadline required to be agreed for closure of this gap.	
Assurance (Level 2: Reports / metrics seen by Board / committee etc)						
Digital delivery plan reviewed by Digital Committee at each meeting		Committee identified that greater assurance over data quality would be beneficial to see at Digital Committee. Work is being progressed through the Digital Assurance Group to expand the data quality reporting and will be reported to Digital Committee following this.	Chief Digital Information Officer	Jun 23	Nov 23 – update to be provided at the December meeting.	**On track**
Digital & Data Strategic objectives update report reviewed by Digital Committee		KPIs: Committee requests further assurance in the form of narrative explanations for the items RAG-rated as red in the Digital Service KPI report	Chief Digital Information Officer	Feb 23	Apr 23 – this remains a work in progress, linked to action below regarding 'leading	**Overdue**

				indicators' Nov 23 – as required, the KPIs were escalated to Board in September 23 as part of the Digital Committee reporting. An action plan has been developed and escalation processes are in place.	
Digital & Data KPIs reported to Digital Committee	KPIs: Risk Management Programme with IAOs at 22% compliance vs 100% target. Improvement plan and interim targets requested.	SIRO	Jun 23	Apr 23 – compliance routinely reported to SMT for management action. June 23 – issue identified by the Committee for Board escalation Nov 23 – confirmed that this has been escalated to Board and to Audit Committee.	**Overdue**
AuditOne outstanding actions – progress report presented to Digital Committee	KPIs: Review of digital KPIs is taking place with high level indicators to be developed and aligned to the emerging 'leading' indicators.	Head of Digital Transformation and Assurance	Jun 23	Apr 23 – commenced June 23 – lack of progress on delivery of some KPIs to be escalated to Board. Nov 23 – as required, the KPIs were escalated to Board in September 23 as part of the Digital Committee reporting. An action plan has been developed and escalation processes are in place.	**Overdue**
Digital workforce capacity tracker reviewed at Digital Transformation Group					
Digital Committee receives tracking report on open audit actions to monitor implementation					
Assurance (Level 3 – external)					
AuditOne reports – Docstore IT General Controls (reasonable), Cyber Incident Response Planning (reasonable), Health Information Exchange (good), Outpatient	Complete Peer Review and submit National Digital Maturity Assessment return	Chief Digital Information Officer	Jun 23	June 23 – peer review was completed in May 23 and submitted to NHSE. The results will be considered in a	**Complete**

Digital Programme (substantial), DSP Toolkit follow-up (moderate), IT Change Management (limited), IT Asset Management (limited)	[redacted]				follow-up piece of work to understand development opportunities.	
Global Digital Exemplar Fast Follower accreditation	[redacted]					
Digital Maturity Assessment and peer review completed	[redacted]					

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 9ii

Report Title:	**Quarterly Strategic Aims and Objectives Q2 Update**			
Name of Meeting:	Trust Board			
Date of Meeting:	29 November 2023			
Author:	Executive Directors Nicola Bruce, Interim Director of Strategy, Planning and Partnerships			
Executive Sponsor:	Executive Directors			
Report presented by:	Nicola Bruce, Interim Director of Strategy, Planning and Partnerships			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
	To provide assurance over progress made towards the delivery of the strategic objectives for 2023/24.			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☒ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	Board committees have considered the objectives which have been mapped to them.			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	• The Board of Directors approved the strategic objectives for 2023/24 at their meeting in May 2023. • Strategic objective delivery action plans have been developed by Executive Director owners of each of the objectives since this time. • They have been reviewed by the relevant Board Committee. • This report presents a Quarter 2 update on the delivery of the strategic objectives for 2023/24. • Note that there has been a request to amend the delivery date on two of the actions associated with strategic objective SA1.3 that is aligned to the Digital Committee. Also a request to split actions associated with one of the objectives relating to digital knowledge and skills. This request is to better reflect work that is underway.			
Recommended actions for this meeting:	The Board is requested to:			

<table>
<tr><td>Outline what the meeting is expected to do with this paper</td><td colspan="5">review the accompanying action plan summary contained within this report
consider and approve the request to amend the delivery dates for SA1.3 and split the actions associated with delivery
note progress towards delivery of the strategic objectives in 2023/24.</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:</td><td>Aim 1
☒</td><td colspan="4">We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>Aim 2
☒</td><td colspan="4">We will be a great organisation with a highly engaged workforce</td></tr>
<tr><td>Aim 3
☒</td><td colspan="4">We will enhance our productivity and efficiency to make the best use of resources</td></tr>
<tr><td>Aim 4
☒</td><td colspan="4">We will be an effective partner and be ambitious in our commitment to improving health outcomes</td></tr>
<tr><td>Aim 5
☒</td><td colspan="4">We will develop and expand our services within and beyond Gateshead</td></tr>
<tr><td>Trust corporate objectives that the report relates to:</td><td colspan="5">All</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">Risks which may pose a threat to the delivery of the corporate objectives are recognised via the Board Assurance Framework.</td></tr>
<tr><td>Has a Quality and Equality Impact Assessment (QEIA) been completed?</td><td colspan="2">Yes
☐</td><td colspan="2">No
☐</td><td>Not applicable
☒</td></tr>
</table>

					Quantity			12	32	2			
Strategic Aim	Strategic Objective	Summary of Actions	How	Action Owner	Start Date	End Date	Overdue	Some Risk	Work in Progress	Action Complete	Completion Date	Expected Outcomes/measures	Comments/progress
1) We will continuously improve the quality and safety of our services for our patients	SA1.1 Continue to improve our maternity services in order to improve performance against key indicators and ensure improved patient outcomes by March 2024. Executive Lead - Chief Nurse Assurance Committee: Quality Governance Committee	Assess and benchmark performance against key national inquiry reports in order to assure safety and promote learning	Action plan to be developed and implemented according to findings and monitor impact via quality committee.	JC	Apr-23	Mar-24						Delivery of the 19 safety priorities and improvement in the maternity metrics outlined and reported in the IOP	National maternity and neonatal plan has now been published. Gap analysis has been completed and we have joined with the regional team to agree how we implement some of the actions. We are linking this year 5 maternity incentive scheme. Concerns remain about our ability to achieve safety action 8 because of the significant cost of training and backfill. Options are being considered
		Assess and Implement the agreed plan for maternity Continuity of Carer and seek to measure improved outcomes according to expected benefits aligned to leading indicators.	Maternity team to be reconfigured to meet actions outlined in the MCOC plan	JC	Apr-23	Dec-23					Jun-23		We have met with staff and consulted on a range of options. The option chosen was to continue with one team and some enhanced support for the most vulnerable women. This has been implemented and is being evaluated. No further changes will be made at this stage.
		Implement any actions from the maternity CQC inspection 2023	Develop and implement action plan once final report is received and measure the impact, reporting via quality committee	GF/JC	Apr-23	Mar-24							The final CQC report has been received and actions have been added to the Trust wide CQC plan
	SA1.2 Develop and implement a continuous Quality improvement plan that enables the delivery of improved performance against key indicators by March 2024 Executive Lead - Chief Nurse Assurance Committee: Quality Governance Committee	Review, refresh and implement Quality Account Priorities to ensure that they align with Trust core goals and contribute to the agenda of reducing LOS	Implement the actions within the Quality Account and monitor the progress and impact on a monthly basis via divisional performance and quality governance meetings	GF	Apr-23	Mar-24						Quality Account Priorities achieved	Quality account actions have been presented to Quality Governance Committee and agreed. Actions will be monitored via the safecare risk and patient safety
		Monitor Quality Account Priorities implementation	Monitor the implementation plan for the Quality Account Priorities at SafeCare, Risk and Patient Safety Council	GF	Apr-23	Mar-24							Action plan is on the cycle of business for the safecare, risk and patient safety council.
	SA1.3 Ensure that there is a Digital first and data led approach to transformation and improvement across all domains of activity in order to contribute to delivery of the key indicators by March 2024 Group Director Finance and Digital Assurance Committee: Digital Committee	Enhance the basics - We will provide fast, modern, safe technology and services that users want and can rely on	Undertake the national Digital Maturity Assessment, user experience surveys and develop an improvement plan.	NB	Feb-23	Mar 24 ~~23/09/2023~~						Agreed Electronic Patient Record plan Improved data quality and data driven decision making Improved patient outcomes and staff experience	Q2 Update: Partially complete - DMA completed and peer reviewed, gap analysis complete. User surveys complete/ongoing. Outstanding - Development of the improvement plan is linked to the completion of the EPR OBS and due to delays in the supplier engagement and therefore collating stakeholder feedback this has been delayed. The date has been amended to reflect the current/revised date aligned to the EPR OBS. Q1 Update: Digital Maturity Assessment completed in draft; gap analysis currently taking place and will inform the specification for the EPR proposal.
			Implement the data quality strategy and develop indicators that provide assurance on clinical systems use and clinical coding depth.	NB	Dec-23	Mar-24							Q2 Update - Unable to progress KPIs specifically linked to the data quality strategy as this is outstanding. The initial draft was rejected in Oct 23 and information & performance team are progressing. Digital KPI reporting is established and under review, cross service working with performance and information is required to deliver and ensure integration with cross trust performance reporting. Initial scoping meeting to be arranged. Q1 Update - Some digital indicators developed and built into DAG reporting. This will be shared with service representatives to support an increase in this area. Looking at KPIs to track both digital performance and trust compliance with the ability to drill down to business units/service level.
		Deliver Improvements - We will provide technology to reduce inefficiencies, poor processes and duplicate records	Develop and agree the electronic patient record outline business case with full clinical ownership.	CB	Dec-21	Mar 24 ~~23/12/2023~~							Q2 Update - The market engagement event for the EPR had to be rescheduled due to industrial action, this represents a 3 month delay in the proposed procurement timeline; the date has been updated accordingly. There are 4 EPR suppliers scheduled to join the trust to present their EPR offering at the CSG away day in December. Feedback from this event will be used to enhance the draft specification and develop the supporting business case. Q1 Update - Outline business case agreed in February 23. Checkpoint requested to ensure full clinical ownership. Market engagement sessions to be arranged Autumn 2023 to agree the right strategic direction for the Trust.
			Develop a systems and data exploitation plan that supports the delivery of leading indicators, supporting safe and efficient patient care.	DT/DR	Apr-23	Mar-24							Procedure for system exploitation management currently being developed. Initial roadmap to focus on agreed activity for 23/24. Longer term developments not started - longer term plan linked to the outcome/discussions regarding EPR.
			Expand access to patient record, results and images from across the region; sharing our data to support patient care cross the ICS.	CB	Dec-22	Mar-24							Q2 Update - this is a regional programme led by the ICB's PMO. There has been delays in the programme relating to the technical processes which have now been resolved and ongoing delays with clinical sign off across all engaged trusts. GHFT continue to support the project and progress locally. Q1 Update - Global worklist testing completing, awaiting neighbouring Trusts. Delays in project due to regional timescale and cross organisational clinical sign off.

					Quantity			12	32	2			
Strategic Aim	Strategic Objective	Summary of Actions	How	Action Owner	Start Date	End Date	Overdue	Some Risk	Work in Progress	Action Complete	Completion Date	Expected Outcomes/measures	Comments/progress
		Open, share and transform - We will focus on joining up the needs of the user across the whole patient pathway	Implement a patient portal to empower patients to manage their own health and care, and enable services to interact digitally with the patient.	CB	Mar-23	Dec-23							Q2 Update - Partially complete - The Health Call Patient Engagement Portal is the patient portal linked to the Great North Care Record. GHFT completed a successful pilot with the breast screening service, bringing together the PEP and the trusts hybrid mail solution meaning that patients at Gateshead were the first to go live with enhanced functionality - accessing both appointment information and supporting correspondence within the PEP. The trust continue to rollout the PEP to services according to the project timeline. Services live include •**S**ymptomatic Breast •**T**rauma & Orthopaedics •**A**udiology •**D**ietetics & Nutrition Next services to go live: •**R**heumatology •**G**astroenterology •**G**eneral Surgery Q1 Update - Contract in place, project work underway. Pilot clinic (breast) to go live July 23 with other areas to follow. GHFT to be the first trust to go live with supporting correspondence (linked to hybrid mail solution)
		Invest in people - We will focus on enhancing the skills and knowledge of the user involving them in digital	Implement the digital skills and inclusion plan for staff and patients; undertaking a workforce survey, completing a business case if required.	CB	Nov-22	Mar 24 ~~23/09/2023~~							Q2 Update - Patients, Citizens and Staff GHFT are a key contributing member of the Gateshead Digital Inclusion Group. This group is led by the local authority and comprises of health, social care, education, and charitable organisations at a Gateshead Place level. The group are collaborating to develop a Gateshead Digital Inclusion/equality strategy with a target date of December. The intention is that this will further be refined to a supporting organisation level action/delivery plan. Current activities of this group include a organisational skills survey which will also feed into the identification of the needs of our employees. The Group were shortlisted for a 'Dynamite Award' in the category "Equality, Diversity, and Inclusion" with the ceremony taking place 16/11. Staff Specific In addition to the activity above, a baseline assessment of current digital skills across our workforce will be undertaken to support the development of the EPR business case and will form the foundation of the training strategy for any subsequent deployment. NB It is suggested that this objective is split into two to allow for appropriate tracking of the two workstreams. Q1 Update - Talent management discussions have started in Dec 22, with a view to implement Scope for Growth talent management. Action plan currently being developed with the support of OD. Digital inclusion for patients - linked in to discussions at a place level.
	SA2.1 Caring for our people in order to achieve improved compliance of key indicators by March 2024 **Executive Lead - Executive Director of People and OD** **Assurance Committee: People and OD Committee**	Getting the basics right and looking after you in every way we can.	Providing a working environment where all basic needs are met for all colleagues working within the organisation.	LF	Apr-23	Mar-24						**Key Indicator: Absence rate reduction to 5% by March 2024** **Even better if target of 4.8% by March 2024**	Vending machines have been changed across the site to enable card payment. Out of hours catering offer continues. During strike action, free catering provision continues to be provided as part of the standard response. Work underway to place coffee machines in the Surgery Centre and on the Bensham site. Two junior doctor messes that have been renewed, refreshed and are accessible across the QE site. All existing offers remain and in addition, a review of out of hours catering has been completed in partnership with QEF, with a number of different options scoped. The option currently leading is the introduction of a new 24-hour vending machine that would replace the current vending machine and offer more cost-friendly and diverse meal options. Contract termination implications are being explored and a proposal paper is currently being developed by Associate Director of Estates and Facilities, ready for presentation to SMT.
			Working in partnership with managers to support the needs of our people.	DB	Apr-23	Mar-24							Managing Well and Leading Well embedded as part of the development offer for people managers and leaders across the organisation. Professional policy training has been commissioned by Capsticks to provide a legal lens in addition to internal training supporting key policies including Grievance, Investigation/Disciplinary and Promoting and Supporting Attendance. Matrix approach and model of working across POD is well embedded, provides the foundations for supporting managers and providing access to specialist skills and expertise to support them in meeting the needs of their people. Policy Training has now moved back to internal delivery. LTS Clinics are creating capacity and building managers capability in the delivery of procedural excellence. Matrix Approach continues.
			Embedding an organisational wellbeing culture embedded and aligned to the national Health & Wellbeing Framework.	LF	Apr-23	Mar-24							Continue to deliver against the three workstreams set out in the HWB strategy. The HWB Manager position has now been permanently recruited too. The Trust have also been awarded Silver Status for the Better Health at Work Award - which measures our activity against nationally recognised benchmark standards. The Health & Wellbeing Board is now closed and is succeeded by a bi-monthly engagement forum. Work continues on the delivery of the HWB Strategy and funds were secured to extend the Health & Wellbeing Facilitator role for another 12 months, to support the Health & Wellbeing Manager in delivery against objectives.
			Target driven, efficient and effective approach to promoting and supporting attendance and a coaching approach to supporting managers.	DB	Apr-23	Mar-24							Absence management policy refreshed and relaunched on 1 October 2022. A collective leadership approach has been taken between POD team and operational around short term absence in addition to a target setting approach via case conferences having being introduced for long term absence. Professional training for managers has been designed and delivered by Capsticks, going forward this training will be carried out locally with our POD Advisory and L&D Teams. Although absence % has increased, we have grip and control through the robust LTS oversight, monthly clinics and target yet compassionate approach to absence management. Management capacity and capability has increased through dedicated support and focused approach to absence management. Each business unit receives monthly Short Term and Long Term absence reports and analysis of the attendance position in their area.
	SA2.2 Growing and developing our people in order to improve patient outcomes and reduce reliance on high cost agency staff by March 2024 **Executive Lead - Executive Director of People and OD**		Providing a professional and comprehensive customer focused Education, Learning and Development service to the organisation, working with services to ensure our people have the appropriate learning and professional development alongside a well-established core skills training programme.	SN	Apr-23	Mar-24						**Key Indicator: Vacancy rate reduction to 5% by March 2024** **Even better if target of 4% by March 2024**	The Trust's first Learning at Work week was launched and ran in May 2023. L&D Facilitators have been working in partnership with business units to identify performance and development gaps and undertaking a comprehensive gap analysis. The Learning Needs Analysis is becoming embedded in the systems of the Trust enabling leads, managers and individuals to highlight training and development requirements. Each entry is reviewed and action taken. As a Trust we have also developed a key partnership with CBC, the voluntary sector and the local authority to run place based joint workforce development offer and approach through the Gateshead Health and Care Academy. Work is progressing on the review of core skills requirements, with all areas identifying a Statutory and Mandatory Training Link. A pilot of the revised process is underway.

					Quantity			12	32	2			
Strategic Aim	**Strategic Objective**	**Summary of Actions**	**How**	**Action Owner**	**Start Date**	**End Date**	**Overdue**	**Some Risk**	**Work in Progress**	**Action Complete**	**Completion Date**	**Expected Outcomes/measures**	**Comments/progress**
2) We will be a great organisation with a highly engaged workforce	**Assurance Committee: People and OD Committee**	Building our workforce and helping you be the best you can be.	Develop a Trust wide strategic approach to workforce planning that is informed by population health needs, local and national strategy. With an ability to forecast and horizon scan.	NB	Apr-23	Mar-24							Work completed with Whole Systems Partnership to lead us through a process to explore and adopt a strategic approach to workforce planning. Final report received, which has been developed into a draft action plan. To be discussed with Trust management to then operationalise and ensure integration and alignment. Although the work undertaken to date contains both the approach and essential data and tools to enable a plan to be generated, it does not constitute a workforce plan it its current form as workforce plans require connection with the Trust Boards strategic goals, financial constraints and an assessment of opportunities. Delays in progressing this since last PODC due to capacity issues. Ability to progress will depend on dedicated resource to be able to progress and being able to put a formalised, structured approach in place that involves multiple stakeholders. A session on the NHS Long Term Workforce Plan was delivered at Trust Board Development Day on 23 August 2023.
			Have an agreed Trust wide retention strategy which includes a customisable range of high impact, effective tools that are deployed at a local level, depending on service need.	NB	Apr-23	Mar-24							A focus on retention paper has been drafted to present at November POD Committee to provide an overview of what our leavers data is telling us, review our position against the NHS Employers retention standards that form part of the national retention programme and provide recognition of what we are doing well and what future action needs to be taken. Ability to progress will depend on dedicated resource to be able to progress and being able to put a formalised, structured approach in place that involves multiple stakeholders. Exit Interviews currently being explored with a pilot of a new approach that increases feedback channels currently being conducted.
	SA2.3 Being a great place to work in order to improve staff survey outcomes and impact upon patient outcomes within 2-years. **Executive Lead - Executive Director of People and OD** **Assurance Committee: People and OD Committee**	Being a values led organisation with compassionate and inclusive leadership, where you have a long, lasting and valuable career.	Leaders will role model compassionate, inclusive and collective leadership in all of their interactions, aligning with our ICORE Values and the national Our Leadership Way Framework.	LF	Apr-23	Mar-24						**Leading Indicator: Maintain a target engagement score of 6.9 by March 2025.** **Even better if target of 7.5 by March 2025.**	One area of improvement noted in the 2022 staff survey was around "Your Manager", which saw the scoring for every question significantly improve, indicating a positive shift. Both Managing Well and Leading Well are successful, well embedded development programmes across the Trust but as part of POD's commitment to continuous improvement are due a review to ensure that these are still current and reflecting our direction of travel as an organisation under new leadership to best support the organisation to be clinically led and managerially supported. As Leading Well winds down for 2023, the feedback received continues to be extremely positive, with colleagues finding the development a valuable addition to their role. The Learning & Development team have also recently launched a New Managers Induction, to support those moving into management positions within the Trust, ensuring there is consistency in message around expectations and behaviours. Work is underway on a STAMP It Out. zero tolerance campaign, with a focus on irradicating bullying, harassment, discrimination and abuse from all colleague, patient and service user interactions. A stakeholder working group has been established and an engagement event planned for the 24 November 2024.
			Flexible working practices will be commonplace across all staffing groups.	AV	Apr-23	Mar-24							The Trust's Flexible Working Policy has been updated to reflect changes to Section 33 of the national terms and conditions and also the NHS People Promise. Comms has started around this including why flexible working matters and that it is for everyone regardless of role, grade, or the reasons for wanting to work flexibly, with further communication and access to information planned. The Trust's Homeworking policy is due to be updated and this will consider Agile Working more broadly that just home working. However a true cultural shift is required to make this common place moving forward, with role modelling at all levels of the organisation. A workshop is also scheduled for November including operational management and professional nursing lead representatives.
			Continue to work closely with our Freedom to Speak up Guardian, enabling and supporting colleagues to Raise Concerns where they need to, encouraging and facilitating a working environment where we can all speak up and speak out about issues that concern us.	AV	Apr-23	Mar-24							New National FTSU Policy and guidance launched, and Trust paperwork being updated. Full time FTSU Guardian appointed who commenced in role in October 2023 and this role has moved to sit within the POD Directorate. 9 voluntary Champions have been appointed, all of whom have received induction training, with an on-going comms / recruitment plan in place to recruit more Champions. A national reflection and planning tool has been completed with actions to be reviewed on an on-going basis.
			Work closely with the Trust EDI and engagement lead to provide support, experience and opportunities to promote, embed and champion the Inclusion agenda and Trust strategy.	AV	Apr-23	Mar-24							The Trust's EDI and Engagement Manager joined the POD Directorate at the beginning of July 2023. The Trust's EDI strategy has been approved by SMT and the HREDI Programme board have deliberated the strategy and incorporated this into the overarching EDI action plan.
	SA3.1 Ensure that there is a strong focus on improving productivity and efficiency and best use of resources in everything that we do to meet the required performance standards/recovery requirements by March 2024. **Executive Lead - Chief Operating Officer** **Assurance Committee: Finance and Performance Committee**	Assess and benchmark services using tools including Model Hospital, GIRFT, the national cost index and other datasets to understand our position and opportunities to improve. Returning to the delivery of constitutional standards (egg zero >52 week waiters)	Via the Sustainability Programme and in particular Making Services Sustainable, Productivity and Planning workstreams.	JH	Apr-23	Mar-24						**Monitored via the Integrated Oversight Report and Leading Indicators. Achieved through Delivery Oversight board, Performance Clinics and Monthly Oversight meetings**	Plans in place to focus on increasing productivity through a variety of workstreams and will be monitored through the Delivery Oversight Group. Access & Performance meeting were refreshed in October 2023 under the Interim Chief Operating Officer to review activity recovery plans in depth by specialty. A dedicated Strategic Finance Business Partner for Costing and Transformation is now in post to support with Model Hospital and other benchmarking tools and analysis.
		Ensure we monitor the return on investment of all business cases relating to operational performance.	Via the business case review group.	JH	Apr-23	Mar-24							Return on investment of the New Operating Model (NOM) linked to performance is subject to ongoing review. Estates work associated with the NOM are due to complete in November 2023. The Trust's Business Case Review Group (BCRG) are reviewing the process to measure return on investments.
3) We will enhance our productivity and efficiency to make the best use of our resources	**SA3.2 Achieve financial sustainability by in-year delivery of Trust CRP plan and development of robust sustainability plan for delivery within 3-years**	In year activity to deliver against the financial plan through the development, implementation and monitoring of clinically led CRP plans	Use of financial accountability framework and internal focus on delivery of cost improvement programme. Supported by robust budget monitoring and reporting to F&PC - capital and revenue. Establish a monitoring forum to manage and report in month variance to plans.	KM	Apr-23	Mar-24						**Delivery of the financial projections as per submitted phased plan.** **Production of robust and achievable financial sustainability/recovery**	Weekly CRP working group replaced by Delivery Oversight Group. This group meets fortnightly and reports on delivery against eight key workstreams: digital, estates, finance, workforce, productivity, planning, making services sustainable and innovation, improvement and transformation. The outputs of which are monitored closely at EMT but monthly reporting into FPC. Separate finance engagement sessions form part of the finance workstream action plan.

					Quantity			12	32	2			
Strategic Aim	Strategic Objective	Summary of Actions	How	Action Owner	Start Date	End Date	Overdue	Some Risk	Work in Progress	Action Complete	Completion Date	Expected Outcomes/measures	Comments/progress
	Executive Lead - Group Director of Finance and Digital Assurance Committee: Finance and Performance Committee	Ongoing focus on financial sustainability to improve the underlying financial position through assessment of service vulnerability and sustainability and using benchmarking tools to robustly assess efficiency at scale.	Ongoing assessment of underlying run rate, increase in effective organisational communication and engagement, use of benchmarking information and HFMA checklist. Continually horizon scan for developments and opportunities. Optimise estate strategy to reduce estate and seek to increase home working to optimise recruitment and minimise costs.	KM	Apr-23	Mar-24						plan that returns the organisation to financial balance.	HFMA checklist, grip and control tool and internal audit actions being monitored by finance and performance committee. Restructure of finance function established a small team dedicated to efficiency and transformation, including use of benchmarking information. Finance team are servicing the system working on the MTFP which is predicated on a robust understanding of the underlying run rate position. Organisational awareness of and engagement in the financial position is part of the Finance workstream.
		Automation of transactional processes optimising digital impact and reducing cost.	Work collaboratively with digital and transformation teams to utilise RPA function.	KM	Apr-23	Mar-24							Digital service have requested services propose further projects that virtual workers could be deployed to support. Michael Smith, Assistant Director of Finance for Governance and Control is leading on automation within the finance function. Key projects are being identified and scoped.
		Enhance capacity and capability of the finance team.	Complete recruitment to new structure and supporting organisational development programme of work.	KM	Apr-23	Mar-24					Jul-23		Organisational development work is underway with the finance team. Commencing with clarity in roles and responsibilities and ensuring tasks are allocated appropriately. Operational workplan is aligned to delivery of priorities and Trust Strategic objectives. New Assistant Director of Finance for Strategic Finance is in post and has an overriding objective to support cultural development and improved reporting.
	SA4.1 Identify key local health inequalities challenges and ensure improvement plans are in place by March 2024 Executive Lead - Medical Director Assurance Committee: Quality Governance Committee	Mitigating against 'digital exclusion' ensuring providers offer face to face care to patients who cannot use remote services and ensure more complete data collection to identify who is accessing face to face /telephone/video consultations is broken down by patient age, ethnicity, disability status	Included in the data scoping will be to review DNA and link with the learning disability team and also the MECC community teams.	AB	Apr-23	Mar-24						The delivery of an agreed health inequalities action plan and implementation of the Health Inequalities Strategy	Work in progress around outpatient transformation
		A framework for action across the NHS: Core20plus5 is NHS England's new approach to tackling health inequalities. It focuses on improvements for the most deprived 20 per cent of the population (core20), reducing inequalities for population groups identified locally (plus) and accelerating improvements in five clinical areas (5).	A gap analysis to be completed across the 5 clinical areas. Maternity, severe mental health, chronic respiratory disease, early detection of cancer and hypertension.	AB	Apr-23	Mar-24							Work is due to start - we have recruited an individual on secondment to collate the work already underway which will allow us to identify were we have gaps
4) We will be an effective partner and be ambitious in our commitment to improving health outcomes	SA4.2 Work collaboratively as part of Gateshead Cares system to improve health and care outcomes to the Gateshead population Executive Lead - Chief Operating Officer Assurance Committee: Quality Governance Committee	Work in partnership to influence and shape the place based vision. Increase clinical visibility within place	Map out meetings to ensure appropriate representation from the trust and carry out engagement by CEO & MD with key stakeholders	AB	Apr-23	Mar-24						Secure our alignment to Gateshead Place to achieve best outcomes for residents closer to home and reduce the reliance on the acute Trust. Develop strategic partnerships to ensure we are the delivery partner of choice within Gateshead.	Gateshead Health continue to be an active partner within Gateshead Cares System Board. Focus has been on health, housing and safety with all staff within Community Division now aware of recent guidance to improve this and referral routes to LA. Worked with LA to develop and submit the Better Care Fund submission focusing on improving and expanding health and social care services outside hospital to reduce admissions and improve health. Working with partners to develop a system level winter plan Support to Health and Wellbeing Board to review and agree the "Gateshead Plan" relating to ICB metrics. Increased clinical presence in place based discussions following re-direction of MD job plan and introduction of MD of Operations. MD is deputy chair for IPC Committee at (Gateshead) Place
5) We will look to utilise our skills and expertise beyond Gateshead	SA5.1 We will look to utilise our skills and expertise beyond Gateshead in order to ensure organisational sustainability and contribute towards innovative care and provision within 23/24 Executive Lead - QE Facilities Director Assurance Committee: Finance and Performance Committee	Undertake SWOT analysis of future commercial opportunities for the trust and QEF in order to prioritise and establish commercial strategy for delivery.	Stakeholder engagement internal and external	SH	Apr-23	Dec-23						Development of a commercial Strategy	Presentation by QEF shared at Trust Strategy session held on 26/4/23 which included a SWOT analysis and areas of potential growth. This was further shared at the Medical Staff Committee held on 20/6/23 to understand the aspirations of clinicians and how QEF can help realise these linked to work being undertaken on sustainable services and Trust strategy. Trust Board Development session held on 18th October included SWOT and PESTEL and strategic positioning. Director of Strategy, Planning and Partnerships met with Commercial Director at Health Innovation Network (prev. Academic Health Science Network (AHSN)) to explore opportunities for development. This includes the potential to join the Health and Life Sciences Pledge.
		Identify through the Making Services Sustainable work which services we can grow and develop	Engage with CSG. Clinical services to complete a review making recommendations for consideration;	NBr/KR	May-23	Dec-23						Service Sustainability Plan developed for board approval by December 2023	Work shared with CSG 10/5/23 followed by the development of a template for completion by teams to determine the clinical assessment of services - fragile, vulnerable or exceptional (phase 1). Numerous returns received that are being worked through to determine any gaps or immediate vulnerabilities. Corporate working group established and met 13/6/23 with clinical leadership from the Medical Director of Operations. Clinical assessment complete. Business / economic viability assessment underway. Needs to link to 2024/25 planning and strategic positioning discussions.

Gateshead Health NHS Foundation Trust

Agenda Item: 9iii

Report Title:	Organisational Risk Register (ORR)			
Name of Meeting:	Board of Directors			
Date of Meeting:	29th November 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:** ☐
	ORR 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. **InPhase** To provide an overview of current compliance with training of the risk module within InPhase and seek support to ensure organisationally agreed compliance level of 80% for go live to be implemented.			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☒ *No gaps in assurance*	**Partially assured** ☐ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by:	The attached report is now received in the Executive Team Meeting each week, and at the Executive Risk Management Group meeting every month.			

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*	**ORR** Accompanying Report shows the following and is detailed within this report. Risks on the ORR were comprehensively discussed at previous two ERMG meetings in October and November, and the following updates and movements agreed: -There were 4 risks added, 1 risk removed, and 3 risks reduced, demonstrating active management of organisational risks within policy timeframes. -5 actions have been completed in period and are shown (shaded) within the risk register on the accompanying report. -Compliance with risks reviews 79%. -Compliance with actions reviews 94% **InPhase** The contract with InPhase is now live due to the launch of the incident management application going live to meet national LFPSE requirement, however the Enterprise Risk Management Application for InPhase, has not yet been able to go live due to a slow uptake in essential training for anyone with responsibility for a risk register or action. Current performance is 60% compliance and go live cannot take place until we reach a minimum of 80%. (as of 16th November 2023)	
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	The Board are asked to: • Review the risks and actions on the attached report and discuss and seek further information relating to risks as appropriate. • Take assurance over the ongoing management of risks on the ORR. • Be clearly sited on the top 3 risks for the organisation. • Note current compliance with risk training within InPhase and provide supportive conversations to risk owners to ensure agreed organisational compliance of 80%.	
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:	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 September- 16th November 2023 (extraction date for this report).

Organisational Risk Register – Movements

Following ERMG meetings in October and November 2023, there have been 3 additions to the ORR, 3 reductions and 1 removal.
There are currently 19 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.

New additions:
3277(CSS) - Risk of MRI service interruption. Potential to close department for 8-15 weeks. This will require mobile provision in the car park over winter month meaning staff and patient are exposure to poor weather conditions. Resulting in poor patient and staff experience. (20)
2373 (POD)- Staff exposure to incidents of violence and aggression from patients and visitors. (15)
3298 (POD)- Promoting an environment that encourages speaking out and creating a psychologically safe culture may lead to increased reports of poor behaviour, with a negative impact on staff and additional time needed to appropriately address the concerns. (12)

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

Risks Reduced:
3095 (POD)-Risk of Significant, unprecedented service disruption due to industrial action (16)
3127 (Finance) There is a considerable risk that the Trust is unable to meet the financial projections included in its plan. (16)

3261 (COO)- Failure to Deliver Operational Plan of Zero > 52 week waits by March 2024 (12)

Risks closed in period:

0 risks closed in period

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

Finance - 3 significant financial risks on the ORR.
Performance – Risk of delivery of performance targets (collective activity)
Reputation – Risk of maintaining trust and confidence in our services.

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

2. **Performance:**

- **3261 (COO)** There is a risk that the Trust will not achieve zero > 52 week waiters by March 2024. (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. **Reputation:**

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

Current compliance with Risk reviews within the Organisational risk remit:

Risk and action review compliance is currently at 79% and 94% consecutively. This is an improvement on last reporting period.
Support with reviews continues to be offered by Corporate and Clinical Risk Lead where able.

InPhase
InPhase incident management application launched in September 2023 in order meet national LFPSE requirements. However the Enterprise Risk Management Application has not yet been able to go live due to a slow uptake in essential training. As of 16th November 2023, compliance is 60%. The minimum agreed organisational figures have been set to 80% and therefore further work is required to ensure compliance is reached prior to go live.

Recommendations

The Board of Directors are asked to:

- Review the risks and actions and discuss and seek further information relating to risks as appropriate.
- Note current compliance with InPhase risk training and provide supportive conversations to risk owners to ensure agreed organisational compliance of 80%.
- Take assurance over the development and review of the Organisational Risk Register by the Executive Risk Management Group

Organisational Risk Register Report

Reporting Period: 01-Nov-2023 to 16-Nov-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)

Staff Safety - 1

POD 2373 - exposure to incidents of violence and aggression in ECC (15)

Wellbeing - 1

POD 3298 - Increase in incivility and disrespectful behaviours being reported (12)

Business Continuity - 2

IMT 1636 - 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 - 3

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)

Information Governance - 1

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

No Risks

Business Continuity - 1

CSS 3277 - Risk of no MRI facility in the hospital (20)

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)

Experience - 1

CEOL2 3255 - People may lose trust an confidence in our services (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 (16)

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

Compliance - 2

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

COO 3261 - Failure to Deliver Operational Plan of Zero > 52 week waits by March 2024 (12)

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

Organisational Risk Register Report

Reporting Period: 01-Nov-2023 to 16-Nov-2023

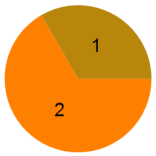
Gateshead Health NHS Foundation Trust

People & Resources

Sub Category

Resources
Staff Safety
Wellbeing

Cause



Resources/Skills
Systems/Processes

Quality Outcomes

Sub Category

Business Continuity
Effectiveness
Experience
Safety

Cause

Environment/Equipment
External/Partnership
Resources/Skills
Systems/Processes

Finance & Efficiency

Sub Category

Business Continuity
Digital
Finance
Information Governance

Cause

Environment/Equipment
External/Partnership
Finance
Resources/Skills

Regulation & Compliance

Sub Category

No Data Available

Cause

No Data Available

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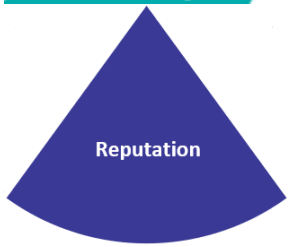
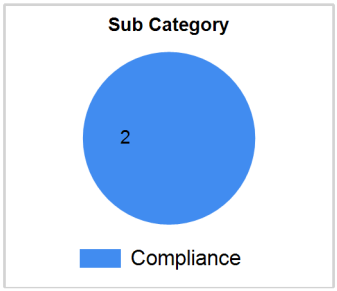
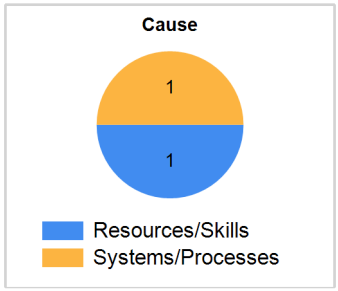
Organisational Risk Register Report

Reporting Period: 01-Nov-2023 to 16-Nov-2023

Gateshead Health NHS Foundation Trust







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

Organisational Risk Register Report

Reporting Period: 01-Nov-2023 to 16-Nov-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
3277 14/08/2023 Christopher Robson Clinical Support & Screening Diagnostics 15/12/2023 BU_DIR COO FPC ORG QGC SA1.2 Continuous Quality improvement plan	Risk of MRI service interruption. Potential to close dept for 8-15 weeks. This will require mobile provision in the car park which is not suitable for most IP scans. This will be over winter months which means patients on trolleys going outside exposed to cold weather. Further risk to staff health and well being as a result of not be able to work in the department and will have to work on mobiles scanners. Resulting in poor patient and staff experience.	20	Current service is still running until works commence after which no control in place. Negotiations in progress to source a mobile scanner to complete some of the functions of the existing service provision. provision of PPE to aide in colder weather.	20	Finalised plans	Anthony Pratt 01/12/2023	8	provision of procurement of mobile scanner on site underway
					Check pad	Phil Davidson 01/12/2023		
					Identify contractor to complete works	Anthony Pratt 31/12/2023		

Organisational Risk Register Report

Reporting Period: 01-Nov-2023 to 16-Nov-2023

Gateshead Health NHS Foundation Trust

2764 17/11/2020 Natasha Botto People and OD Human Resources 03/12/2023 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. 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. 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. November 2023- AV- Trust Interim Director of Strategy and Planning appointed and working closely to agree an integrated Trustwide approach to planning, including finance and performance	**16**	Transfer Window - establish as is position and action required to progress and operationalise	Sarah Neilson 31/12/2023	**8**	d/w AV- score to reamin as we do not have a robust workforce planning approach in place.review of controls and actions undertaken. 1 further action added for SN.
					Develop systems, processes and comms to support increasing exit interview completion rates across the Trust	Natasha Botto 31/01/2024		
					Review current retention offer and scope retention offer moving forward.	Natasha Botto 31/01/2024		
					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 28/02/2024		
					Education, learning and Workforce development group to continue work on the implications of the LTWFP and share proposals.	Sarah Neilson 31/03/2024		
					Health and Care Academy internal development opportunities scoped	Sarah Neilson (Completed 22/09/2023)		

Organisational Risk Register Report

Reporting Period: 01-Nov-2023 to 16-Nov-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 17/11/2023 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**	Improved noted, but remain a high rating at this stagem Will be reviwed again next month

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

Organisational Risk Register Report

Reporting Period: 01-Nov-2023 to 16-Nov-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 30/11/2023 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.	20	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.	16	Support twice weekly co-ordination cell and fortnightly industrial action Trust wide working group.	Amanda Venner 31/12/2023	8	d/w AV- reduced score to impact 4 and likelihood 3 so 16 overall. With no planned strikes notified the risk has reduced. The BMA are entering talks with the Government and we are hopeful this will enable a resolution to be found

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

Reporting Period: 01-Nov-2023 to 16-Nov-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
3102 22/08/2022 Kris MacKenzie Finance Finance 08/12/2023 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. november 2023- access and performance clinic work underway.	16	Timley and detailed reporting information Counting and Coding Review	Jane Fay 31/03/2024 Nick Black 31/03/2024	6	discussed at ERMG. no chane to remain on ORR
3103 22/08/2022 Kris MacKenzie Finance Finance 06/12/2023 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	retain risk rating- and remain on ORR - formal agreement at ERMG.
3127 17/10/2022 Kris MacKenzie Finance Finance 08/12/2023 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 F+P committee and agreed to reduce. formal agreement at ERMG to lower risk to 16. remain on ORR

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3255 27/06/2023 Gillian Findley Chief Executive Office Chief Executive Office 02/12/2023 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 people's trust and confidence in our services.	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 30/04/2024	8	risk has been reviewed and actions updated
1490 11/03/2014 Dianne Ridsdale Digital Digital Transformation and Assurance 29/10/2023 BAF BU_DIR DIGC ORG SA1.2 Continuous Quality improvement plan, SA1.3 Digital where it makes a difference	Risk of inappropriate access/use/disclosure of data. Due to failure to manage the information assets by IAOs across business units and corporate services. Resulting in patient harm, adverse publicity, failure to comply with National standards and contractual requirements.	25	Named System Administrator and Data Manager for every system Actively managed Systems Specific Security Policy (SSSP) for all systems - reviewing user access levels, training, configuration, testing, upgrade management - including business process changes etc Service owned Business Continuity Plan should systems fail Disaster Recovery Plan - how to recover the system Signed user registration forms Formal ITIL best practice change control procedure in place Formal Business case and project acceptance route through Digital Transformation Group Audit programme underway, focussed on critical systems	15	Bring resource in to support services to complete IARs Getting IAOs to take ownership of their information assets	Dianne Ridsdale 25/01/2024 Nick Black 31/03/2024	3	Agency was engaged - currently going through approval process

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2373 01/08/2018 Laura Farrington People and OD Workforce Development 11/10/2023 BU_DIR COO HSC ORG QGC	Staff exposure to incidents of violence and aggression from patients and visitors. Risk of harm to staff, risk to staff well-being through challenging behaviour demonstrated by some patients and/or visitors to ECC resulting in injury, increased absence from work, potential effect on recruitment and retention of staff, staff morale and confidence	20	policies in place to support staff training available reporting tools available forums for debrief/discussion and support available	15	Review of V&A policy	Kirsty Roberton (Completed 18/10/2023)	6	risk reassigned to POD following agreement at ERMG
2398 28/12/2018 Kate Hewitson Surgical Services Obstetrics 02/11/2023 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. 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 24/11/2023 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	20	Systems management audit programme. Approved Trust Digital Strategy (Jan 2023) 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	4	Discussions are still ongoing on how best to support ease of access to data/records and what systems are needed to support this approach, linking to the Digital Strategy.
					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 07/12/2023 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 31/12/2023	3	reviewed and actions updated

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2993 28/01/2022 Kirsty Roberton Chief Executive Office Corporate Services & Transformation 30/11/2023 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	Establish process for gaining assurance over policy compliance and embed	Kirsty Roberton 28/02/2024	4	review of controls and mitigations undertaken with KR. 1 action completed.
					Begin to address overdue policy backlog	Kirsty Roberton (Completed 26/09/2023)		
3089 25/07/2022 Gillian Findley Nursing, Midwifery & Quality Quality Governance 02/12/2023 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	implementation of winter plan	Jo Halliwell 29/03/2024	6	no change to risk or mitigations
					improve flow through hospital	Claire Ellison (Completed 15/09/2023)		

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3186 07/02/2023 Philip Glasgow Chief Operating Officer 11/11/2023 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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3261 05/07/2023 Debbie Renwick Chief Operating Officer Planning & Performance 07/12/2023 BU_DIR COO FPC ORG QGC SA1.2 Continuous Quality improvement plan, SA3.1 Improve the productivity and efficiency of our operational services through the delivery of the New Operating Model and associated transformation plans	There is a risk that the Trust will not achieve zero > 52 week waiters by March 2024. There are a number of services projecting long waiters over planned levels for multiple reasons Industrial Action, capacity deficits, workforce issues. This could result in patients waiting too long for treatment (potential for harm and litigation claims) and potential reputational damage for the Trust.	20	Performance clinics established to support overall delivery plans, recovery actions and future projections. Weekly Access & Performance Meetings: Progressing actions with relevant Service Lines at Risk.	12	work with BUs to explore mutual aid and independent sector supportesidual actions- mutual aid Theatre roadmap aligning capacity and productivity to delivery plan	Debbie Renwick 29/12/2023 Debbie Renwick 30/12/2023	8	Weekly Access & Performance Meetings: Progressing actions with relevant Service Lines at Risk. Current Risk is best case 46 and worst case 182 against a plan of 20. Projection Risks for Year are: Trauma & Orthopaedics 26Best Case -46Worst case General Surgery - 37 Worst case Gynae - 20-30 best to worst Gastroenterology - 36 worst case Cardiology - 36 worst case OPMH - 7 Paeds- autism assessment pathway year end trajectory has reduced significantly following coding and classification agreement

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3298 24/10/2023 Amanda Venner People and OD Workforce Development 26/11/2023 BU_DIR ORG HRC SA2.1 Protect and understand the health and well-being of our staff by looking after our workforce	Promoting an environment that encourages speaking out and creating a psychologically safe culture may lead to increased reports of poor behaviour, with a negative impact on staff and additional time needed to appropriately address the concerns. The current culture suggests that staff may not feel safe to speak out and discriminatory behaviours continue, unaddressed. This could lead to further health and wellbeing concerns and staff absence.	15	Zero-Tolerance Campaign underway, focusing on clarifying expectations and providing training and support for colleagues in identifying and responding to bullying, harassment and discrimination from colleagues, patients or service users. Establishment of a full time, permanent Freedom to Speak Up Guardian and increasing number of FTSU Champions, creating an increasing number of avenues for colleagues to report incidents.	12	Create a zero-tolerance campaign	Laura Farrington 30/11/2023	6	score agreed. moved to Current.
					Embed FTSU Champions within the Organisation	Tracy Healy 31/01/2024		
					Deliver training for managers	Laura Farrington 31/01/2024		
					Review existing Bullying & Harassment policy	Natasha Botto 01/02/2024		

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1636 10/11/2014 Dianne Ridsdale Digital Digital Transformation and Assurance 25/10/2024 BU_DIR DIGC MDMG ORG	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.	15	AV on all end points AV up to date ATP in place site wide NHSD & Microsoft group policy templates Ongoing updates routinely planned as they are released Patching regime Network fully supported and maintained	10	Review trust asset register for EOL hardware/Software	Mark Bell (Completed 25/10/2023)	5	discussed at ERMG- to be reviewed by Digital and potentially removed from ORR
								19

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Organisational Risk Register Report

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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

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
3127 17/10/2022 Kris MacKenzie Finance Finance 08/12/2023 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	Jane Fay 31/03/2024	4	d/w F+P committee and agreed to reduce. formal agreement at ERMG to lower risk to 16. remain on ORR	20
					Monitoring and modelling of impact of industrial action	Jane Fay 31/03/2024			
					Comprehensive cost analysis	Jane Fay 31/03/2024			

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Handler BU Service Line Next Review Date BAF / Risk Register Objectives						Action Due			
3261 05/07/2023 Debbie Renwick Chief Operating Officer Planning & Performance 07/12/2023 BU_DIR COO FPC ORG QGC SA1.2 Continuous Quality improvement plan, SA3.1 Improve the productivity and efficiency of our operational services through the delivery of the New Operating Model and associated transformation plans	Failure to Deliver Operational Plan of Zero > 52 week waits by March 2024	**20**	Performance clinics established to support overall delivery plans, recovery actions and future projections. Weekly Access & Performance Meetings: Progressing actions with relevant Service Lines at Risk.	**12**	work with BUs to explore mutual aid and independent sector supportesidual actions- mutual aid	Debbie Renwick 29/12/2023	**8**	Weekly Access & Performance Meetings: Progressing actions with relevant Service Lines at Risk. Current Risk is best case 46 and worst case 182 against a plan of 20. Projection Risks for Year are: Trauma & Orthopaedics 26Best Case -46Worst case General Surgery - 37 Worst case Gynae - 20-30 best to worst Gastroenterology - 36 worst case Cardiology - 36 worst case OPMH - 7 Paeds- autism assessment pathway year end trajectory has reduced significantly following coding and classification agreement	**16**
					Theatre roadmap aligning capacity and productivity to delivery plan	Debbie Renwick 30/12/2023			

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2

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

0

Risks Added in Period

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

0

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Reporting Period: 01-Nov-2023 to 16-Nov-2023

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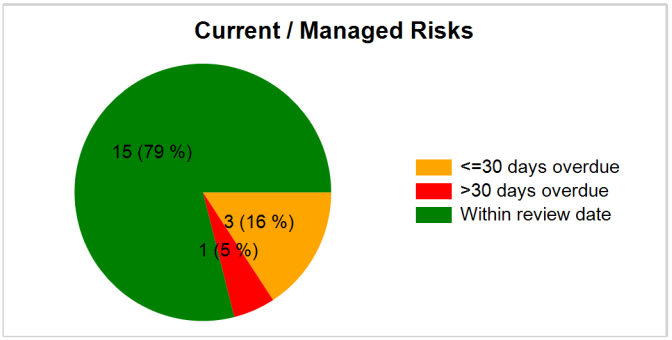
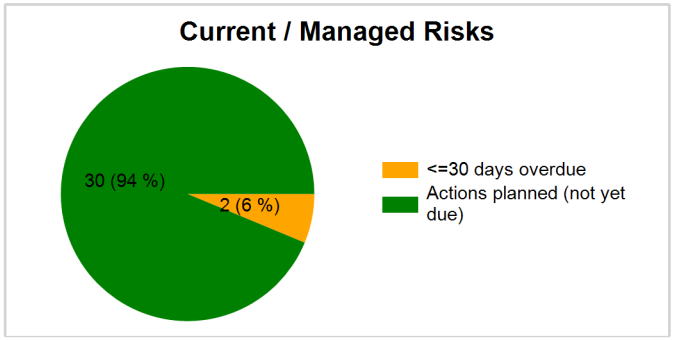
Risks Removed in Period

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register / Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR	Latest Progress Note / Date Removed from ORR
3128 17/10/2022 Kris MacKenzie Finance Finance 06/12/2023 BU_DIR 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	formal agreement at ERMG to remove from ORR. possibilty to reduce at next review. 08-11-2023
								1

Risk Review Compliance



Risk Action Compliance



Organisational Risk Register Report

Reporting Period: 01-Nov-2023 to 16-Nov-2023

Gateshead Health NHS Foundation Trust

Movements in CRR

				CRR
BU	Service Line	ID	Risk Description	Today
Chief Executive Office	Chief Executive Office	3255	People may lose trust an confidence in our services	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.	12
Chief Operating Officer		3186	There is a risk to ongoing business continuity of service provision due to ageing trust estate	12
	Planning & Performance	2945	Risk of ineffective and inefficient management of services due to availability and access to appropriate and timely BI.	12
		3261	Failure to Deliver Operational Plan of Zero > 52 week waits by March 2024	12
Clinical Support & Screening	Diagnostics	3277	Risk of no MRI facility in the hospital	20
Digital	Digital Transformation and Assurance	1490	Risk of inappropriate access/use/disclosure of data	15
	Health Records	1797	Multiple sources of clinical records stored in systems and paper format leading to potential patient harm	12
Finance	Finance	3102	Activity is not deliverved in line with planned trajectories, leading to reduction in income	16
		3103	Risk that efficiency requirements are not met.	16
		3127	There is a considerable risk that the Trust is unable to meet the financial projections included in its plan.	16
Medical Services	Medical Services - Divisional Management	2982	Risk of delayed transfers of care and increased hospital lengths of stay	16

Organisational Risk Register Report

Reporting Period: 01-Nov-2023 to 16-Nov-2023

Gateshead Health NHS Foundation Trust

Movements in CRR

				CRR
BU	Service Line	ID	Risk Description	Today
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
People and OD	Human Resources	2764	Risk of not having clearly agreed workforce plans for the next 3, 5 and 10 years.	16
	Workforce Development	2373	exposure to incidents of violence and aggression in ECC	15
		3095	Risk of Significant, unprecidented service disruption due to industrial action	16
		3298	Increase in incivility and disrespectful behaviours being reported	12
Surgical Services	Obstetrics	2398	Risk that MDT are delayed to a maternity emergency/delayed CCU transfers for maternity patients due to separate buildings	15

Gateshead Health NHS Foundation Trust

Assurance Report

Agenda Item: 10i

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☐
Committee Reporting Assurance:	Finance and Performance Committee			
Name of Meeting:	Board of Directors			
Date of Meeting:	31 October 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:	None			
Executive Summary: ***(outline assurances and gaps including mitigating actions)***	<u>Transformation Board Closure Report</u> The report was presented informing the proposal for the closure of the Transformation Portfolio Board in its current format and to establish a new Improvement Innovation and Transformation Group that will report to the Delivery Oversight Group. The Improvement Strategy was agreed by the Senior Management Team on 12 October 2023 and the New Operating Model programme is due to close in November 2023. The Committee approved the future proposal outlined within the report noting the future terms of reference of the Improvement Innovation and Transformation Group will be discussed at the Transformation Board in October 2023. <u>Leading Indicators</u> The report was presented informing that slide 3 of the presentation includes a strategic picture and heat map that focuses on areas to check, challenge, improve or note no improvement. It was discovered that if a domain is delivering above target it is not easily picked up if there is a deterioration of performance within our reporting so this is an opportunity to under pick this. The Committee were made aware that at the time of writing the report the 52 week waiters were predicting 183 but from the latest Access and Performance meeting on Friday we now have resolution to some of the Paediatric long waiters. The target of zero 12 hour ambulance handovers were not met with 66 recorded between April and the end of August 2023 of which 50 were in the latest month of September relating to flow issues.			

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	Integrated Oversight Report (IOR): The report was presented informing the activity in September is below the planned levels of year to date over where we should be and day cases are over performing. There are big risks against overnight and elective which are impacting on waits. The diagnostic performance was at 88.6% which is driven by under performance in Audiology and we are monitoring in the Access and Performance Meetings. It was agreed to correlate the IOR, Leading Indicators and Single Elective Recovery reports. New Operating Model Learning Report: Deferred to the next meeting. Month 6 Financial Report: The report was presented informing in terms of revenue the Trust reported an actual deficit of £9.538m to a plan of £6.8m that relates to activity of variable income, bank and agency spend and unachieved CRP. In the month position there is focused work on productivity on agency controls and limited discretionary spend. There is a deficit of £66m against a planned deficit of £44m and there is a £21m gap in the ICS which has improved from £27m in Month 5. Delivery Oversight Group Report: The report was presented informing the eight work streams have been previously presented to the Committee which are overseen by the DOG that represents change in the internal governance and grip and control. We have scoping documents for all of the work streams but not the delivery plans for all yet, the focus on the work streams have been a medium term and have not got the retraction we wanted. It was noted a dedicated finance session was held that identified scenario modelling and agreed a programme of work outlined in the paper with actions in the appendix. The oversight meetings last week concentrated on performance and held Business Units to account for delivery with a follow up meeting on 14 November 2023 to expedite the actions. Medicine Business Unit Financial Analysis: Deferred to the next meeting. Community Diagnostic Centre Update: The report was presented informing the Trust Board received a paper for assurance relating to the Strategic Oversight Group that are meeting this afternoon. The group continues to focus on the same themes of the emerging financial risk, considering risks, project update, update on the landlord works and the programme highlight report.

	Treasury Management Report: The report was presented informing the proposed governance framework for management of cash is for consultation and comments from the Committee. The Committee approved the draft Treasury Management Policy with the amendments suggested for consideration at the Policy Review Group prior to submission to the Senior Management Team for approval. Single Elective Recovery Report: The report was presented informing as discussed at the last meeting we are aware of the significance of the elective recovery agenda but there was not a series of key metrics in one place. We have taken a similar approach to the IOR with a heat map on the summary page and included current cancer wait targets which will be replaced with the new standards moving forward. It was noted there are concerns of the reduction in activity across most of the domains of deterioration and not being achieved and also with the 52 week waits. Internal Audit Reports: None. Supply Procurement Committee Report: The report was presented informing there were 8 items requesting waiving of standing orders and 3 items on report via competition conducted via a framework. In total 11 reports were received with a total value of £8.9m. Capital Steering Group (CSG) Update: The report was presented informing discussions link to item 20 on agenda of governance arrangements between the Trust and the Group therefore CSG will be revised. The terms of reference are being revised as they are not fit for purpose and the minutes are presented for information. NHSE Monthly Meeting Update: The report was presented informing that the Trust has met with NHSE and ICB colleagues for the first monthly financial oversight meeting that took place on Tuesday 17 October 2023. NHSE have requested a copy of the full set of papers for the Finance and Performance Committee meetings to be shared on a monthly basis. Cancer Tracker Paper: The report was presented informing we received guidance in August to take in effect from 1 October 2023 of standardising and modernising the cancer waiting times. The two week wait standard and the rationalisation of the other standards into three core measures for the NHS have been removed. There is also clarity surrounding

	counting and recording of clinical patient upgrades onto cancer pathways and expectation at MDT. Subsidiary Governance Arrangements: The report was presented informing as a result of the work undertaken by Deloitte, a recommendation was to look at the contract management between the Trust and QE Facilities. The Executive Management Team have approved these arrangements and are in the process of being mobilised. The Contract Oversight Meeting is the revamp of the OHFC where the Trust is holding QE Facilities to account and the Reverse SLA Oversight Meeting is holding the Trust to account. 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. The Committee agreed to decrease the score risk for 3127 from the likelihood of 5 to 4. Board Assurance Framework (BAF): The Committee reviewed and updated the BAF. Strategic Objective Delivery: The report was presented informing an update on quarter two with all objectives in progress and one is complete. The return on investment of the NOM is linked to the performance subject to ongoing review and the estate work is associated with the NOM which is due to complete in November 2023. With reference to SA5.1 the Trust have met with the Commercial Director at the Health Innovation Network to explore opportunities for development including the potential to join the Health and Life Sciences Pledge. A proposal was presented to the Executive Management Team to join the pledge and here for ratification. The Committee agreed to support joining the Health and Life Sciences Pledge. Improvement Strategy: The report was presented informing the strategy has been in development for several months and engagement has taken place across various forums and staff. The strategy was considered and approved at the Senior Management Team on 12 October 2023. The strategy will aim to ensure the Trust creates a culture of improvement where we strive to improve patient care together. It was noted it will be aligned to the NHS Impact five components which are all evidence based improvement methods which underpin a systematic approach to continuous improvement. The Committee agreed to ratify the Improvement Strategy policy and implementation plan.

	Oversight Meeting Action Delivery Plan For information. 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			

Gateshead Health NHS Foundation Trust

Assurance Report Agenda Item: 10ii

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☒
Committee Reporting Assurance:	Quality Governance Committee October 2023			
Name of Meeting:	Trust Board			
Date of Meeting:	October 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 Psychology Service funding is coming to an end and looking at options but this is dependent on one individual which is included on the Risk Register. The Committee noted the number of children in care has increased by 40% since Covid to 521 therefore a report was submitted to the ICB. No additional funding has been forthcoming. Some of the key performance indicators are now behind target. The Committee noted the national profile for band 2 and band 3 HealthCare Support Workers has changed. The GHNFT job description is being re-written and rebanded. An implementation programme is being developed. The ICB were in attendance at the meeting and felt that they gained good assurance as a result of attendance.			
Executive Summary:	**Items received for assurance:** **Medicines Quarterly Report** The report was presented informing that the metrics relating to medicines management are mainly in line with expectations. There has been a dip in oxygen prescribing, which has been attributed to industrial action. Additional training has been implemented. It was noted there is a Non-Medical Prescribing meeting in place that is chaired by the Deputy Chief Nurse which will report to the Medical Committee followed by SafeCare. **Complaints Update** The report was presented informing there has been 56 informal complaints received in August 2023 with the			

	majority in the Medicine Business Unit. The top themes include communication, facilities and clinical treatment. There are currently 6 overdue informal complaint responses with 3 being Medicine and 3 in Surgery. It was agreed that the Committee will receive an update at the next meeting of the escalation process in place for overdue complaints once it has been agreed at the Senior Management Team. **Cancer Services Annual Report** The report was presented informing that the Lead Cancer Nurse is in post and waiting times continue to be a challenge. Psychology Service funding is coming to an end and currently there is no plan for ongoing funding. It was agreed for SPC charts to be used in the next report to be able to identify trends. **Mortality 6 Month Update Report** The report was presented informing we now have a system in place and the only issue is capacity. The Committee will be kept informed of the mortality alerts from the health care evaluation data as there is only 1 case that was alluded to within the data. **IPC 6 Month Update Report** The report was presented informing that the IPC Committee is well attended, the main issue has been CDIFF as the threshold has been reduced to 23. The Committee noted that we do not expect to see anything further in terms of the IPC BAF moving forward as this was mainly related to covid. **Safeguarding Annual Report** The report was presented highlighting that the number of children in care has increased by 40%. The numbers are currently at 521 therefore a paper was submitted to the ICB. The ICB has declined to provide any further funding. KPIs have shown a dip as a result of the additional workload. Agreed for the Director of Nursing at the NENC ICB to take this back. **Safer Nursing Care Staffing Bi Annual Report** The report was presented informing that an agreed evaluated tool has been used to assurance that we are providing safe staffing levels in our inpatient areas. A business case will be required for some changes to the way we provide night time cover and supervisory management at ward level. **Integrated Oversight Report (IOR)** The report was presented informing there are additional beds open. Urgent and emergency care performance is the most urgent area for improvement.

Maternity Oversight Report
The report was presented informing there has been changes to the MIS standards. These will need to be reflected in future reports. Training is now mainly back on track.

Assurances from Strategic SafeCare Risk and Safety Council
The report was presented informing that the council received an update from the Medicines Governance Committee in relation to a recent Audit One review of Medical Gases which achieved 'Good' with minimal recommended actions required. The council also received an update from the Clinical Procedures Committee that it was highlighted of poor attendance and a number of actions in developing staffing levels in the Research and Development Annual Report.

Patient Safety Report
The report was presented informing that falls are on a downward trajectory and pressure damage has remained constant. The Central Alerting System (CAS) Alerts are now closed and as of last week we no longer report serious incidents since moving to InPhase in line with national guidance.

It was noted a patient safety culture survey was undertaken over the last few months which will be analysed and shared at the SafeCare meeting in November 2023. At the last SafeCare meeting there were 16 serious incidents that were closed and agreed for this to be included in the next report.

Safer Staffing Report
The report was presented informing the average fill rates reported on a monthly basis were 84.5% for registered nurses / midwives in the day and night were 89.8%. The average fill rates were for 119.5% for care staff in the day and night were 94.9%.

Neonatal Staffing Position
The report was presented informing following a number of listening events with staff a review of staffing has been undertaken. A business case will be developed to address any shortfalls.

Quality Account Q1 Progress Report
The report was presented informing there are no areas to highlight and to note the progress in the report for information.

Strategic Objectives

<table>
<tr><td></td><td colspan="6">The report was presented informing the main update is the health inequalities agenda and for the Committee to note the progress in the report for information.

Items received by the Committee for information:

• Committee Meeting Dates for 2024/25
• Mental Health Act Compliance Group Frequency of Meetings
• Internal Audit Report – WHO Surgical Checklist
• 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
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☒</td><td colspan="5">We will develop and expand our services within and beyond Gateshead</td></tr>
<tr><td>Financial Implications:</td><td colspan="6">None to Note</td></tr>
<tr><td>Links to Risks (identify significant risks and DATIX reference)</td><td colspan="6">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
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</table>

Gateshead Health NHS Foundation Trust

Assurance Report Agenda Item: 10iv

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☐
Committee Reporting Assurance:	People and OD Committee – 14 November 2023			
Name of Meeting:	Trust Board			
Date of Meeting:	November 2023			
Author:	Amanda Venner, Director of People & OD			
Executive Lead:	Amanda Venner, Director of People & OD			
Report presented by:	Maggie Pavlou, Non-Executive Director			
Matters to be escalated to the Board:	• Some historic bullying issues highlighted in GMC survey – being managed locally via the Director of Medical Education, MD office and local teams • Low levels of vaccination uptake			
Executive Summary: ***(outline assurances and gaps including mitigating actions)***	**Items received for assurance:** **Executive Director POD Summary Report:** Members were informed that this was the first time this report has been pulled together for this Committee, as all tier 1 Committees had been requested to provide a summary report of all of the papers that are presented at each meeting. The report provides a triangulated summary of the People and OD issues articulated in the reports. This will develop going forward. It was noted that a more detailed report will come to the next committee on the Band 2-Band 3 healthcare assistant regrading project. **Corporate Objective Update Report:** The report was presented informing members that this provides assurance for Q2 over the progress made in delivering against the following three corporate objectives that contribute to our corporate aim of Being a great organisation with a highly engaged workforce. • SA2.1 Caring for our people in order to achieve improved compliance of key indicators by March 2024. • SA2.2 Growing and developing our people in order to improve patient outcomes and reduce reliance on high-cost agency staff by March 2024. • SA2.3 Being a great place to work in order to improve staff survey outcomes and impact upon patient outcomes within 2-years.			

The Committee noted that vacancy rates have decreased however sickness absence levels are rising.

People Strategy Six Month Update:
The detailed report was presented and members noted that this provides a 6 monthly update on the delivery of the People Strategy, with a focus on activity underway in a number of key areas including management development, colleague engagement, absence management and apprenticeship levy utilisation. Areas yet to be progressed include workforce planning, retention, and the increased use of automation.

Guardian of Safe Working Quarterly Report:
The report was presented informing members that there are no immediate safety concerns, and that the majority of exception reports are raised within the acute specialities of medicine and general surgery. Within Q1 and Q2, 66 exception reports were raised. All of the reports raised were for working hours while no exception reports were submitted for missed education.

Vaccination Programme Update Report:
The report was presented informing members of the following:

- 33.66% of colleagues vaccinated against Flu.
- 13.14% of colleagues vaccinated against Covid.
- Gateshead Health NHS Foundation Trust are third in the region for the number of front-line healthcare workers vaccinated against flu, currently sitting at 35.3%.

It was suggested that it may be worthwhile to hold another jabathon campaign in the near future and that more comms would be circulated to staff in order to increase the vaccination uptake.

Independent Review:
The report was presented informing members that the purpose of this report is to provide a summary of the learning actions agreed from the review into the death of a Trust colleague in order to provide assurance that these are being progressed. The Committee noted that 15 out of the 17 actions had been completed.

Focus on Retention:
The report was presented and members noted that the purpose of this report is to update the committee on retention work underway as follows:

- Provide an overview of what our leaver's data is telling us.

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- Review our position against the NHS Employers retention standards that form part of the national retention programme, which is linked to the core elements of the people promise.
- Provide recognition of what we are doing well and what future actions need to be taken.

The Committee noted that turnover rates have decreased from 17% to 13% in the last 12 months. Exit data between October 2022 and September 2023 indicates that almost 50% of staff leave from Admin & Clerical and Nursing & Midwifery Staff Groups.

GMC Survey Results:
The above was presented and members noted that the survey collects data on the views of doctors in training on the posts they are working in on 21st March 2023. The Committee noted the following headlines:

- There are problems in some areas with Induction and not receiving rotas and work schedules in a timely fashion
- There is limited allocated space to deliver training
- There have been issues regarding historic bullying raised in various areas.

There are plans in place to improve these issues and the bullying issues have been addressed.

ADQM Outcome:
The report was presented advising that the visit was held in June this year and there had been a delay in receiving the report. This provides a summary of the education and training provided by the named Local Education Provider (LEP). The report received was positive with no Trust specific areas of concern highlighted.

Zero Tolerance Programme:
The report was presented and members noted that there is an Engagement Event planned for 24 November 2023 along with a development of a dedicated intranet site to provide support and guidance. There is also a working group to move this issue and show racism the red card forward however, there is still a lot of work to do

Anti-Racism Charter:
The Committee noted that the Anti-Racism Charter has been signed and that a signatory ceremony had been held. There are a couple of issues to be discussed with the staff side, prior to a more detailed update being provided.

Historic Pre-Employment Checks:
The report was presented and members noted that this report provides assurance on activity in the final stages of

	the DBS project, which is now complete with all checks in place. It also provided an update on progress against the wider pre-employment checks standards project. Assurances in place around the priority checks for the files checked to date, which was 40.2%. The project was due for completion on 31 December 2023, however, this may need to be extended to February 2024 due to capacity pressures. Additional staff will be required to support this project if the original deadline is to be achieved. The committee received assurance that this work is in hand and the risks are being managed closely. **Fit and Proper Persons:** The Committee noted that the new Group Fit and Proper policy is in the reading room for members to view. **Review of Effectiveness – Action Plan:** This shows the outcome of the recent POD Committee effectiveness survey. The Committee noted that there were a few minor concerns raised and the chair is to meet with the Director and Non Exec Director to discuss. **People and OD Organisational Risk Register:** The report was presented informing the Committee that 1 risk has been reduced (3095) relating to quality of care due to Industrial Action, and 1 risk has been added (3298) promoting an environment that encourages speaking out and creating a psychologically Safe Culture. **Items received by the Committee for information:** • Cycle of Business • Leading Indicators • Integrated Oversight Report • People & OD Additional Metrics • Industrial Action Update	
Recommended actions for Board	Note main assurances against the strategic People and OD themes detailed and key associated risks.	
Trust Strategic Aims that the report relates to: (Including reference to any specific risk)	**Aim 1** ☐	We will continuously improve the quality and safety of our services for our patients
	Aim 2 ☒	We will be a great organisation with a highly engaged workforce
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	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:	No significant new financial implications to highlight to the Board.	

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<table>
<tr><td>Links to Risks (identify significant risks and DATIX reference)</td><td colspan="5">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="5">As set out</td></tr>
<tr><td>Links to CQC KLOE</td><td>Caring
☒</td><td>Responsive
☒</td><td>Well-led
☒</td><td>Effective
☒</td><td>Safe
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<tr><td rowspan="3">Trust Diversity & Inclusion Objective that the report relates to: (including reference to any specific implications and actions)</td><td>Obj.1
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</table>

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NHS
Gateshead Health
NHS Foundation Trust

Report Cover Sheet Agenda Item: 11

Report Title:	**Consolidated Finance Report**			
Name of Meeting:	Trust Board			
Date of Meeting:	29th November 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 October 23, the Trust has reported an actual deficit of **£10.248m** after adjustments for donated assets and gain & losses of asset disposal. This is an adverse variance of **£1.943m** from its year-to-date target for reasons detailed in the body of this report. As of October 23, the Trust is forecasting achievement of its planned deficit totalling **£12.588m.** The Trust has an approved 2023-2024 capital programme totals **£29.792m.** Following changes to schemes funded from external funds and charitable funds the Trust is reporting internally against a revised plan of **£24.669m**. As of October 2023, the Trust has reported actual capital spend totalling **£4.593m**, and a reported under-spend of **£9.161m** against the year-to-date target, for the reasons detailed in the body of this report.			
Recommended actions for this meeting:	The recommendation to Board is to receive the report, discuss the potential implications and record partial			

<table>
<tr><td>Outline what the meeting is expected to do with this paper.</td><td colspan="6">assurance for the achievement of the 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 October 2023 (Month 7) for the Group (inclusive of Trust and QE Facilities, excluding Charitable Funds).</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:</td><td>Aim 1
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<tr><td>Trust corporate objectives that the report relates to:</td><td colspan="6">Achieving financial sustainability</td></tr>
<tr><td>Links to CQC KLOE</td><td>Caring
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☐</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">3127 Overall risk of not meeting financial plan, with contributing risks relating to activity (3102), efficiency (3103) and cost of delivery of New Operating Model (3128).</td></tr>
<tr><td>Has a Quality and Equality Impact Assessment (QEIA) been completed?</td><td colspan="2">Yes
☐</td><td colspan="2">No
☐</td><td colspan="2">Not applicable
☒</td></tr>
</table>

1. Introduction

1.1 The purpose of this report is to provide a summary of financial performance as of 31st October 2023 (month 7) for the Group (inclusive of the Trust and QE Facilities, excluding Charitable Funds).

1.2 Reporting for October 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 £10.416m for the period April 23 to October 23 and £10.248m after the adjustment for donated assets, gains / loss on disposal of assets.

2.2 This is an adverse variance of £1.943m 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 October 23 the Trust has reported actual income of £31.300m and total year to date income of £215.853m. This is an adverse variance of £6.461m against the Trusts financial plan. The year-to-date variance comprises of less income than planned for variable income streams included in the scope of the national elective recovery fund initiative totalling £2.770m, pathology pillar 1 covid testing £2.281m and the impact of unachieved CRP £0.475m.

2.4 For the month of October 23 the Trust has reported actual operating expenditure of £31.710m and total year to date operating expenditure of £224.318m. This is an adverse variance of £1.244m against the Trusts internal financial plan. The year-to-date variance comprises of the impact of an overspend on pay budgets totalling £2.742m offset by underspends on non-pay budgets of £2.090m and overachievement of CRP totalling £0.111m across pay and non-pay budgets.

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

STATEMENT OF COMPREHENSIVE INCOME

October 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	(339,572)	(29,123)	(28,718)	(198,647)	(196,125)	2,522	2,117	405
Income From Local Authority Care Contracts	(346)	(18)	(19)	(169)	(198)	(29)	(28)	(1)
Private Patient Revenue	(735)	(61)	(69)	(429)	(441)	(12)	(4)	(8)
Injury Cost Recovery	(500)	(42)	(22)	(292)	(218)	74	54	19
Other non-NHS clinical revenue	(153)	(13)	(12)	(89)	(85)	5	4	1
Total Operating Income From Patient Care activities	**(341,306)**	**(29,257)**	**(28,841)**	**(199,626)**	**(197,066)**	**2,560**	**2,144**	**416**
Other Operating Income								
Education and Training Income	(11,292)	(938)	(956)	(6,599)	(6,467)	132	150	**(18)**
R&D Income	(852)	(108)	(90)	(590)	(612)	(22)	(40)	**17**
Funding outside of System Envelope	(3,910)	(326)	(0)	(2,281)	0	2,281	1,955	**326**
Other Income	(20,072)	(2,006)	(1,411)	(12,610)	(11,658)	952	358	**595**
Donations & Grants Received	(229)	(19)	0	(134)	(50)	84	65	**19**
Cost Improvement Programme - Income	(978)	70		(475)	0	475	544	**(70)**
Total Other Operating Income	**(37,333)**	**(3,327)**	**(2,458)**	**(22,688)**	**(18,787)**	**3,901**	**3,032**	**869**
Total Operating Income	**(378,639)**	**(32,584)**	**(31,300)**	**(222,314)**	**(215,853)**	**6,461**	**5,177**	**1,284**
Operating Expenses								
Employee Expenses - Substantive	256,991	21,026	20,601	144,855	140,878	(3,978)	(3,553)	**(424)**
Employee Expenses - Bank	486	90	861	314	5,020	4,706	3,935	**771**
Employee Expenses - Agency	1,566	109	141	1,031	2,838	1,807	1,776	**32**
Employee Expenses - Other	1,149	95	121	674	880	207	181	**26**
Cost Improvement Programme - Pay	(2,045)	(202)		1,547	0	(1,547)	(1,749)	**202**
Total Employee Expenses	**258,146**	**21,118**	**21,724**	**148,421**	**149,616**	**1,195**	**590**	**606**
Purchase of Healthcare - NHS bodies	8,246	752	749	4,803	4,730	(73)	(70)	**(3)**
Purchase of Healthcare - Non NHS bodies	3,886	366	255	2,426	2,373	(53)	58	**(111)**
Purchase of Social Care	0	0	0	0	0	0	0	**-**
NED's	187	16	13	109	95	(14)	(11)	**(3)**
Supplies & Services - Clinical	35,482	3,217	3,606	20,811	22,562	1,750	1,361	**390**
Supplies & Services - General	3,158	255	(989)	1,801	39	(1,762)	(518)	**(1,244)**
Drugs	23,133	2,479	1,935	13,769	13,406	(363)	181	**(544)**
Research & Development expenses	11	0	0	11	27	16	15	**0**
Education & Training expenses	1,855	164	180	1,004	1,124	120	103	**16**
Consultancy costs	531	35	44	358	338	(20)	(30)	**10**
Establishment expenses	4,260	358	428	2,542	2,541	(1)	(70)	**69**
Premises	19,538	1,527	1,822	11,221	11,594	373	78	**294**
Transport	1,885	192	150	1,116	973	(143)	(101)	**(42)**
Clinical Negligence	7,940	696	696	4,460	4,460	0	0	**-**
Operating Leases	164	15	21	90	198	108	102	**6**
Other Operating expenses	11,065	646	773	3,743	4,507	764	637	**127**
Cost Improvement Programme - Non Pay	(4,291)	(70)	0	(1,436)	0	1,436	1,366	**70**
Reserves	0	(0)	0	(0)	0	0	0	**0**
Operating Expenses included in EBITDA	**375,197**	**31,766**	**31,408**	**215,249**	**218,583**	**3,333**	**3,692**	**(358)**
Depreciation & Amortisation - Purchased / Constructed	7,591	631	48	4,613	4,022	(591)	(8)	**(583)**
Depreciation & Amortisation - Donated / Granted	290	25	22	172	168	(4)	(2)	**(2)**
Depreciation & Amortisation - Finance Leases	5,112	426	279	2,982	2,025	(957)	(810)	**(147)**
Impairment & Revaluation	100	8	(48)	58	(480)	(538)	(482)	**(56)**
Operating Expenses excluded from EBITDA	**13,093**	**1,090**	**302**	**7,825**	**5,736**	**(2,090)**	**(1,302)**	**(788)**
Total Operating Expenses	**388,284**	**32,856**	**31,710**	**223,075**	**224,318**	**1,244**	**2,390**	**(1,146)**
(Profit)/Loss from Operations	**9,644**	**272**	**410**	**760**	**8,465**	**7,705**	**7,567**	**138**
Non Operating								
Non-Operating Income								
Finance Income	(2,224)	(215)	(194)	(1,150)	(1,408)	(258)	(279)	**21**
Total Non-Operating Income	**(2,224)**	**(215)**	**(194)**	**(1,150)**	**(1,408)**	**(258)**	**(279)**	**21**
Non-Operating Expenses								
Finance Costs	483	40	100	282	451	169	109	**60**
Gains / (Losses) on Disposal of Assets	0	0	0	0	0	0	0	**0**
PDC dividend expense	3,885	324	324	2,266	2,267	1	1	**0**
Total Finance Costs (for non-financial activities)	**4,368**	**364**	**424**	**2,548**	**2,718**	**169**	**109**	**60**
Other Non-Operating Expenses								
Misc. Other Non-Operating expenses	0	0	0	0	0	0	0	
Total Non-Operating Expenses	**4,368**	**364**	**424**	**2,548**	**2,718**	**169**	**109**	**60**
(Surplus) / Deficit Before Tax	**11,788**	**421**	**641**	**2,158**	**9,774**	**7,616**	**7,397**	**219**
Corporation Tax	914	115	92	428	642	213	237	**(23)**
(Surplus) / Deficit After Tax	**12,702**	**536**	**732**	**2,587**	**10,416**	**7,829**	**7,633**	**195**
Balancing Adjustment to NHSE Plan		(54)		5,788		(5,788)	(5,843)	54
(Surplus) / Deficit After Tax from Continuing Operations	**12,702**	**482**	**732**	**8,375**	**10,416**	**2,041**	**1,791**	**250**
Remove capital donations / grants I&E impact	(114)	(10)	(22)	(70)	(168)	(98)	(85)	(12)
Adjusted Financial Performance (Surplus) / Deficit	**12,588**	**472**	**710**	**8,305**	**10,248**	**1,943**	**1,705**	**238**

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 £7.444 as of October 23 and £9.265m for the financial year. This equates to 58.3% of the annual target.

Business Unit	23-24 Annual Target £000	23-24 YTD Target £000	23-24 YTD Achieved £000	23-24 YTD Variance £000	23-24 Annual Achieved £000	23-24 Annual Variance £000	23-24 Annual Achieved %
Chief Executive	(0.012)	(0.005)	0.000	(0.005)	0.000	(0.012)	0.0%
Chief Operating Officer	(0.111)	(0.046)	(0.010)	(0.036)	(0.010)	(0.102)	8.6%
Clinical Support & Screening	(3.479)	(1.449)	(1.835)	0.386	(1.954)	(1.525)	56.2%
Community	(1.211)	(0.505)	(0.563)	0.058	(0.605)	(0.606)	50.0%
Director Of Nursing	(0.186)	(0.078)	(0.237)	0.159	(0.237)	0.051	127.2%
Estates & Facilities	(0.195)	(0.081)	0.000	(0.081)	0.000	(0.195)	0.0%
Finance & Information	(0.566)	(0.236)	(0.385)	0.150	(0.473)	(0.093)	83.5%
Medical Director	(0.025)	(0.011)	(0.029)	0.018	(0.029)	0.004	116.4%
Medicine & Elderly	(3.129)	(1.303)	0.000	(1.303)	0.000	(3.129)	0.0%
People & Organisational Development	(0.202)	(0.084)	(0.165)	0.081	(0.165)	(0.038)	81.4%
Surgical Services	(3.284)	(1.368)	(1.487)	0.119	(1.538)	(1.746)	46.8%
Corporate Cost Reduction	(3.500)	(1.963)	(2.733)	0.770	(4.254)	0.755	121.6%
Total	**(15.900)**	**(7.129)**	**(7.444)**	**0.315**	**(9.265)**	**(6.635)**	**58.3%**

4 Cash and Working Balances

4.1 Group cash as of 1st April 23 totalled £49.335m. The cash position as at the end of October totals £37.744m and is a reduction of £0.374m from the balance as at the end of September, this cash balance is equivalent to an estimated 36.64 day's operating costs (37 days September).

4.2 The liquidity metric has deteriorated by 0.40 days against September to -1.24 days, this is 8.03 days below plan (+6.79 days). This is due to a £7.878m decrease in working capital balance against estimate and an increase of £9.467m in operating costs net of depreciation.

4.3 The balance sheet is presented in Table 2.

Statement of Position - October 2023

	2023/2024 September 2023 Group	2023/2024 October 2023 Group	Movement from Prior Month	2023/2024 October 2023 QEF	2023/2024 October 2023 FT
	£000's	£000's	£000's	£000's	£000's
Assets					
Non-Current Assets					
Investments	80	80	0	80	16,824
Property, Plant and Equipment, Net	143,132	142,892	(241)	1,205	141,687
Right of Use Assets	11,710	11,710	0	0	11,710
Trade and Other Receivables, Net	1,914	1,903	(12)	814	1,089
Finance Lease - Intragroup				41,326	0
Trade and Other Receivables - Intragroup Loan	0	0	0		7,403
Total Non Current Assets	156,836	156,584	(252)	43,424	178,712
Current Assets					
Inventories	5,098	5,071	(28)	2,804	2,266
Trade and Other Receivables - NHS	10,476	10,360	(116)	667	9,693
Trade and Other Receivables - Non NHS	4,941	6,154	1,214	1,306	4,848
Trade and Other Receivables - Intragroup				8,122	132
Trade and Other Receivables - Other	0	0	0		0
Prepayments	6,546	6,333	(213)	525	5,807
Cash and Cash Equivalents	38,118	37,745	(373)	7,091	30,653
Other Financial Assets - PDC Dividend	0	0	0		0
Accrued Income	1,592	1,579	(13)	1,087	492
Finance Lease - Intragroup				303	0
Trade and Other Receivables - Intragroup Loan					1,795
Total Current Assets	66,769	67,241	472	21,907	55,687
Liabilities					
Current Liabilites					
Deferred Income	9,270	11,048	1,778	106	10,942
Provisions	3,237	3,003	(234)	579	2,424
Current Tax Payables	5,270	5,101	(169)	442	4,659
Trade and Other Payables - NHS	1,977	2,843	867	932	1,911
Trade and Other Payables -Intragroup				132	8,122
Trade and Other Payables - Other	10,220	8,144	(2,076)	2,674	5,470
Lease Liabilities	4,081	4,091	10	0	4,091
Trade and Other Payables - Capital	0	0	0	0	0
Other Financial Liabilities - Accruals	32,058	32,466	408	7,652	24,815
Other Financial Liabilities - Borrowings FTFF	499	499	0	0	499
Other Financial Liabilities - PDC Dividend	0	324	324	0	324
Other Financial Liabilities - Intragroup Borrowings	0	0		1,795	0
Finance Lease - Intragroup	0	0		0	303
Total Current Liabilities	66,613	67,521	908	14,311	63,562
NET CURRENT ASSETS (LIABILITIES)	156	(279)	(436)	7,595	(7,875)
Non-Current Liabilities					
Deferred Income	2,023	2,015	(8)	1,719	296
Provisions	2,280	2,332	52	0	2,332
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	24,317	44	9,122	63,924
TOTAL ASSETS EMPLOYED	**132,719**	**131,987**	**(732)**	**41,898**	**106,913**
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)	(26,942)	(27,674)	(732)	25,074	(52,748)
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	132,719	131,987	(732)	41,898	106,913
TOTAL ASSETS EMPLOYED	**132,719**	**131,987**	**(732)**	**41,898**	**106,913**

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 £12.756m are now expected to fund the revised CDC programme of £9.383m; Digital Diagnostics £0.847m; confirmed MRI of £2.381m; and Screening Equipment £0.145m. Approved charitable funds funded schemes total £0.130m. This results in estimated capital funding of £23.355m.

Capital Funding	£000's	£000's
Net Depreciation*		7,677
Internal Cash		2,792
PDC Funded Schemes		
CDC	9,383	
Digital Diagnostics	847	
MRI	2,381	
Screening Equipment	145	12,756
Charity Funded Schemes		
Jubilee Gardens	70	
Patient Quiet Room	30	
ECC Staff Room	18	
Private Patients Cubicle	12	130
Total		23,355

* After Principal Loan Repayments

5.2 The Trust's approved capital programme for 2023-2024 now totals £24.669m incorporating the revised CDC spend of £9.383m; additional screening equipment PDC award; revised I.T. capital schemes; and charitable funds funded schemes; an oversubscription of £1.314m and is summarised below.

2023/2024 Capital Programme	Plan £'000s
Estates	
CDC	9,383
New Operating Model	3,145
MRI	3,255
Equipment Replacement	1,200
Digital Diagnostics	847
Backlog Maintenance	1,100
Air Handling Units	600
Contingency	400
Water Pipe Works - Pathology	500
Bowel Screening	480
Pathology Decant	442
Carry Forward of Schemes 2022/23	335
Screening Equipment	145
H&S Investment	100
Energy Conservation Schemes	90
Traceability Scheme	70
Dementia Environment	60
Sustainability Agenda	50
CERA for Peads	30
Patient Experience Works	20
Blaydon Fence	15
Highways Works	10
Bensham Garden Fence	10
Water Supply Survey	7
	22,294
I.T.	
Nutanix - storage	1,200
Netapp for PACS/RIA/Vna	500
Core Network (Year 1 of 2)	485
Hardware Replacement	0
Server 2012 Upgrades	0
Winscribe Replacement	60
	2,245
Charity Funded Schemes	
Jubilee Gardens	70
Patient Quiet Room	30
ECC Staff Room	18
Private Patients Cubicle	12
	130
Total	**24,669**

5.3 Capital spend to 31st October totalled £4.593m; £9.161m less than the year-to-date plan. Expenditure in the year was in respect of the new operating model, community diagnostic centre, building maintenance, MRI, equipment replacement, Bowel Screening, H&S Investment, Energy Conservation Schemes and schemes carried forward from the 2022-2023 programme.

Kris Mackenzie, Group Director of Finance & Digital
November 2023

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 11i

Report Title:	**NHSE Letter**			
Name of Meeting:	Finance and Performance Committee			
Date of Meeting:	28th November 2023			
Author:	Kris Mackenzie, Group Director of Finance and Digital			
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:** ☒
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☐ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☒
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	EMT November 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*	On 8 November 2023, the Trust received a letter from NHSE entitled 'addressing the significant financial challenges created by industrial action in 2023/24, and immediate actions to take'. The letter set out some clarity on funding and actions that the NHS has been asked to take to manage the financial and performance pressures created by industrial action. Noting that priorities are: • Achieving financial balance • Protecting patient safety • Prioritising emergency performance and capacity • Protecting urgent care • Protecting high priority elective • Protecting cancer care Nation action taken was to: • Allocate £800m to systems • Reduce the elective activity target by two percentage points In return providers were asked to agree steps required to deliver the priorities, confirmation submitted via ICBs.			

<table>
<tr><td></td><td colspan="6">The Trust responded positively to both the financial and performance asks, and this response was sanctioned by the Chair and Chief Executive in line with the required approvals.

Attached to this paper is:
• A copy of the initial letter</td></tr>
<tr><td>Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper</td><td colspan="6">To note the information in the attached documents.</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:</td><td>Aim 1
☒</td><td colspan="5">We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>Aim 2
☒</td><td colspan="5">We will be a great organisation with a highly engaged workforce</td></tr>
<tr><td>Aim 3
☒</td><td colspan="5">We will enhance our productivity and efficiency to make the best use of resources</td></tr>
<tr><td>Aim 4
☒</td><td colspan="5">We will be an effective partner and be ambitious in our commitment to improving health outcomes</td></tr>
<tr><td>Aim 5
☒</td><td colspan="5">We will develop and expand our services within and beyond Gateshead</td></tr>
<tr><td>Trust corporate objectives that the report relates to:</td><td colspan="6">Achieving financial sustainability</td></tr>
<tr><td>Links to CQC KLOE</td><td>Caring
☒</td><td>Responsive
☒</td><td>Well-led
☒</td><td>Effective
☒</td><td colspan="2">Safe
☒</td></tr>
<tr><td colspan="7">Risks / implications from this report (positive or negative):</td></tr>
<tr><td>Links to risks (identify significant risks and DATIX reference)</td><td colspan="6">N/A</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>

To:
- ICB and Trust:
  - Chief executives
  - Chief finance officers
  - Chief operating officers

cc.
- ICB and Trust:
  - Chairs
  - Chief Nurses
  - Medical Directors

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

8 November 2023

Dear colleague

Addressing the significant financial challenges created by industrial action in 2023/24, and immediate actions to take

We are writing to provide clarity on the funding and actions the NHS has been asked to take to manage the financial and performance pressures created by industrial action following discussions with Government.

As a result of these pressures, for the remainder of the financial year our agreed priorities are to achieve financial balance, protect patient safety and prioritise emergency performance and capacity, while protecting urgent care, high priority elective and cancer care.

In response, we are asking systems to complete a rapid two-week exercise to agree actions required to deliver the priorities for the remainder of the financial year.

Financial pressures in 2023/24

We asked you to set ambitious plans for 2023/24 in the context of NHS funding increasing in real terms between 2019/20 and 2023/24 to over £160bn, recognising the actions you have had to take to deal with a range of significant new pressures.

Plans were set on the basis that there would not be significant ongoing industrial action. Despite 10 months of strikes, the NHS has made progress on the delivery of the UEC, primary care access and elective recovery plans, while also displaying professionalism in planning for and managing periods of action. The strikes have nonetheless had a significant impact on patients and staff.

The impact of the more than 40 days of industrial action this financial year has created unavoidable financial costs that we estimate to be around £1 billion, with an equivalent loss of elective activity.

National action

To cover the costs of industrial action to date we are taking the following actions which have been agreed with Government:

- Allocating a total of £800 million to systems sourced from a combination of reprioritisation of national budgets and new funding.

- Reducing the elective activity target for 2023/24 to a national average of 103%, which will now be maintained for the remainder of the financial year. Discontinuing the application of holdback to the Elective Recovery Fund (ERF) for the rest of the year and formally allocating systems their full ERF funding.

Actions for ICBs and Trusts

We are asking ICBs and providers, by 22 November, to agree the steps required to live within their re-baselined system allocation and reflecting the impact of the reduced elective activity goal. Plans should be based on a scenario where there are no further junior doctor or consultant strikes.

The foundation of this reset should be protecting patient safety, including in maternity and neonatal care, and prioritising UEC so that patients receive the best possible care this winter. Progress on existing commitments on elective and primary care recovery programmes, as well as other goals, should build on that foundation.

Actions to deliver UEC performance should include the agreed investments in capacity – including beds and ambulance services – as well as other components of UEC plans, including admissions avoidance and discharge schemes. Following the additional funding and changes to the ERF threshold, these are expected to be fully implemented without further delay.

The primary focus for elective activity should be on long waits and patients with urgent care and cancer needs, including reducing the cancer backlog. Primary care plans should protect improvements in access.

In showing how you will deliver financial balance you will need to show:

- you have fully worked up efficiency plans, including the reductions in agency staffing set out at the start of the year;

- where you require flexibility on programme funding;

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- an elective plan that is refocused on driving productivity from core capacity, identifying the insourcing/outsourcing and waiting list initiatives you still consider necessary within a balanced financial plan focused on the longest waits, urgent elective, and cancer care.

Returns should identify the total activity you forecast to do and the implications of any changes on the trajectory to the March 2024 65ww target, including how maintaining existing patient choice, tiering and the GIRFT programme can all support delivery (including on inpatient length of stay, day case rates and capped theatre utilisation).

The current pause in strike action is a positive step. However, it will be important to understand the alternative, and so your plans should also include an assessment of a scenario where the junior doctor and consultant strikes continue in a pattern consistent with the last four months and how those costs can be minimised as far as possible. In this scenario the focus should be on what steps you would take to minimise additional costs.

Next steps

Following yesterday's webinar with ICB and provider CEOs and Directors of Finance, we are holding a further session this afternoon with Directors of Finance.

We will schedule sessions for each individual ICB Executive and their provider colleagues from 27 November to agree proposed actions.

We know how hard you have been working to maintain progress on implementing the recovery plans for elective care, urgent and emergency care, and primary care – as well as wider Covid recovery and priority transformation programmes – in the face of extraordinary pressures from prolonged industrial action.

We hope that this letter provides the clarity you have been seeking to now enact, along with system partners, those actions necessary to balance these financial challenges with your wider responsibilities.

Yours sincerely,

Julian Kelly
Chief Financial Officer
NHS England

Dame Emily Lawson, DBE
Interim Chief Operating Officer
NHS England

Professor Sir Stephen Powis
National Medical Director
NHS England

Dame Ruth May
Chief Nursing Officer, England

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Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 12

Report Title:	Integrated Oversight Report			
Name of Meeting:	Board of Directors			
Date of Meeting:	29th November 2023			
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 September / October 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 102.6% of planned for levels in October, Diagnostic activity was 100.2%, new outpatient 95.4%, elective overnight activity 110% (the highest month of the year so far), and a further increase on last month's highest value of 85%. Key elective performance headlines are: • RTT <18 weeks waiters' performance is at 66.9% (92% target) • RTT waiting-list list increased by 70 (or 0.5%) to 13,904, which is 24 above planned for levels • Diagnostic performance was 92.4%, the highest month so far this year (95% target). Audiology continues to be the biggest long-term risk but improved to 57% and now projecting recovery by March 2024 • 28 day and 31 day cancer standards are achieving their target levels for the latest validated month. With 2ww and 62 day performance remaining below target. • Patients waiting over 62 days on a 2ww pathway increased to 58, but remained below planned for level of 60.			

	The average number of G&A beds open increased in as a result of the start of opening of winter beds, standing at 457. The number of long stay patients in all groups, +7, +14 and +21 days fell for the first time since May. Average length of stay again increased, this month quite significantly from 4.73 in September to 5.52, the 5th month in a row average length of stay has increased. Attendances at A&E remain high at and increased to 9878, increasing by around 474 from September, paediatric attendances also increased and were not back inline with typical monthly levels. 1981 patients arrived by Ambulance, the highest number this year, and around 100 more than the average over the past 12 months, UEC performance measures in October • 4-hour A&E waiting times reduced to 70.8% • There were 24 12-hour trolley breaches. • 41.7% of Ambulance handovers were within 15 mins of arrival, 94.2% within 30-60 mins. • 30-60 minute handovers were 99 • 60+ minute handovers were 100 Workforce metrics show a continuing worsening picture in relation to sickness rate (6.2% October) and appraisal compliance (78% October). Vacancy rates again decreased to the lowest so far this year (1.6%). Total agency spend, as a percentage of the pay bill reduced again to around 0.5%, from around 1.5% in September. Transacted CRP in October was £2,231m, £478k above planned levels for the month. The year-to-date variance for CRP improved to £309k above planned for levels at this point in the year. Pay spend was £1,047m above plan in October, and £5,022m year to date overspend against plan. Non-pay spend was -£522k below plan in October, resulting in a £861k year to date overspend on this measure. This however is an improvement £1,383m overspend at the end of last month. Cumulative year to date with a planned deficit at the end of October of -£8,305m, the Trust stood at -£10,248m, £1,943m more than planned, and a slight increase from £1,705m more than planned at the end of September.	
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 – November Committees

1. Introduction

1.1 This report summarises performance across key NHS standards, requirements and KLOE's outlining the risks and ongoing recovery plans 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. October saw the percentage of patients reporting a positive experience remain at 95.0% (95.5% average last 3 months). National Benchmarking data (for the latest month published September 2023) shows we remain above the national average of 94.4%. Response rates have fluctuated in 2023 ranging from a low of 5.6% in October; (a reduction from 7.8% in September) to a high of 9.2% in received in April.

3.2 In *A&E services* the proportion of patients rating their experience as positive increased to 83.3% from 81.2% (83.9% average last 3 months) with common cause variation observed. Benchmarking data (for the latest month published September 2023) shows that we remain above the national average of 79.4%. Response rates in October were lower than usually observed at 3.6% (typical values are around 5.5%)

3.3 Themes identified from patients who rated their experience as 'poor or very poor' this month were very similar to the previous month. Themes focussed on long waiting times, pain relief whilst waiting, poor care, and staff attitude.

3.4 The number of formal complaints have increased for the past 2 months, with the 36 received in October, the highest since June 23. Although noting an increase this the number of formal complaints 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, with distribution spread across a range of all clinical areas proportionately.

3.5 The number of overdue complaints at the end of October fell to the lowest level since May 22. There were 4 overdue complaint at the end of October, down from 8 at the end of September. Of the 4 outstanding complaints 3 sat with the Medicine Business and 1 with Nursing, Midwifery & Quality – Cancer Services.

4.0 Safe Domain

4.1 There were no Serious Incidents (SI's) reported to StEIS in October, the first month since March there has been none reported. The number of reported SIs in the first 7 months of this year to October continue to be lower than the same period last year, reporting 26 this year compared to 46 last year, a 43% reduction year to date.

4.2 The number of patient safety incidents reported each months continues to fall, and in October the figure stood at 418, this is the 6th month in a row where numbers have reduced. 4.5% were recorded as resulting in moderate, severe, or major harm. Over the past 12 months the average is 2.0% of incidents recorded as moderate, severe, or major so August, September and October's figures are above this average. However actual number remain small (19 in October). Patient falls are consistently the top reason for incidents, as they were in October. 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 20 year to date. In October the Trust reported 6 Hospital Onset (HOHA), the highest individual month so far this year, however no Community Onset (COCA). The trust is therefore reporting 20 cases against the annual allowance and is now above the trajectory for this point in the year. Challenges influencing the numbers identified by the IPC team include high levels of C Diff currently circulating in the community, more virulent strain of C-diff identified by UKHSA, high bed occupancy rate, de-escalation of IV to oral antibiotics. This measure has been identified as a Trust Leading Indicator.

4.4 The Trust reported five COVID outbreaks in October, down from 10 in September, with the number of actual infections also dropping from 65 to 27. The number of definite health care associated incidents reduced from 19 to 8.

4.5 There continues to be no MRSA cases reported in the financial year. In October there were 5 Healthcare Associated E.coli infections and 14 Community associated, that means half the number of healthcare associated and 1 extra community.

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

5 Effective Domain

5.1 The HSMR is showing deaths 'As Expected' with a score of 105.7 against the national average figure of 100. Following a recent upward trend this indicator is close to triggering more deaths than expected. The SHMI has returned to As 'Expected' deaths with the latest figure of 0.90. A likely explanation for the recent reduction in the SHMI score is the inclusion of SDEC activity within the inpatient dataset from Sep-21. The Mortality review data for the last 12 months demonstrates that 99.6% of deaths reviewed were 'Definitely not preventable' with 96.2% of cases reviewed identified as 'Good practice', both figures are the same as last months.

5.2 The number of General and Acute beds open in October again increased to 457, from 449 last month. This increase is associated with the move towards the opening of additional winter beds. At the same time bed occupancy remains consistently well above 92% threshold and the ICB average, standing at 95.0%, which is a slight fall from 95.4% in September. Daily levels peaked at 98.3% on the 27th of October.

5.3 The average number of patients in the hospital at the start of the day who no longer meet the criteria to reside stayed stable at 40 in both September and October. The local ambition remains to is to reduce to no more than 18 patients per day. There was also a significant increase in the days accrued between the patient becoming medically optimised (MO) to discharge from 1,818 to 2407 which is an increase of circa 32% on the previous month, having decrease significantly in the previous month.

5.4 Average length of stay again increased, quite significantly this month, from from 4.73 in September to 5.52. the 5th month in a row average length of stay has increased. This months increase was driven by an increase in length of stay for non-elective patients in the month, which also increase from 4.83 to 5.79. However more positively, the number of patients in the hospital with lengths of stay of over +7, +14 and +21 all saw numbers reduce for the first time since May.

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

6 Responsive Domain

6.1 **ED and Ambulance attendances** – Attendances increased in October to 9,798 from 9,404 in September, daily attendances averaged 10 per day more than September 2022 (representing an increase of 3.2%). Paediatric attendances increased to account for typical levels of around 10% of attendances, having been lower for the past 2 months. April to October is seeing consistently high levels of Ambulance conveyances, averaging 1874 per month. October recording the highest number of Ambulance attendance in the past 12 months at 1981, more than 100 above the year to date average.

6.2 **Ambulance handovers continue to see pressures** with times having deteriorated again to 41.7% of handovers within 15 mins of arrival, down from 42.4% last month. However, 30-60 mins improved to 94.2% from 92.2% last months. 99 patients waited between 30-60 minutes for handover (a decrease from 123 last month) and 100 patients waited longer than 60 mins (a decrease from 122 last month). The Trust continues to benchmark fairly well across the ICS, ranking top for 30–60-minute handovers in October, and fourth for 60 minute+ handovers.

6.3 **Total waits in ED** – the proportion of patients waiting more than 12 hours in ED reduced to 5.69%, from 6.53% last month. There were 24 12-hour DTA breaches in the month, down from 50 in September. The total year to date is 90 12 hr DTA breaches since April, the same period last year saw 438 12 hr DTAs. Performance for the proportion of patients waited more than 4 four hours to be seen and treated, fell slightly to 70.8% in October, compared with 71.4% in September. This placed the Trust 38th out of 137 of Trusts, compared with 41st in September.

6.4 **Rapid response** - validated performance in September slightly below the 70% target standing at 68.9% (the fall in performance is attributed to staff sickness challenges). However cumulative performance since April stands at 72.4%. Activity levels also continue to be consistently high with 801 contacts recorded in the month, the second highest month this year.

6.5 Diagnostic 6-week performance was 92.4% in October, an improvement from 88.6% in September and highest monthly value so far, this financial year**.** October's performance continues to exceed benchmarking averages for NENC which stands at 83.7% and continues to exceed the latest national average of 73.7%. The number waiting for a diagnostic test fell to 5506 in October, with the number of patients waiting >6 weeks also falling to 416. Two areas continue to be a challenge stand out in relation to risks in achieving the Trust wide 95% diagnostic standard: Audiology, who account for 267 (64%) of the long waiters, however their long waiters reduced in October from 348 in September. Performance was the lowest of any test again in October at 57.3%, however this was an improvement from 45.7% the previous month. The service has developed a recovery plan and recovery trajectories have been revised with the Service is now aiming to achieve the DM01 95% target by the end of this current financial year, 31st March 2024. The other test is Barium Enema, which has the second lowest percentage performance of any test again in October, like Audiology however seen an improvement in October to 61.9%. Waiters for this test reduced to 97 from 111, and long waiters from 55 to 37. Barium accounts 8.9% of the long waiter's cohort, the service have identified a number of challenges impacting on performance and have developed a recovery plan, with recovery trajectories have also aiming to be achieved by March 2024 next year. Overall, with recovery plans in place, the DM01 95% target for the Trust is aimed to be achieved in February next year

6.6 **Cancer Waiting Times**: In October 2ww performance continues to be below standard at 80.4%, but improved from Septembers 76.8% and was above the latest England average, but slightly below the latest NENC average. The 28 Day Faster Diagnosis target for all pathways was above standard at 77.7% in September and 81.7% in October (indicative). The Trust met all three 31-day standards. The 62-day standards (2ww, screening and upgrade) continue to be below standard, and fell to 70.8% in September. The number of long waiters at the end of October was 58, so below the plan of 50, but 3 more than September. 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, however October has seen some improvements in elective overnight activity, and continues to place pressures on the Trust's waiting lists. In October the number of patients on the waiting list only slightly by 70 (or 0.5%) to 13,904, which is 23 above planned for levels at this point in the year. The proportion waiting less than 18 weeks for Treatment fell to 66.9%, the lowest of the year so far, however, remains better than the national average, but again 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 was 1 at the end of October under the General Surgery speciality. The number of patients waiting more than 65 weeks increased to 76 (59 above plan, the majority of which, around 70%, sit in the Paediatric long waiters cohort). Those waiting more than 52 weeks, fell in October to 274 at the end of October (232 above the planned level of 42). The most challenged specialities for 52w waiters remain Paediatrics, Pain, Trauma and Orthopaedics and General Surgery. In Peadiatrics pressures, best case projections based on current cohort indicate by the end of November number are expected to be around 125 waiters, which would be similar to the end of October, however, will increase further longer term. Paediatric long waiters are exclusively children aged 0-4 awaiting an autism assessment. Discussions continue around the Pathways for these children to align them to guidance. Pain projections based on current cohort indicate by the end of November there will be circa 29 over 52-week waiters, around half the current

volume. Plans are now in place for the pain specialities, which includes new staff starting in posts. As a result, the service has revisited the projections of their long waiters and expects to have 0 52-week waiters by the end of March 24. Currently the service is on target to meet this trajectory. Trauma and Orthopaedics projections based on current cohort indicate by the end of November there will be circa 40 over 52-week waiters, broadly in line with the latest monthly values. A range of proposals are being address the challenges in T&O, with trajectories being revised with an aim to reduce these further. These are being overseen by the Access and Performance meeting. General Surgery challenges in capacity indicate that general surgery will maintain at current levels of 52-week breaches in November of around 32. A business case for increasing capacity is due at November's business case review group.

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 in October, and the gap between planned and contracted staffing levels continued to narrow. As a result the Trust vacancy rate fell from 2.3% as of September, to 1.6% as of October, well below plan and a 0.6% reduction (25.8 WTE decrease) from September.

7.2 Sickness absence rates increased in October again to 6.2% across the Group, an increase 0.2%, and rolling 12m sickness levels remained stable at 5.7%. Both the Trust and QEF are above 6% now, and on an upward Trajectory. Core training saw a slight improvement by 0.5% to 87.2% compliance for the Group, with both the Trust and QEF above the 85% target. In relation to appraisals, there has been a further decrease this month to 78.0% for the Group, with the Trust at 76.9% and QEF 84% against the 85% target. While there had been a sustained improvement since May 2022, in each month since June the overall performance figure has reduced month on month. QEF continue to remain fairly stable for this metric, however the Trust continues to note a steady decline.

7.3 The month of October saw a decrease in both bank and agency requests. Fill rates for bank shifts remains consistent with previous months, however agency fill rates have increased significantly in October from a low position in September. Total Agency spend has reduced across nursing and other workforce groups, with medical workforce demonstrating an increase. Overall percentage of the pay bill continues a decline, standing at around 0.5% in October. Bank spend in the registered and non-registered nursing workforce has increased from the previous month.

We will achieve financial sustainability

7.4 **Finance -** Transacted CRP in October was £2,231m, £478k above planned levels for the month. The year-to-date variance for CRP improved to £309k above planned for levels at this point in the year. Pay spend was £1,047m above plan in October, and £5,022m year to date overspend against plan. Non-pay spend was -£522k below plan in October, resulting in a £861k year to date overspend on this measure. This however is an improvement £1,383m overspend at the end of last month. Cumulative year to date with a planned deficit at the end of October of -£8,305m, the Trust stood at -£10,248m, £1,943m more than planned, and a slight increase from £1,705m more than planned at the end of September.

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

NOVEMBER 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	Oct 23	***
Datix - Patient Safety Incidents	5	Oct 23	***
Infection Prevention & Control	6 – 7	Oct 23	***
Effective			
Hospital Standardised Mortality Ratio and Summary Hospital Level Mortality Indicator	8	Mar 21 to July 23 / Jan 21 to May 23	***
Discharge & Delays	9	Jan 22 to Sept 23	*
Long Length of stay patients	10	Sept 23 CDS	***
Efficiency and Productivity – Theatres	11	Oct 23	***
Responsive			
Urgent & Emergency Care	12	Oct 23	***
Ambulance handovers	13	Oct 23	***
Community Waiting List and 2hr Rapid Response	14	Wlist Oct 23 / RR Sept final	*** / ***
Elective Recovery	15	Oct 23	***
Diagnostics Activity and 6w Performance	16 – 17	Oct 23	***
RTT	18	Oct 23	***
Cancer	19 – 22	Sep / Oct (indicative)	**
Duty of Candour Verbal Compliance	23	Oct 23	***
Complaints	24 - 25	Oct 23	***
Well Led			
Sickness	26	Oct 23	***
Core Training	27	Oct 23	***
Appraisals	28	Oct 23	***
SIP and Vacancies	29	Oct 23	***
Agency and Bank Spend	30	Oct 23	***

NHS Gateshead Health NHS Foundation Trust

Key to Data Quality Signoff:

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

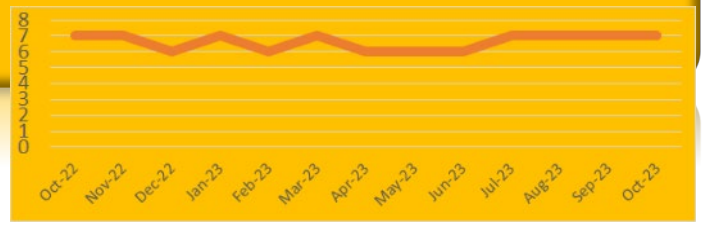
KLOE Summary: Indicators performing against target

Gateshead Health NHS Foundation Trust

Safe

7 of 8 (88%)

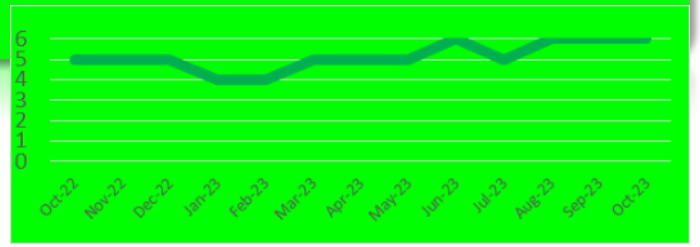
applicable indicators are performing well and/or not triggering SPC or are achieving against targets



Effective

6 of 6 (100%)

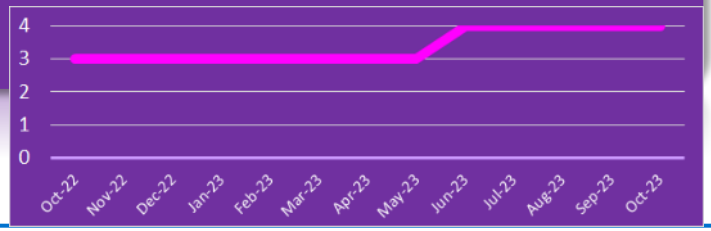
applicable indicators are performing well and/or not triggering SPC or are achieving against targets



Caring

4 of 4 (100%)

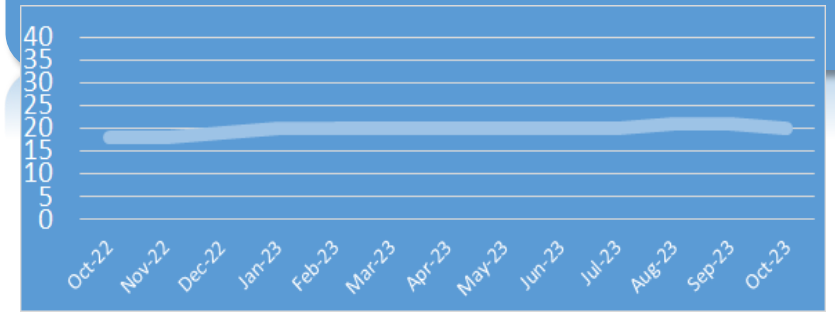
applicable indicators are performing well and/or not triggering SPC or are achieving against targets



Responsive

20 of 41 (49%)

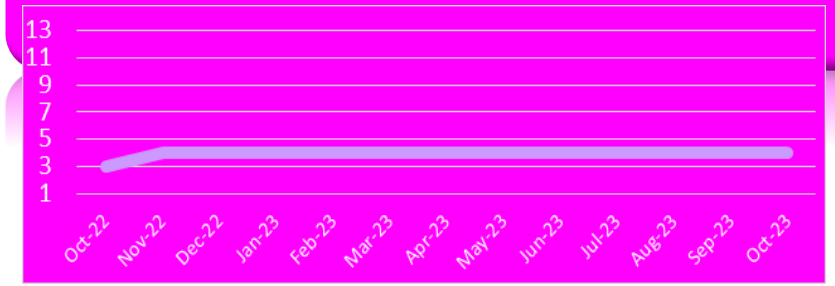
applicable indicators are performing well and/or not triggering SPC or are achieving against targets



Well Led

4 of 13 (31%)

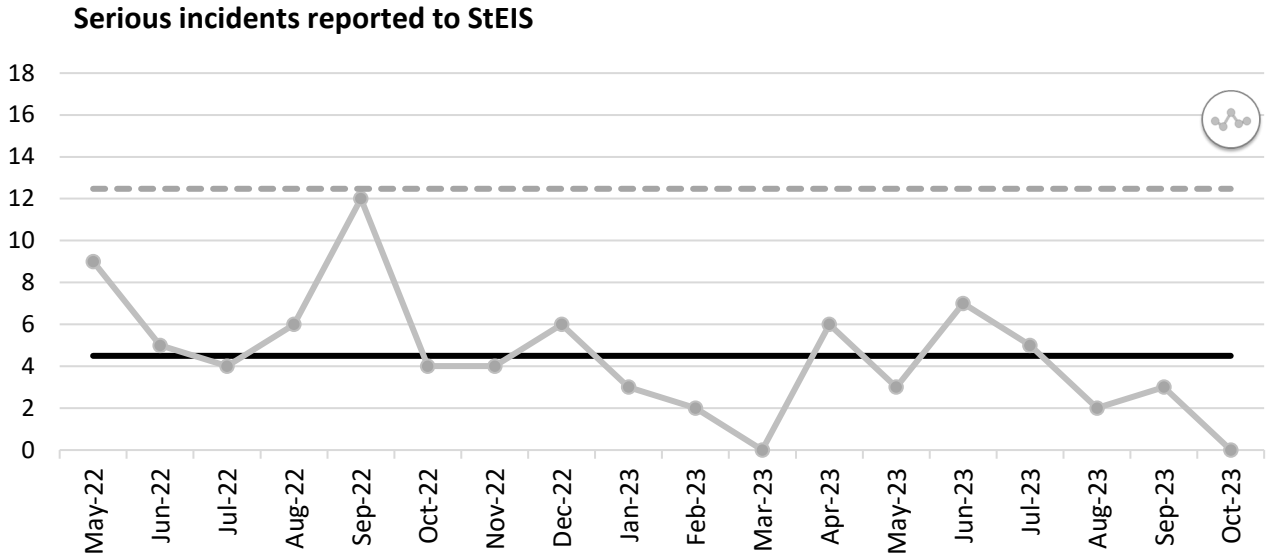
applicable indicators are performing well and/or not triggering SPC or are achieving against targets



Serious Incidents reported to StEIS & National Patient Safety Alerts

Safe

Gateshead Health NHS Foundation Trust



Serious Incidents reported to StEIS

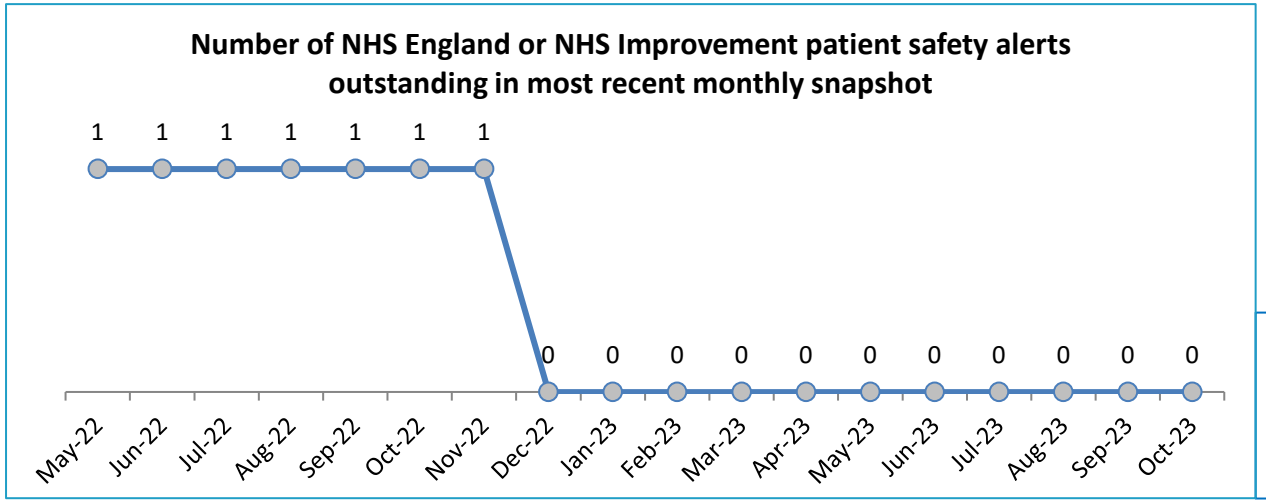
Aim: to ensure SI's are identified, reported and investigated appropriately. Identifying and sharing learning to prevent future occurrence.

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 0 SI's declared in October 2023



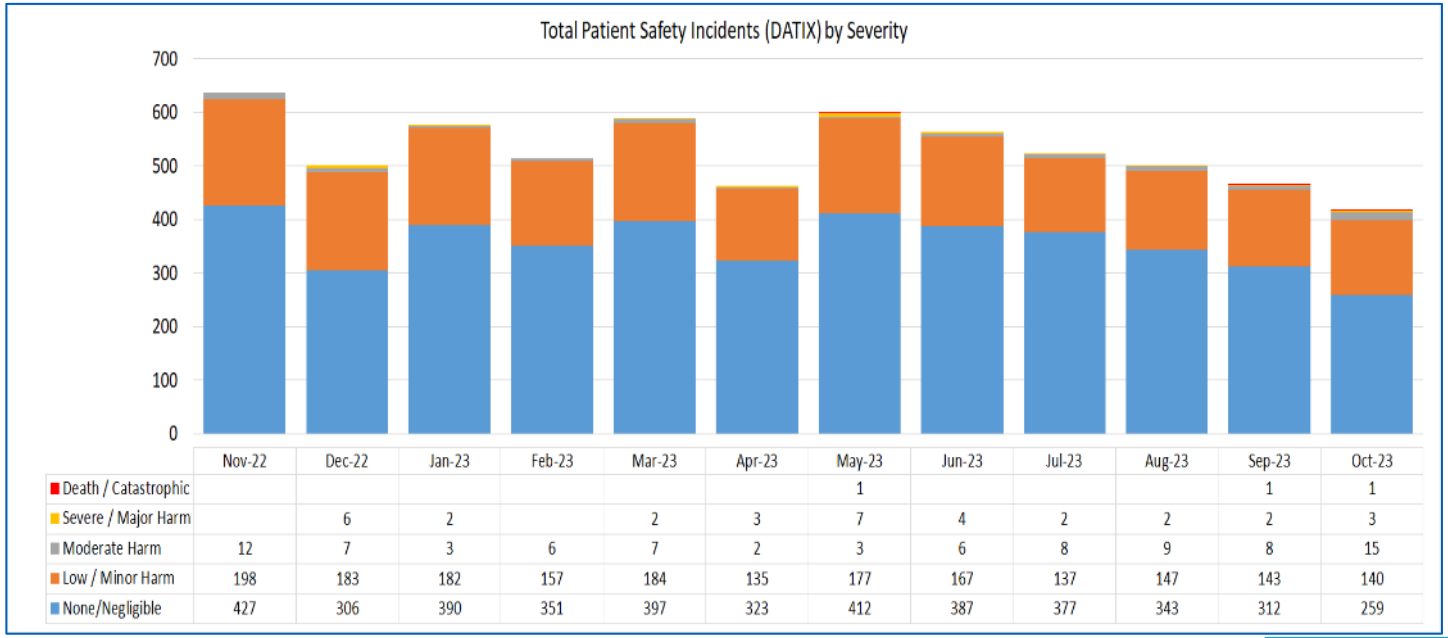
National Patient Safety Alerts

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

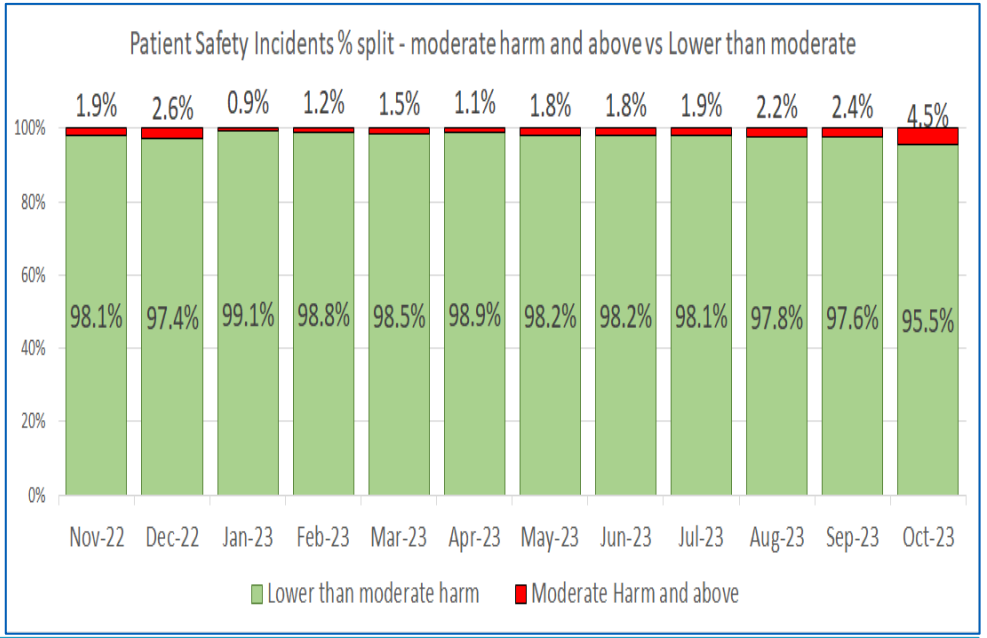
Datix - Patient Safety Incidents - included to provide high level information from Datix incidents

Safe

NHS Gateshead Health NHS Foundation Trust



	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
Death / Catastrophic							1				1	1
Severe / Major Harm		6	2		2	3	7	4	2	2	2	3
Moderate Harm	12	7	3	6	7	2	3	6	8	9	8	15
Low / Minor Harm	198	183	182	157	184	135	177	167	137	147	143	140
None/Negligible	427	306	390	351	397	323	412	387	377	343	312	259



Top 10 Datix incidents Nov-22 to Oct-23

1. Patient falls (1429)
2. Medication (876)
3. Pressure damage (675)
4. Delay/failure to treat/monitor (542)
5. Discharge or transfer issue (500)
6. Violence, abuse and harrassment (482)
7. Communication failure (459)
8. Maternity/foetal/neonatal (334)
9. Infection prevention & control (189)
10. Pathology sample issues (188)

Top 10 Incidents October-23

1. Patient falls (92)
2. Pressure damage (75)
3. Medication (44)
4. Delay/failure to treat/monitor (30)
5. Communication failure (29)
6. Pathology sample issues (23)
7. Maternity/foetal/neonatal (22)
8. Discharge or transfer issue (22)
9. Violence, abuse and harrassment (16)
10. Infection prevention & control (16)

- 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 529 incidents have been logged each month, with monthly figures varying between 418 (latest month of October 23) and 637 (November 22).
- 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 October the same 3 reasons were the most often reported.
- On average 2.0% of incidents each month have been recorded as moderate harm or above (top right), but months ranged from 0.9% to 4.5%. Monthly average of 12 incidents in actual numbers.
- Patient falls, Delay / failure to treat / monitor continue to be the top two incident types in the moderate and above groups with Results / investigations issues, medication and discharge typically next..

IPC – Healthcare Associated Infections

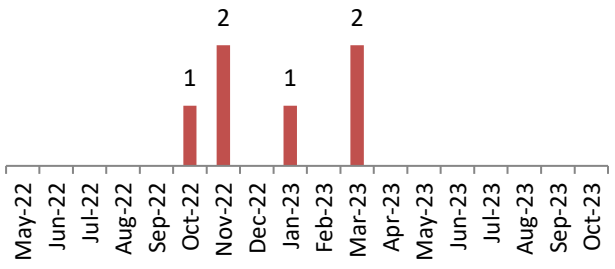
Safe

Gateshead Health NHS Foundation Trust

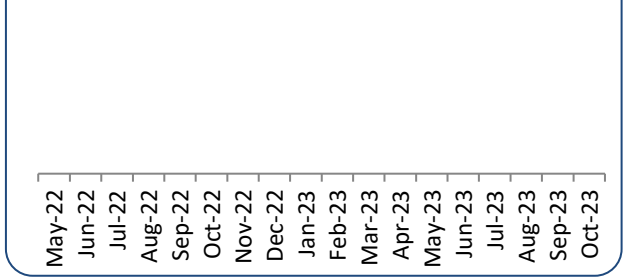
MRSA

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



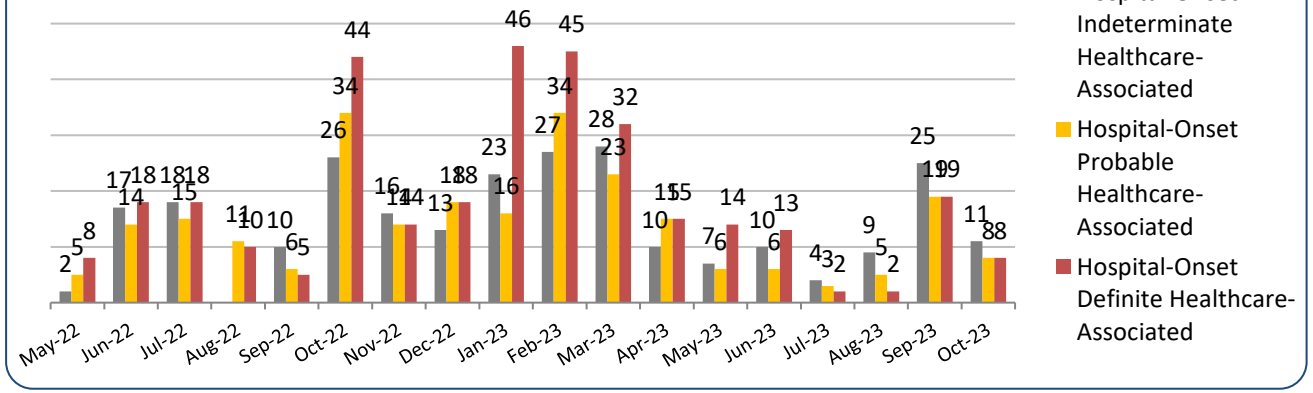
MRSA- Healthcare Associated



Nosocomial COVID 19 cases

All Healthcare associated COVID cases are reported and investigated through the DATIX system. 5 outbreaks related to COVID were declared within the organisation in October, down from 10 in September, with the number of actual infections also dropping from 65 to 27. The trust continue to operate a hybrid model to place patients if unable to isolate on their base ward in side rooms.

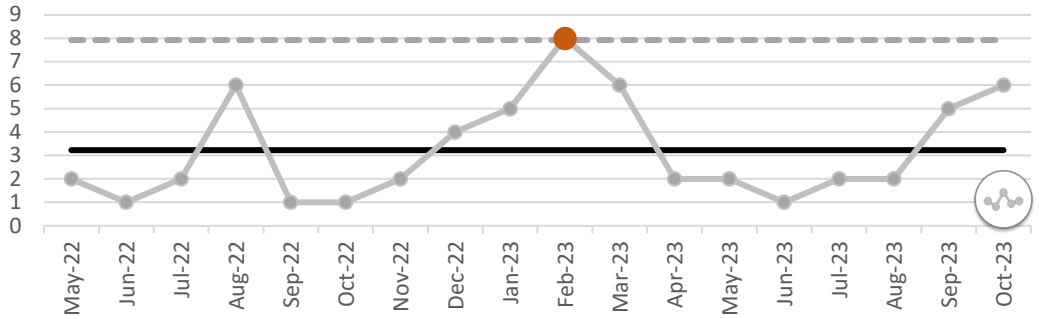
Nosocomial COVID-19



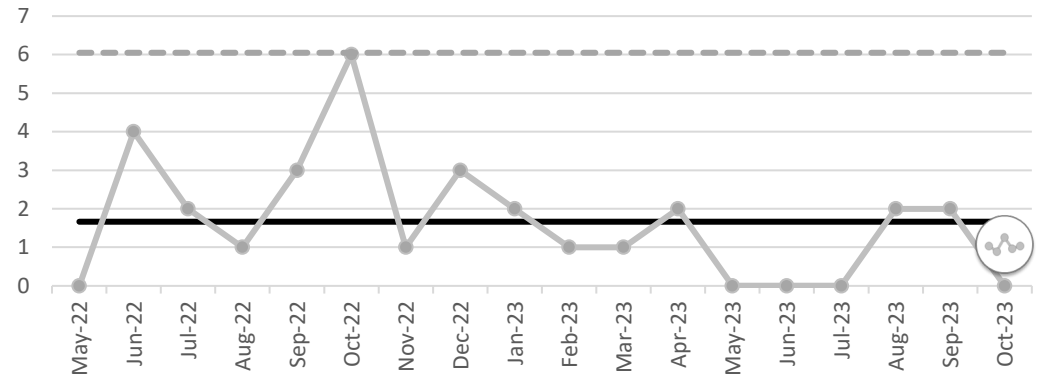
Clostridiodes Difficile Infection

- During October, the Trust reported x4 Hospital Onset Healthcare associated (HOHA) and x2 Community Onset Healthcare Associated (COHA) CDI's. Gateshead Health has been given a threshold of 23 for CDI in 23/24, we have currently had 20 Healthcare Associated CDI's from April 2023 to October 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

Gateshead Health NHS Foundation Trust

MSSA & E Coli

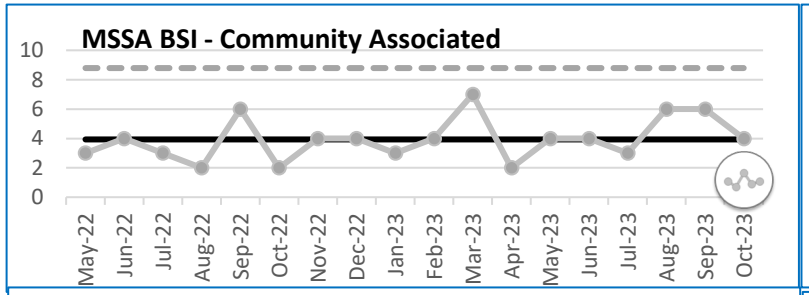
- NHS England has not set a Healthcare Associated MSSA BSI threshold for 2023/24.

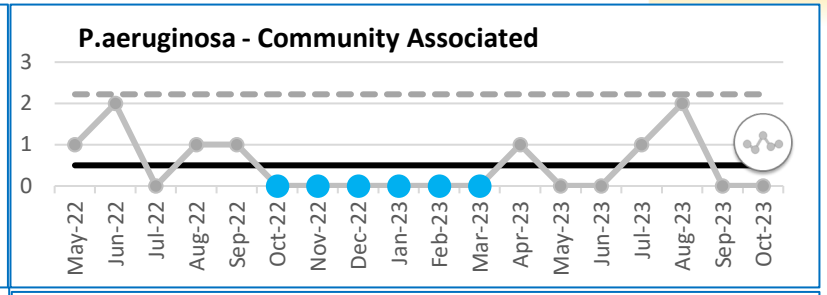
MSSA

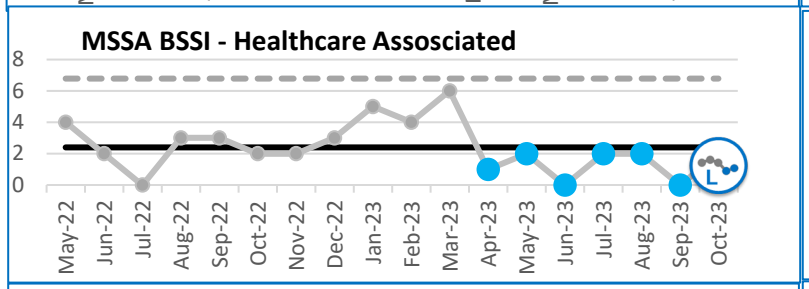
- The Trust has reported x 2 Healthcare Associated and x 4 Community Associated MSSA BSI's in October.

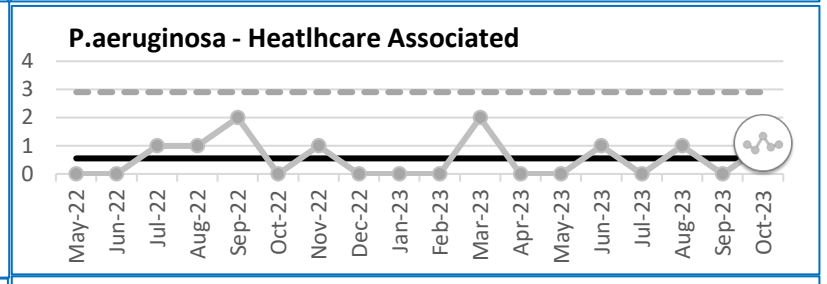
E.Coli

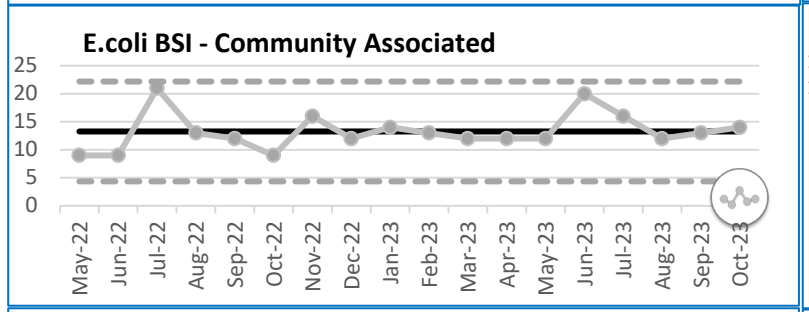
- The Trust has reported x 5 Healthcare Associated E. coli BSI's during October x 5 HOHA's and x0 COHA's.
- 14 Community associated (COCA's) were also reported.
- It should be noted that the majority of the COCA's were samples taken on admission or for assessment in A&E.

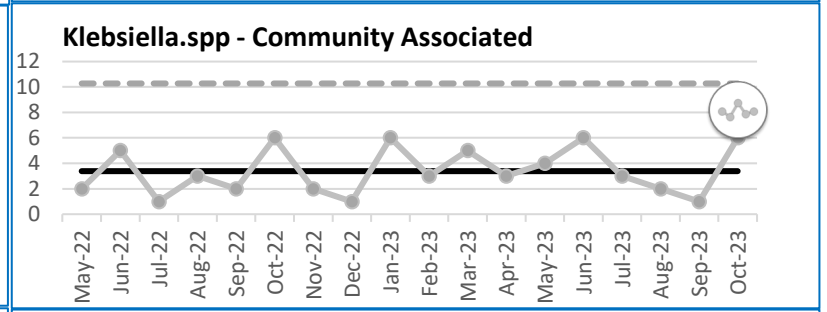


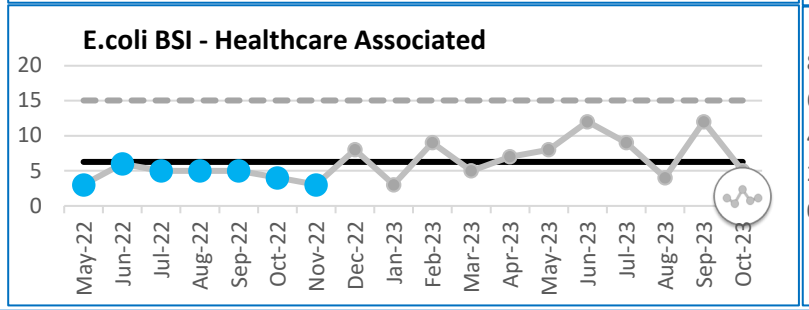


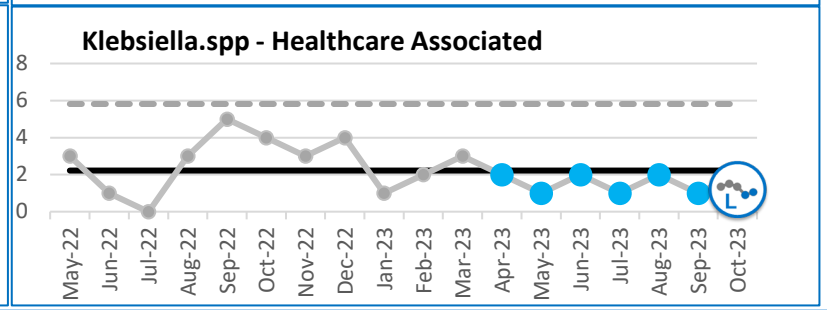












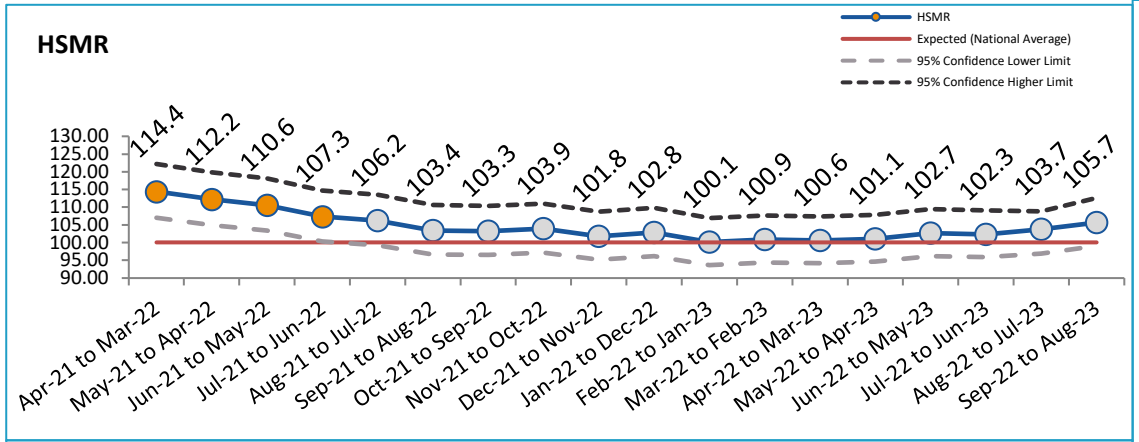
P. aeruginosa & Klebsiella spp

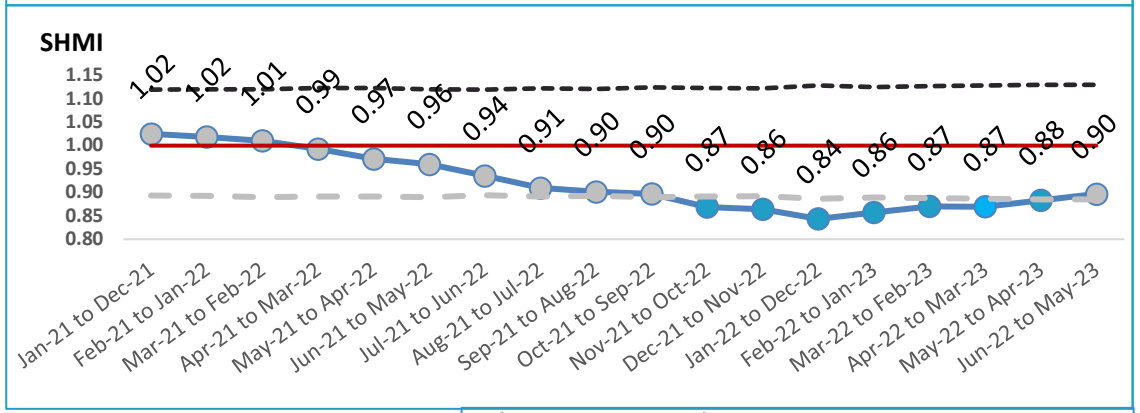
- All Healthcare associated BSI are reviewed, and learning are initiated, if necessary, any BSI's are investigated and learning/themes fed back to the relevant BU's.
- The Trust has reported x1 P. aeruginosa COHA and zero HOHA's in October.
- With regard to Klebsiella spp. BSI's, the trust has reported x2 HOHA's and x6 COCA's in October.

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

Effective

Gateshead Health NHS Foundation Trust





Mortality Review Deaths 01/10/2022 to 30/09/2023 — Data Extracted 30/09/2023

Deaths in period	Deaths reviewed by Medical Examiner	Hogan 1 - Definitely Not Preventable	NCEPOD Score 1 Good Practice
1226	1225	99.6%	96.2%
Denominators	1226		
	* 99.9%		

* 1 case referred to the coroner directly from the police and will not be reviewed by ME office.

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 105.7 against the national average figure of 100. Following a recent upward trend this indicator is close to triggering more deaths than expected.
- The SHMI has returned to As 'Expected' deaths with the latest figure of 0.90. A likely explanation for the recent 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 A&E activity (Planned early 2024-25) then the SHMI score is likely to increase at that point.
- Mortality review data for the last 12 months demonstrates that 99.6% of deaths reviewed were 'Definitely not preventable' with 96.2% of cases reviewed identified as 'Good practice'.
- 93 cases in the period require a review by the Mortality Council and/or the ward-based team.

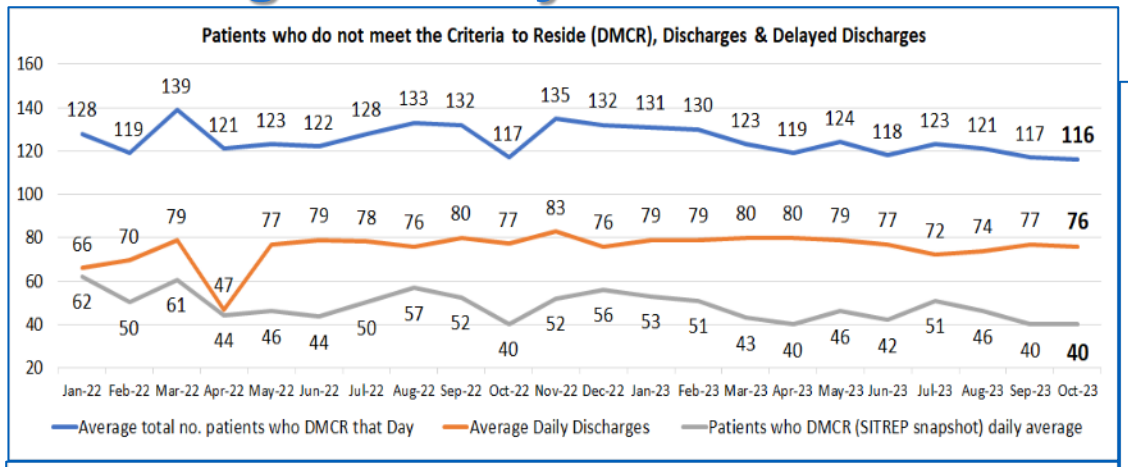
Since the inception of the Medical Examiner Service in September 2020, all deaths are reviewed and cases may be escalated for additional investigations i.e. Mortality Council, patient safety investigation. The only exception is one case which referred directly to the coroner by the police and will not be reviewed by the medical examiner office.

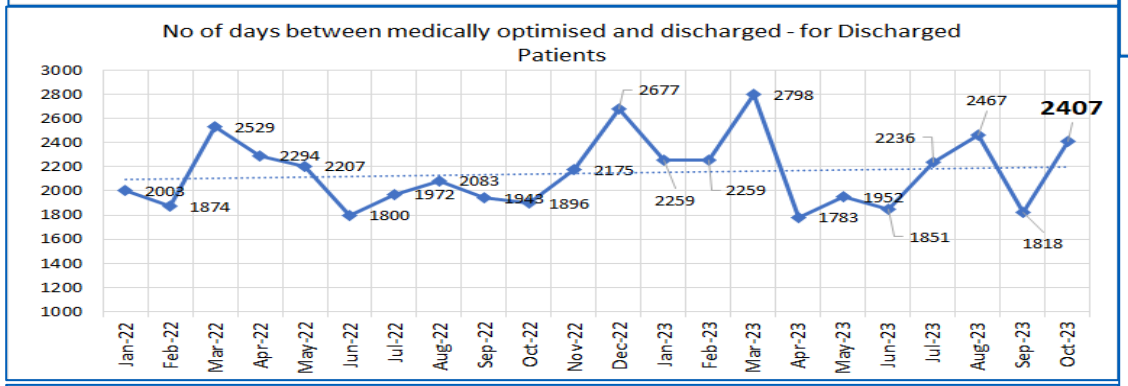
Actions

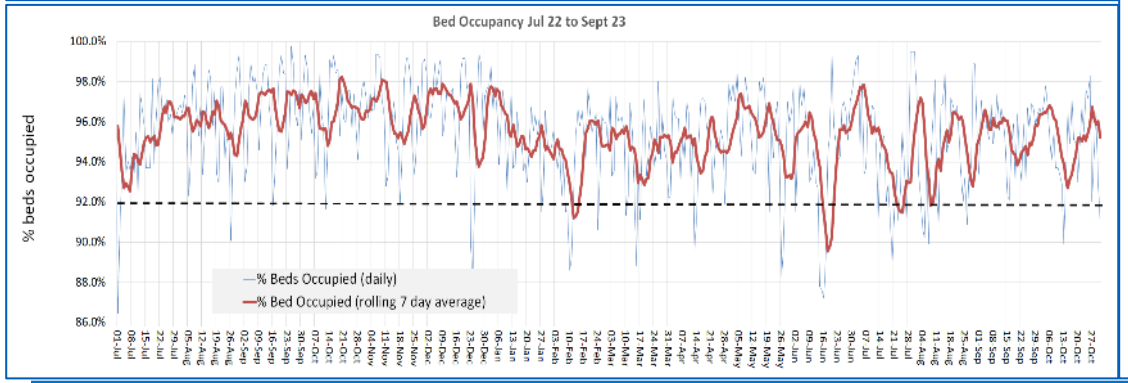
- The process for reviewing deaths were patients had a serious mental illness diagnosis.
- The process is embedded for those over 65, however the process to review under 65s relies on input from CNTW. The process has now been agreed with CNTW, they will review the backlog of cases and present at the 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 as well as additional Councils scheduled. The attendance at the Council by clinicians has increased over the last couple of months, which has reduced the need to cancel the meeting due to quoracy. A governor has joined the meeting to provide input from the patient perspective.
- 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.

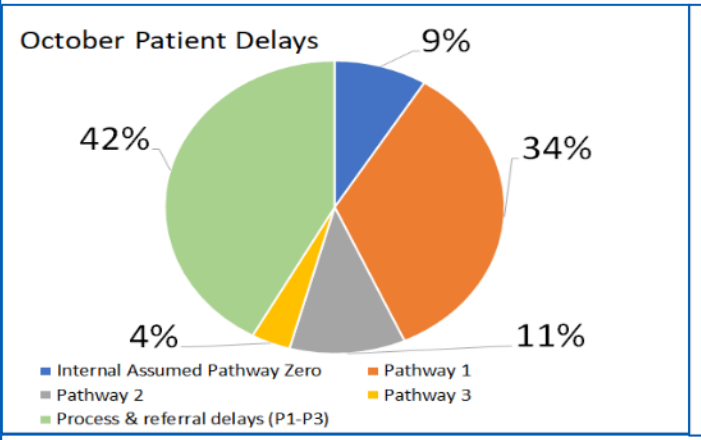
Recommendation - Continue to inform & note actions undertaken at Mortality and Morbidity steering group and Quality Governance Committee via the Integrated Oversight Report and Mortality Paper.

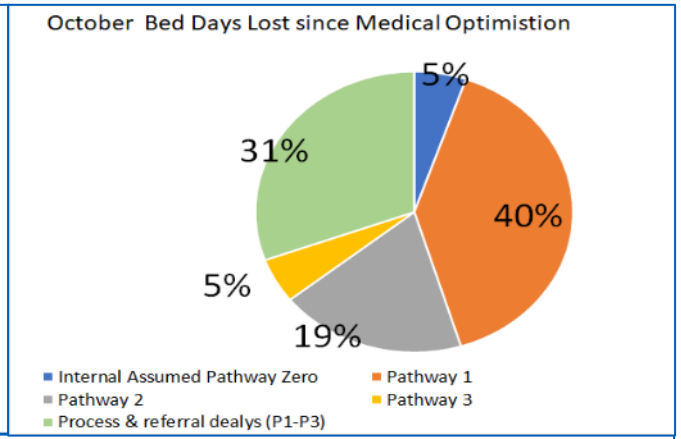
Discharge & Delays











Discharge and Delays – Discharges Jan 23 to present

During the day (on average) 123 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**, is shown in the chart (left). This month, different to the overall criteria to reside patient numbers which remained stable, noted a significant increase in bed days lost from 1818 to 2407, putting the number back on levels notes in August having previously reduced in September.

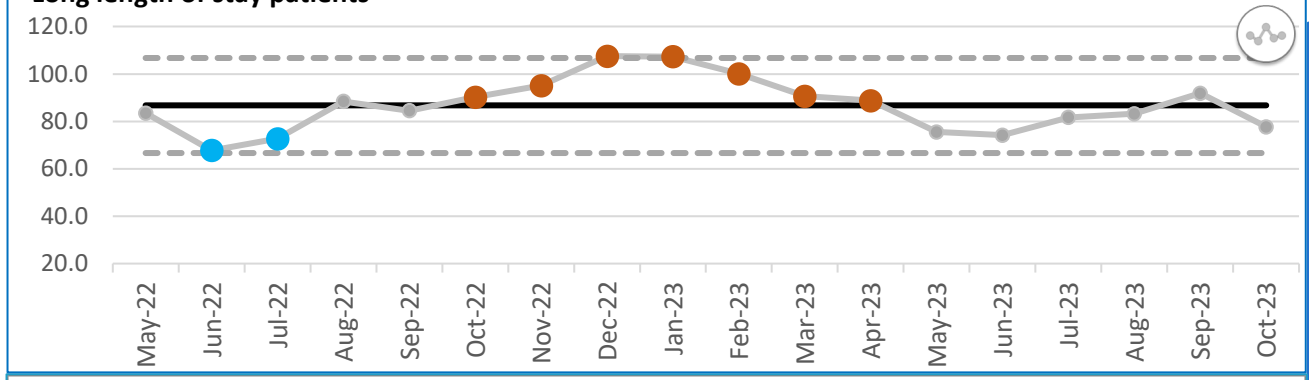
October Update:

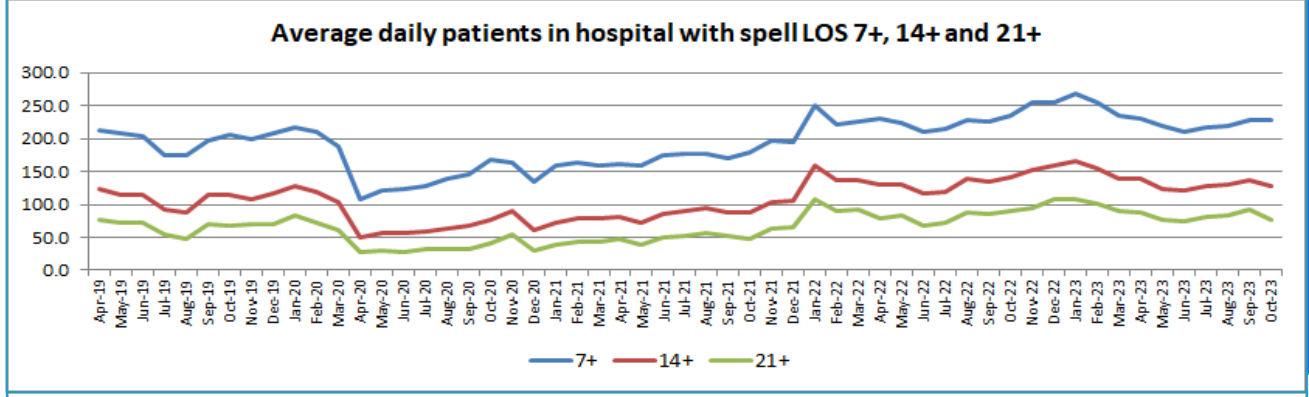
- Av. daily admissions: 94 per day (87 Sep) (range 54–119) / Average daily discharges: 90 per day (range 42-132) (84 Sep)
- CTR average daily patients – 116 per day, a further fall from 117 in September, 121 in Aug.
- CTR average discharges - 76 per day, slight fall from 77 in September
- 54% of discharges occur before 5pm, further fall from 56% in September
- Pathways 1-3 accounted for 49% of the patients and 63% bed day delays, Internal assumed pathways zero and process and referral delays account for 51% of the patients and 37% of the bed days delayed
- The average daily number of patients who no longer meet the criteria to reside remained stable at 40 in October, the same as September. Out of area patients continue to account for variable but significant proportions of our Hub discharges (Sunderland and Durham).
- Trust has the highest bed occupancy levels in ICS since June 22, and October's bed occupancy averaged 95.0%, a very slight decrease from 95.4% in September (ICS average 91.1% in October). Bed occupancy remains consistently well above 92% threshold, using 7 day rolling average basis.

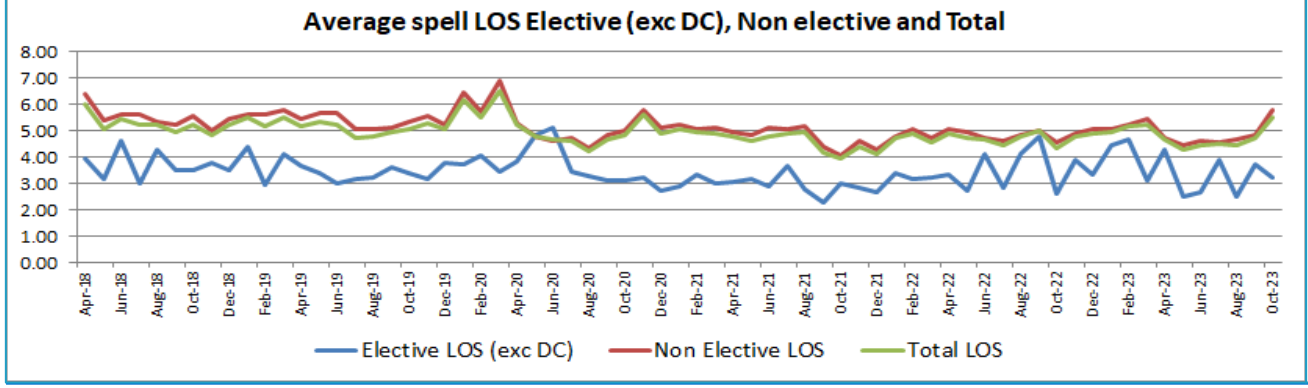
Report by exception: Long Length of Stay Patients

Effective

Gateshead Health NHS Foundation Trust





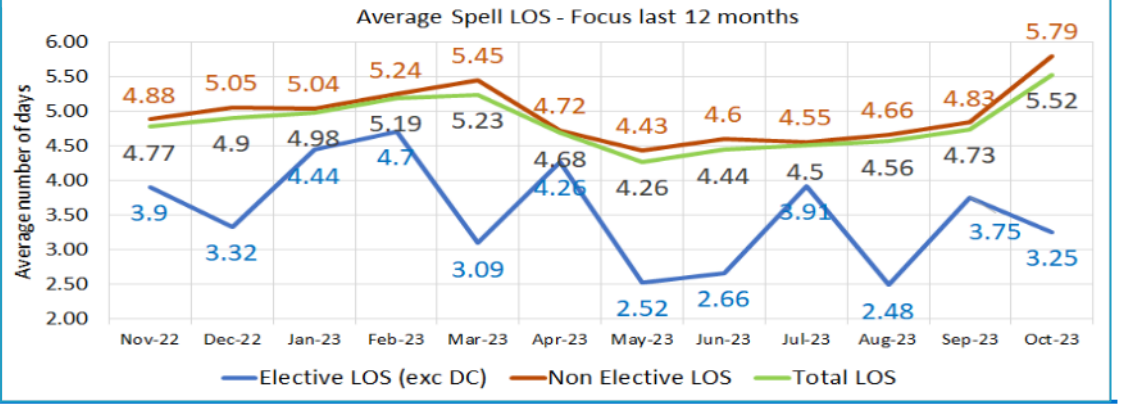


Situation

- 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 until May, since which the trend is of steady increase.

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 decreased in October to 77.7 from 91.9 in September
- The number of patients in the hospital with spells of more than 7+, 14+ and 21+ all reduced in October
- In October there was a daily average 227.3 patients in the hospital with a spell of 7+ days, a 0.5% decrease from 228.4% in September
- A daily average of 129.0 patients in the hospital with a spell of 14+ days, a 6.8% decrease from 137.8 in September
- A daily average of 77.7 patients in the hospital with a spell of 21+ days, a 17.0% decrease from 91.9% in September
- The Trust average length of stay of elective patients (excluding day cases) fluctuates each month, having increased to 3.75 in September fell to 3.25 in October.
- However total LOS again increased to 5.52 in October from 4.73 in September. The figure has increased every month since May. Non elective LOS also increased to 5.79 from 4.83 the previous month. This figure has been increasing since July.



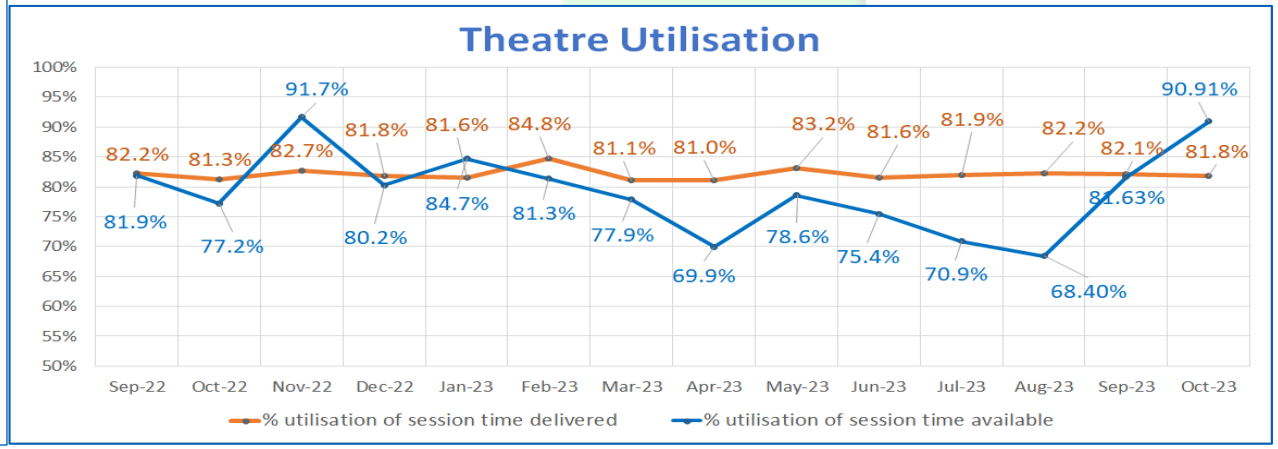
Efficiency and Productivity – Theatres

Effective

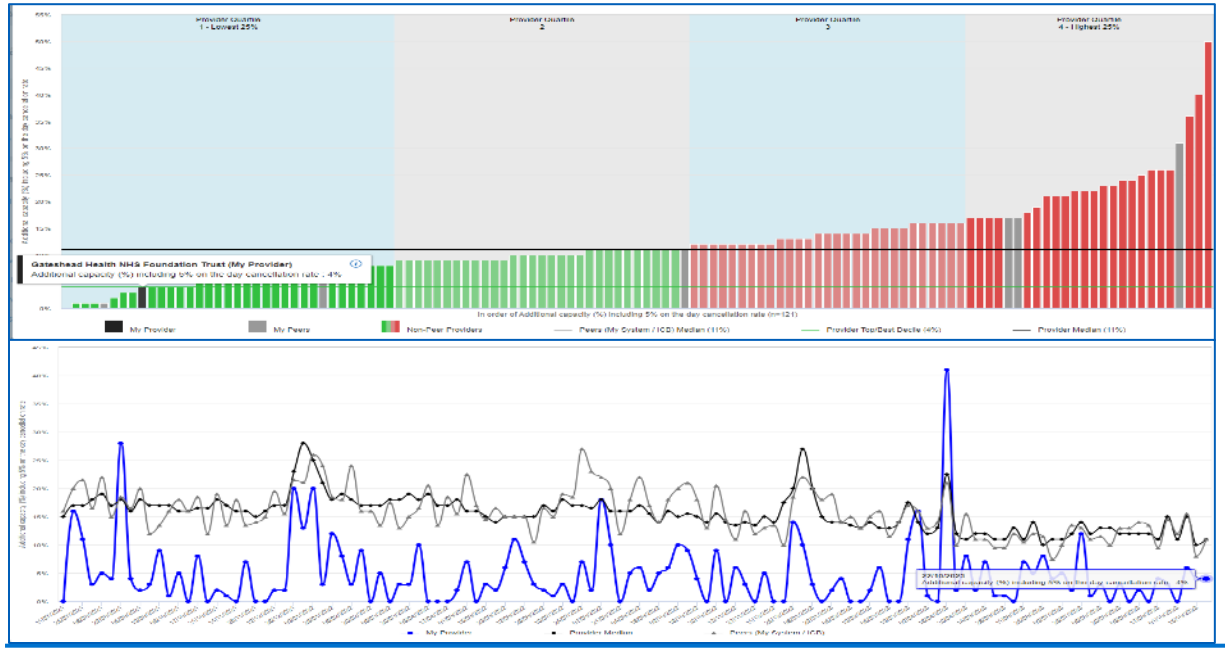
Gateshead Health NHS Foundation Trust

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

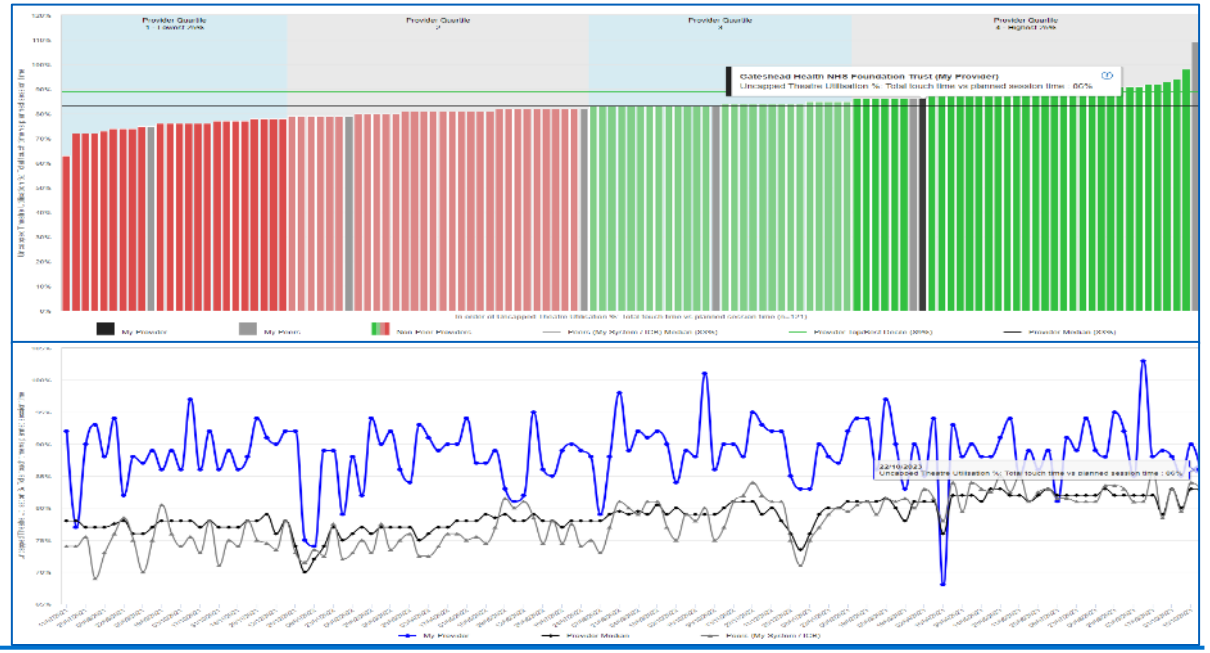
- Maximise our running theatre sessions > =85% with appropriate volumes of cases per list. At the end of October, the Trust continued to be below the threshold at 81.8%, slight fall from September's value of 82.1%.
- Maximising the use of the theatre session time available saw a notable improvement. 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 69.9% to 81.9%. However, in October performance improved to 90.91% from 84.6% last month, the second month in a row where there has been notable improvements.
- Latest published National data shows the Trusts performance on Uncapped theatre utilisation rate of 86% for touch time/planned, which is higher than the latest peer average of 83% and latest national average also 83%. The Trusts Capped theatre utilisation rate of 81.5% for touch time/planned is again higher then latest peer average of 77.8% and national average of 78.0%.
- National data also benchmarks well in relation to additional capacity (%) including 5% on the day cancellation rate which stands at 4%, and continues to be in the best performing quartile, lower than the latest peer average (11%) and national average (11%).



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



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



UEC Measures

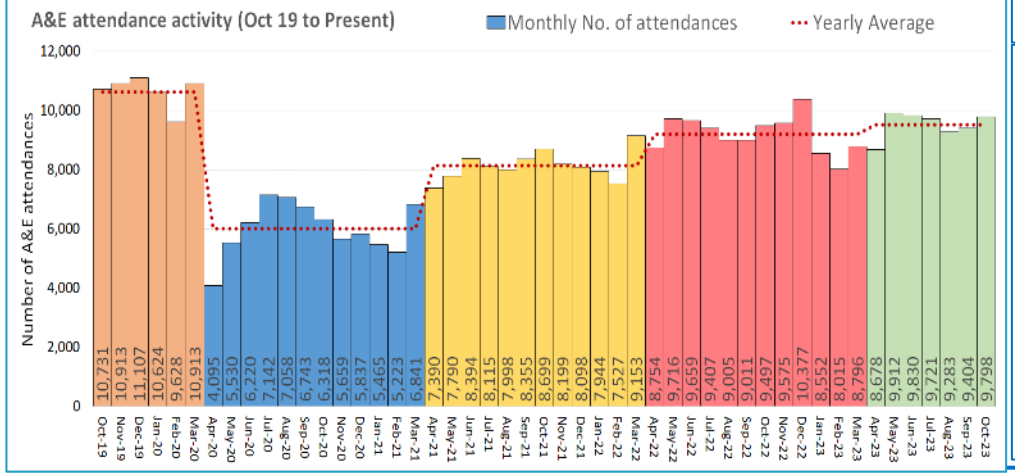
Responsive

NHS Gateshead Health NHS Foundation Trust

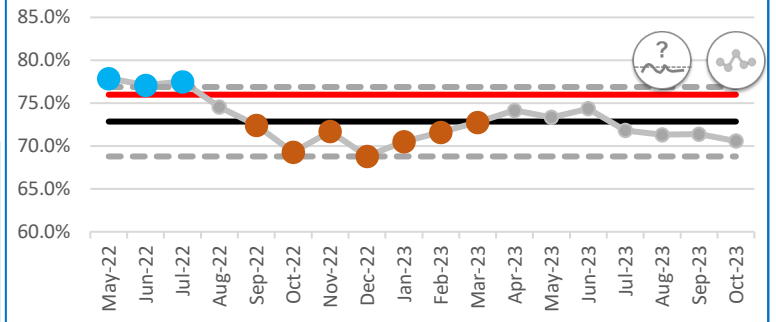
NHSI SOF Operational Performance & National Operational Standards

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

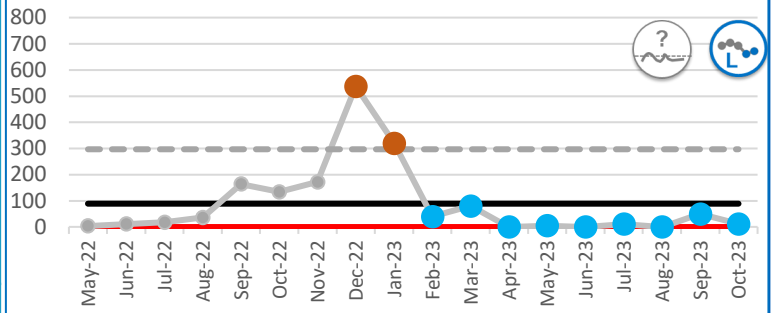
	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Monthly Trend
Attendances: Type 1	6220	7012	5500	5255	5940	5843	6499	6000	6178	5803	5570	5887	
Attendances: Type 3	3355	3365	3052	2760	2856	2835	3413	3830	3543	3480	3834	3991	
Total Attendances	9575	10377	8552	8015	8726	8678	9912	9830	9721	9283	9404	9878	
Total Breaches	2709	3237	2522	2275	2395	2243	2641	2520	2739	2662	2691	2881	
Trust Total - % seen in 4 hours	71.7%	68.8%	70.5%	71.6%	72.6%	74.2%	73.4%	74.4%	71.8%	71.3%	71.4%	70.8%	
National Rank (Accute trusts - Lower is better)	31	25	50	47	37	43	44	39	55	50	41	38	
12 hour trolley waits (DTA breaches)	172	538	320	40	80	0	5	0	11	0	50	24	
Volume in department >12hours	738	1116	710	325	496	237	355	395	380	404	614	562	
A&E >12hour waits (target <2%)	7.71%	10.75%	8.30%	4.05%	5.68%	2.73%	3.58%	4.02%	3.91%	4.35%	6.53%	5.69%	
Peadiatric Type 1 Attendances (number)	1388	2030	977	946	1103	1003	1172	1014	1042	706	820	1010	
Peadiatric Type 1 Attendances (% of all attendances)	14.5%	19.6%	11.4%	11.8%	12.6%	11.6%	11.8%	10.3%	10.7%	7.6%	8.7%	10.2%	
Average bed occupancy	96.5%	96.6%	95.4%	94.4%	94.6%	94.9%	95.6%	94.4%	94.8%	94.6%	95.4%	95.0%	



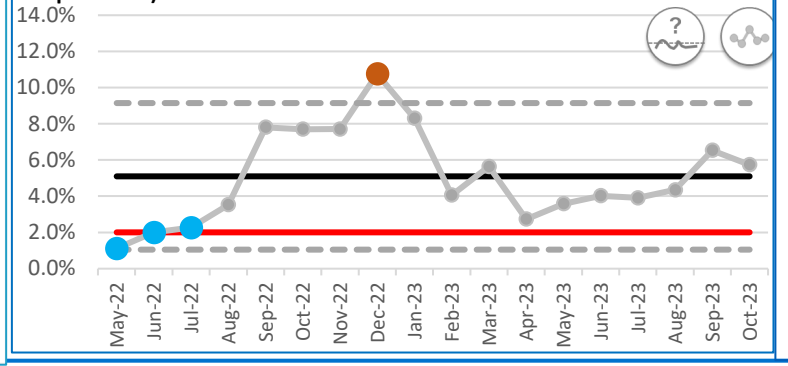
UEC 4 hour



12 hour trolley waits (from DTA to left department)



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



Situation

- Attendances increased in October to 9,798 from 9,404 in September, daily attendances averaged 10 per day more than September 2022 (representing an increase of 3.2%).
- The Trust ranked 38th nationally in October, compared to 41st in September for 4 hour performance.
- Overall time in the department for non-admitted patients was 2 hours 12 minutes (-36 mins to September) and admitted patients 8 hours 53 minutes (-47 mins to August). 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 in October (5.69%, 562 patients) and has not been met since June 22. But this was an improvement from September.
- There were **24** 12hr DTAs in October, around half that of September. The total year to date in October is 90 since April. The same period last year saw 438 12 hr DTAs.
- Bed occupancy levels reduced slightly to 95.0% compared to 95.4% the previous month, with a daily peak of 98.3% on the 27th October .
- General and Acute beds open in October averaged 457 for the month, an increase from 449 in September. However, part of the month saw additional winter wards starting to open.

Context:

- Urgent and Emergency Care remains under pressure, with high monthly attendance numbers and ambulance attendances, as well as pressures associated with high bed occupancy rates.
- 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; 12/31 (39%) in August; 25/30 (83%) in September and 25/31 (80.6%) in October.
- A new site huddle process was introduced on 4 October to drive improvements.

UEC Measures - Ambulance Handovers

Responsive

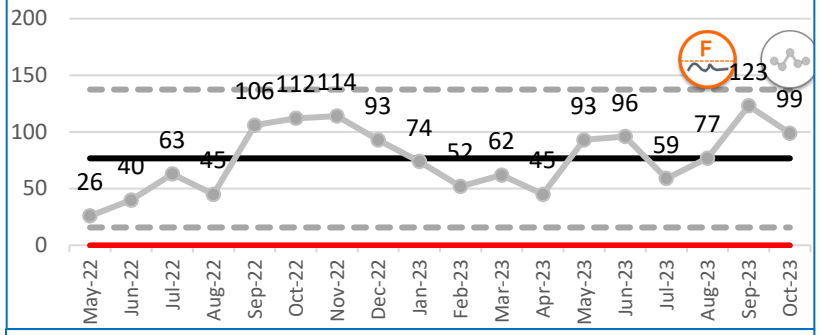
Gateshead Health NHS Foundation Trust

NHSI SOF Operational Performance & National Operational Standards

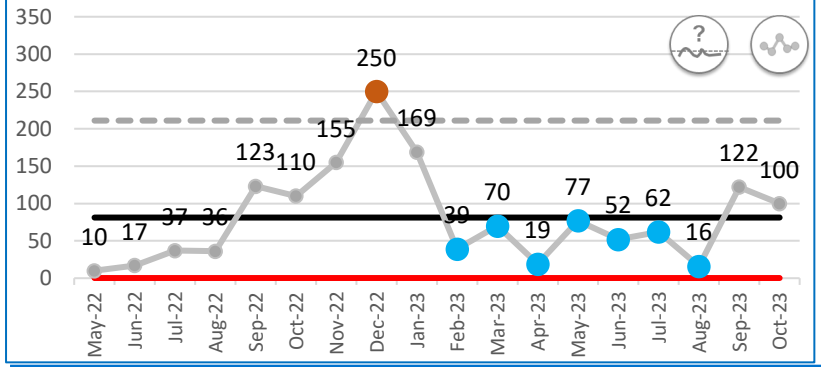
1. No. of ambulance delays
2. No. of ambulance diverts

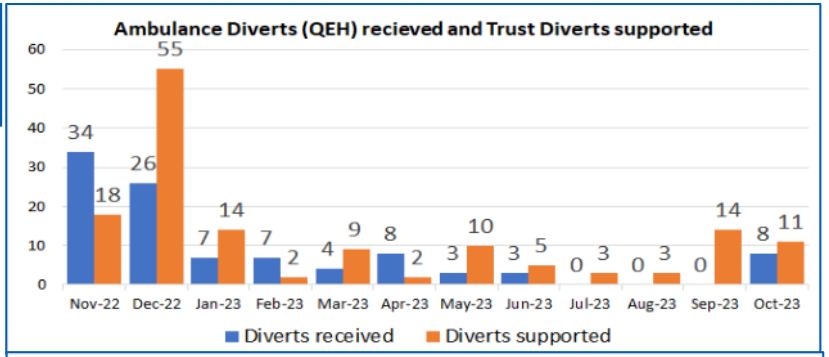
Ambulance Arrivals and handover delays	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Monthly Trend
No. Patients arriving by Ambulance	1679	1563	1629	1597	1778	1809	1885	1821	1941	1875	1810	1981	
% of handovers <15 Minutes	33.6%	24.7%	39.5%	48.6%	48.0%	48.0%	40.3%	46.6%	47.8%	48.3%	42.4%	41.7%	
% of handovers 30-60 Minutes	92.2%	93.4%	94.9%	96.3%	95.9%	97.1%	90.5%	94.1%	96.5%	95.3%	92.2%	94.2%	

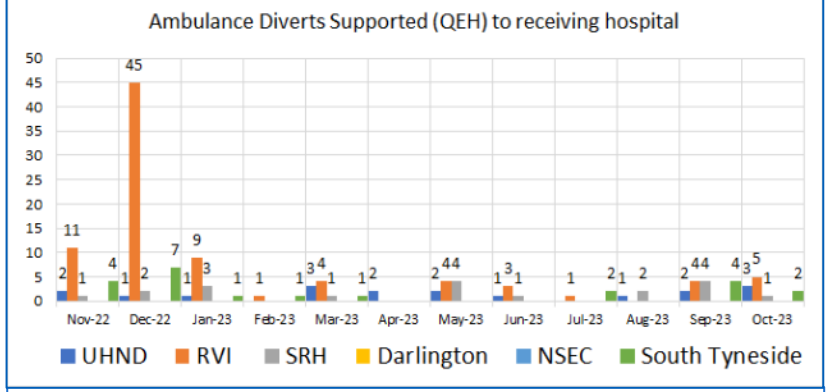
Trust data - 30-60 minute ambulance handovers



Trust data – 60m+ ambulance handovers







Situation

- April to October has consistently seen some of the highest number of Ambulance arrivals in the past 12 months, averaging 1874 per month YTD, with October recording the highest number in the past 12 months at 1981, more than 100 above the year to date average
- In October the Trust received 8 diverts, the first time in 3 months any have been received. And was supported with 11 diverts, down from 14 last month. 3 went to UHND, 5 to the RVI, 1 SRH and 2 South Tyneside.
- 94.2% of patients arriving by ambulance waited between 30-60 minutes for handover, below the 95% target, but an improvement on 92.2% last mont. 41.7% of handovers were within 15 mins, a reduction from 42.4% last month.
- In October the number of 30-60 minute handovers, while still high, reduced to 99 from 123. While and 60+ minutes handovers also reduced to 100 from 122 the previous month.
- NEAS handover data for October shows the Trust had the fewest, so was top performing Trust in the (ICS) region for 30-60m Ambulance hand-over times and forth best numbers for 60+ minute handovers.

NEAS Handover Data – 30-60 minutes (benchmarking)

	2019/20														
Provider	Avge	Min	Max	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
Gateshead Health NHS Foundation Trust	40	5	99	105	116	101	84	54	77	51	90	100	61	81	122	113
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	93	65	109	137	121	161	139	137	136	146	183	137	166	226	228	241
Northumbria Healthcare NHS Foundation Trust	472	283	723	484	405	426	350	288	355	273	383	441	172	314	308	426
South Tees Hospitals NHS Foundation Trust	138	105	184	339	319	187	383	368	387	429	386	387	445	437	392	367
North Tees & Hartlepool NHS Foundation Trust	64	42	116	152	134	160	139	54	55	112	87	71	124	98	96	125
County Durham & Darlington NHS Foundation Trust	313	165	438	394	373	285	225	170	237	171	151	179	193	165	269	198
South Tyneside and Sunderland NHS Foundation Trust	313	208	471	520	468	459	413	267	375	335	380	348	291	269	347	372
North Cumbria University Hospitals NHS Trust	405	265	559	316	320	381	271	111	216	172	126	135	110	126	169	323
NENC	1836	1308	2612	2447	2256	2160	2004	1449	1838	1689	1786	1798	1562	1716	1931	2165

NEAS Handover – 60 minutes + (benchmarking)

	2019/20														
Provider	Avge	Min	Max	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
Gateshead Health NHS Foundation Trust	21	0	81	132	174	279	170	49	62	20	77	53	76	21	139	109
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	2	0	6	10	8	12	9	7	13	8	10	7	17	16	15	24
Northumbria Healthcare NHS Foundation Trust	79	24	206	171	123	236	90	20	72	27	50	102	7	39	29	73
South Tees Hospitals NHS Foundation Trust	47	10	117	289	278	328	174	202	276	206	174	223	134	162	150	163
North Tees & Hartlepool NHS Foundation Trust	6	1	18	39	40	118	96	4	7	22	10	14	16	6	8	9
County Durham & Darlington NHS Foundation Trust	178	32	404	449	410	526	278	60	83	42	28	36	20	11	36	190
South Tyneside and Sunderland NHS Foundation Trust	117	23	268	270	205	407	281	58	198	111	157	70	46	40	70	88
North Cumbria University Hospitals NHS Trust	72	26	117	209	238	319	165	52	115	33	73	42	33	46	62	227
NENC	522	227	1138	1569	1476	2225	1263	452	826	469	579	547	349	341	509	883

Community Waiting List and 2hr Rapid Response

Responsive

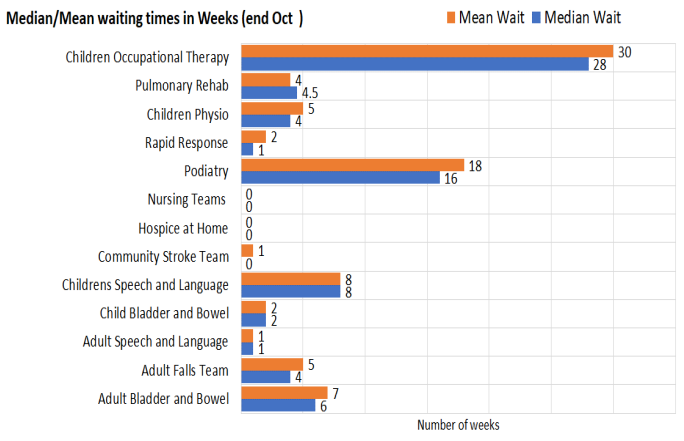
NHS Gateshead Health NHS Foundation Trust

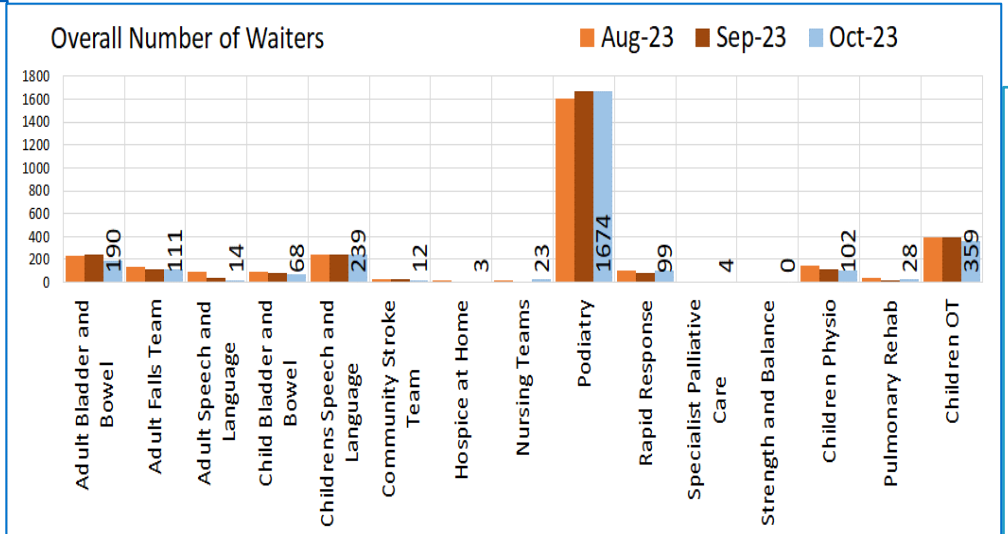
Context

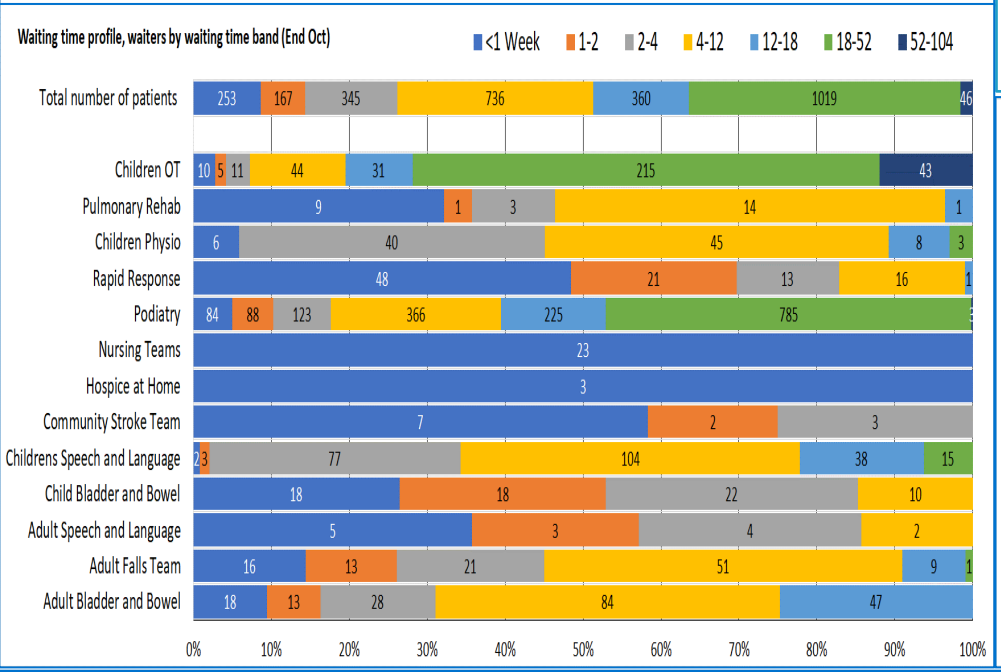
Community waiting list data is now submitted as part of the monthly Community Health Services SITREP. The following data is a summary of the latest submission as the 16th November **Note:** CYP Occupational Therapy service is in the process of transferring data across to the EMIS system, therefore is captured manually with plans for electronic reporting in the upcoming months.

Key points

- As at end of October there were 2926 patients awaiting assessment, which is an 3.7% increase since April 23, but 3.2% fall from the end of last month when the figure stood at 3022.
- At the end of October 57.2% of patients were on the waiting list for Podiatry, followed by 12.3% for Children's OT and 8.2% for Children's SALT
- The longest average waits are seen in Childrens OT, where average waiting times are between 28 to 30 weeks, then podiatry at 16 to 18 weeks.
- Of the total waiting lists (chart middle bottom), 63.6% of patients were waiting less than 18 weeks for assessment, 34.8% waited between 18-52 weeks, and 1.6% were waiting between 52-104 weeks.





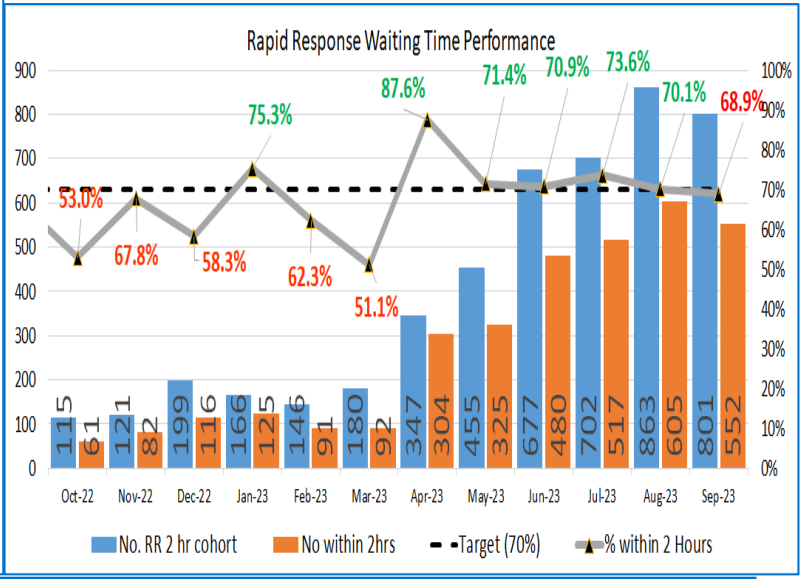


Background

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 September shows the Rapid Response team responded to 801 two-hour Urgent Community Responses (UCRs), of which 552 were seen within 2 hours, just below the 70% target at 68.9% for the month. Year to date however, cumulatively since April, the service stands at 72.4% validated performance, which is above target. **October's 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	Oct-23	Trend	Year To Date
Total - Comined Elective Activity (>100%)	100.7%	101.4%	118.2%	95.7%	111.9%	99.6%	102.6%		104.0%
Daycase (>100%)	85.9%	100.6%	119.9%	92.8%	109.8%	98.7%	104.7%		101.4%
Elective Overnights (>100%)	79.1%	75.4%	71.1%	73.1%	88.6%	95.5%	110.0%		84.1%
Outpatient - New (>100%)	87.3%	94.4%	100.4%	86.2%	105.4%	88.4%	95.4%		93.8%
Outpatient - Followup (Less than <100%)	109.6%	105.0%	127.6%	100.6%	115.4%	104.6%	105.1%		109.2%
Total Outpatient	103.0%	101.9%	118.8%	96.4%	112.5%	99.8%	102.2%		104.6%

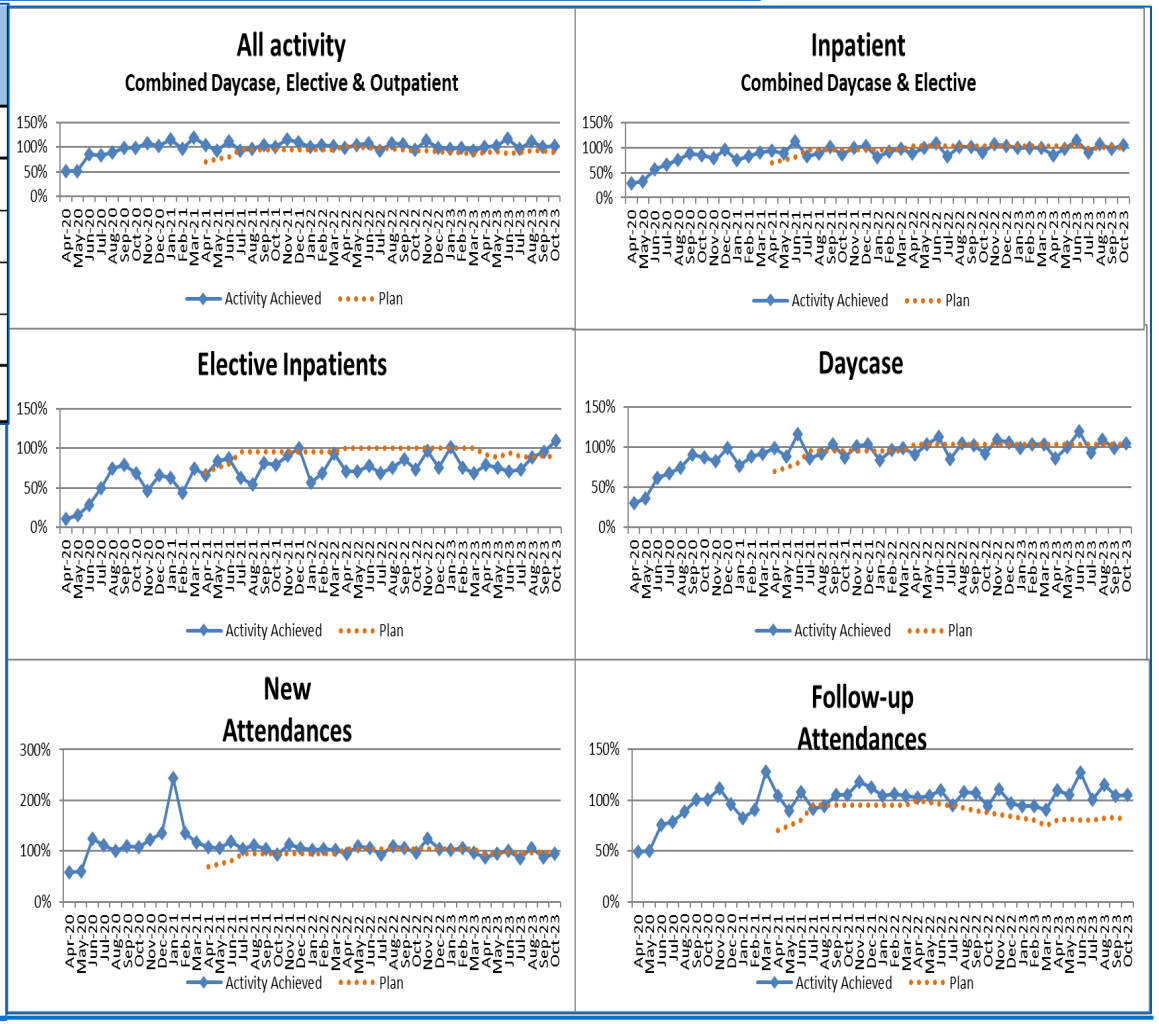
October's activity is above planned levels with **Combined elective activity at 102.6%,** and 104.0% year to date:

- **Day case** activity was 104.7% in month, 101.4% year to date
- **Elective inpatients 110.0%** in month, the first time over 100%, and 84.1% year to date (up from 79% end of Sept)
- **New Outpatients** 95.4% in month. 93.8% year to date.
- **FU Outpatients** 105.8% in month and 109.2% 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 slightly above plan levels of day cases, but also follow-up outpatient activity which was planned to reduce but continues not to be the case so far. Follow-up outpatient volumes have exceeded planned for levels in all 7 months. Elective overnight and new outpatient activity year to date or both below planned for levels overall, but elective overnight recorded the highest monthly activity so far this year in October and exceeded planned for levels for the first time.

Other key requirements in September:

- The Trust is reporting 19.9% of all outpatient attendances conducted remotely, which has reduced from previous months and is below the 25% expectation 3.% 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, and higher than 3.41% last month



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.

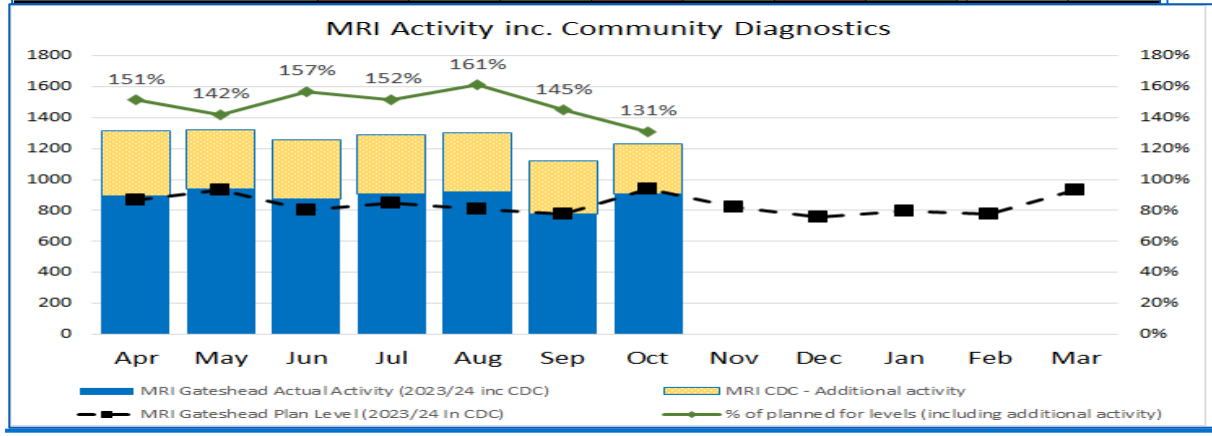
Diagnostic Activity - % of planned for levels 23/24 achieved	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Trend	Year to date
Total (>100%)	95.4%	96.1%	105.3%	90.5%	102.3%	95.1%	100.2%		97.8%
MRI (>100%)	103.0%	101.4%	109.2%	106.9%	113.9%	100.0%	96.4%		104.2%
CT (>100%)	103.5%	101.7%	102.3%	98.3%	102.3%	96.5%	107.1%		101.6%
Colonoscopy (>100%)	86.7%	121.0%	128.7%	100.3%	104.1%	113.7%	113.7%		109.5%
Non Obs Ultrasound (>100%)	90.2%	86.3%	99.5%	76.8%	93.6%	89.1%	98.7%		90.5%
Flexi Sigmoidoscopy (>100%)	65.6%	108.2%	85.2%	79.2%	106.6%	75.3%	90.0%		86.2%
Gastroscopy (>100%)	72.7%	104.6%	124.7%	87.5%	136.1%	80.4%	97.7%		98.5%
Echo (>100%)	99.4%	96.4%	125.7%	101.9%	113.8%	117.2%	82.1%		104.6%
Endoscopy (>100%)	77.1%	111.5%	120.1%	91.8%	118.3%	91.8%	102.6%		101.2%

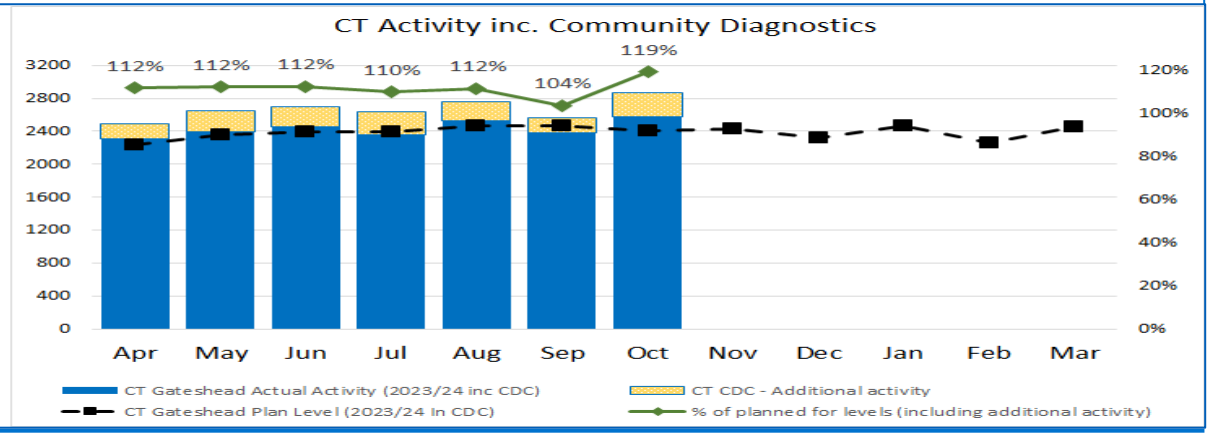
Note: The tests listed on this page are not all diagnostic activity tests undertaken by the Trust, only those that form part of the 23/24 Operational Plan expectations. This page monitors delivered activity against those planned for levels only. Activity in the table right reports on Gateshead only activity, 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 October, the overall level of diagnostic activity delivered was slightly above planned for levels at 100.2% of planned activity, an increase from 95.1% last month. Year to date the figure stands at 97.8% of overall planned activity having being achieved.

MRI, CT, Colonoscopy, Endoscopy combined, and Echo continue to all achieve planned for levels year to date, however MRI and Echo failed to achieve planned for levels in October. Endoscopy overall achieved levels as a result of high colonoscopy activity. The combined endoscopy tests achieved 102.6% of planned levels of activity in October, 101.2% year to date, which has been aided by insourcing of activity. NOUS is the only test consistently below planned for levels of activity, at 98.7% in October and 90.5% year to date.

In October when adding on non-Gateshead activity the percentages of activity delivered including CDC were 131% for MRI and 119% for CT.





Maximum 6-week wait for diagnostic procedures

Responsive

NHS Gateshead Health NHS Foundation Trust

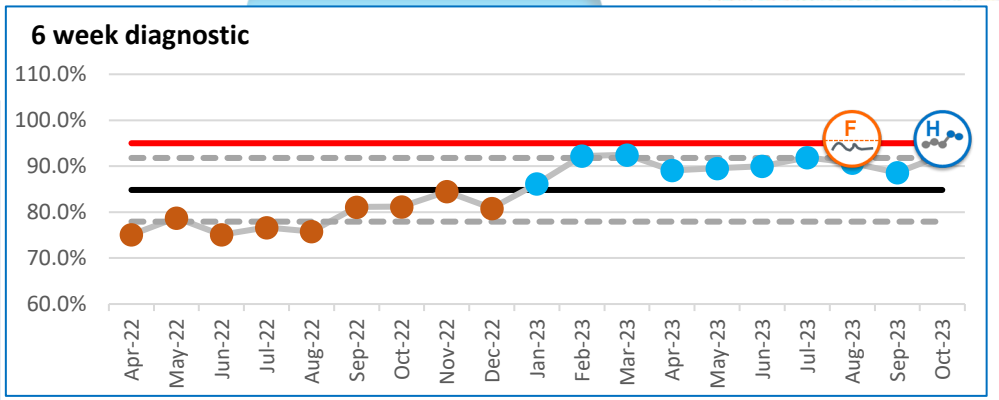
NHSI SOF Operational Performance & National Operational Standard

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

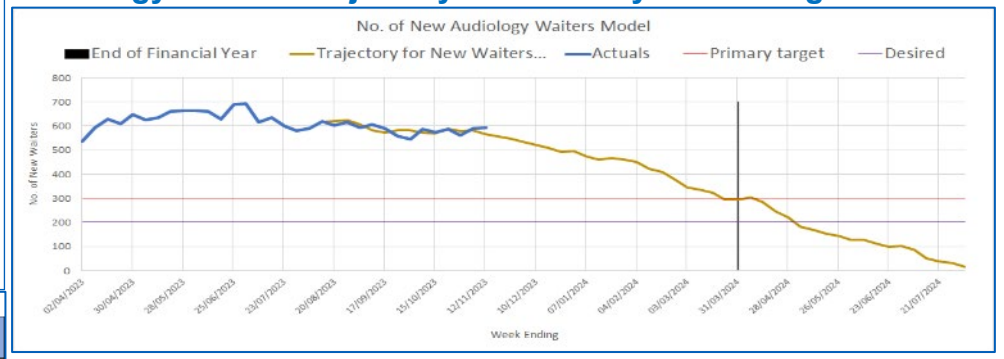
Trust Diagnostic performance:

- Performance 92.4% in October, an improvement from 88.6% in September and highest monthly value so far, this financial year. Overall, Trust performance remains below 95% target.
- October's performance continues to be above the latest NENC average of 83.7% (Sept 23) and continues to exceed the latest national average of 73.7% (Sept 23).
- Numbers waiting for a diagnostic test fell from 5609 in September to 5506 in October, with the number of patients waiting >6 weeks also falling from 640 to 416.
- Currently two particular areas stand out in relation to risks in achieving the Trust wide 95% standard:
- First in Audiology, who account for 267 (64%) of the long waiters, however their long waiters reduced in October from 348 in September. Audiology is the single largest risk area in achieving the 95% standard for the Trust. Audiology performance was the lowest of any test again in October at 57.3%, however this was an improvement from 45.7% the previous month. 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 Access and Performance meetings. Recovery trajectories have been revised at the start of November and the Service is now aiming to achieve the DM01 95% target by the end of this current financial year, 31st March 2024.
- Secondly Barium Enema, which has the second lowest percentage performance of any test again in October, but like Audiology have seen an improvement in October to 61.9% compared to 50.5% in September. Waiters for this test reduced to 97 from 111, and long waiters from 55 to 37. Barium accounts 8.9% of the long waiter's cohort, up from 8.4% last month. The service have identified a number of challenges impacting on performance and have developed a recovery plan, which is being monitored as part of the weekly Access and Performance meetings. Recovery trajectories have been developed the 95% DM01 target is likely to be achieved around March 2024 next year.
- Overall, with recovery plans in place, the DM01 95% target for the Trust is aimed to be achieved in February next year.

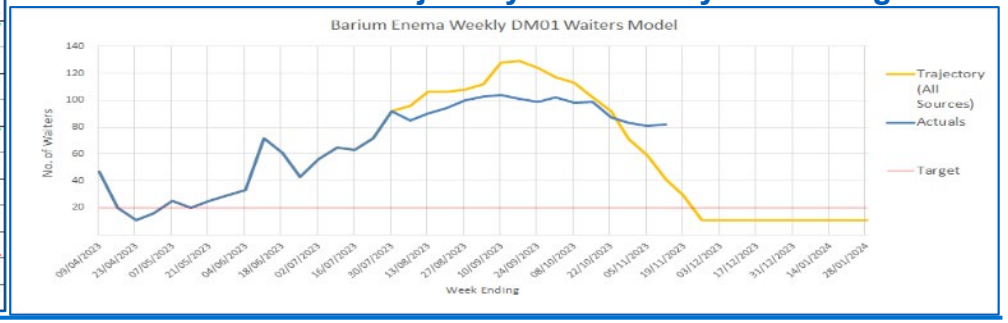
	95 % Standard												
Diagnostic waiters <6 weeks	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Trend
Trust Total (95%)	84.5%	80.8%	86.2%	92.2%	92.5%	89.1%	89.5%	90.0%	91.9%	90.7%	88.6%	92.4%	
Barium Enema (95%)	100.0%	100.0%	97.8%	100.0%	100.0%	100.0%	100.0%	98.6%	85.7%	60.4%	50.5%	61.9%	
CT (95%)	99.3%	99.0%	99.5%	99.3%	99.2%	99.4%	99.8%	99.1%	98.6%	98.8%	98.5%	99.8%	
MRI (95%)	98.4%	95.4%	97.6%	99.7%	100.0%	99.7%	100.0%	100.0%	98.4%	99.4%	98.8%	99.8%	
Non-Obstetrc Ultrasound (95%)	99.6%	99.6%	99.4%	99.4%	99.5%	99.2%	98.9%	99.5%	98.4%	97.4%	94.0%	98.5%	
Audiology (95%)	52.0%	42.3%	51.1%	65.2%	60.1%	51.4%	52.6%	52.0%	56.7%	55.5%	45.7%	57.3%	
Urodynamics (95%)	97.4%	90.7%	91.2%	100.0%	88.2%	92.6%	100.0%	94.4%	96.9%	95.8%	92.0%	100.0%	
Colonoscopy (95%)	98.2%	93.5%	96.3%	92.1%	86.8%	81.6%	85.5%	89.3%	92.3%	90.4%	92.2%	95.2%	
Flexi-Sig (95%)	98.2%	94.5%	96.4%	93.1%	92.1%	81.2%	89.1%	85.5%	85.7%	79.0%	89.7%	96.6%	
Gastroscopy (95%)	97.5%	95.6%	95.1%	98.7%	95.5%	91.0%	88.6%	92.8%	89.9%	90.9%	94.7%	96.5%	
Dexa (95%)	99.0%	98.5%	99.5%	98.2%	98.7%	97.4%	99.1%	98.4%	98.8%	98.9%	98.9%	96.1%	
Echo Cardiology (95%)	52.1%	42.5%	63.0%	85.3%	93.9%	90.6%	86.4%	87.3%	94.8%	94.9%	95.3%	94.8%	
Cystoscopy (95%)	100.0%	97.0%	93.1%	90.0%	91.3%	87.6%	87.4%	84.5%	89.2%	94.5%	89.9%	97.7%	



Audiology Waiters Trajectory from weekly monitoring:



Barium Enema Waiters Trajectory from weekly monitoring:



Referral to Treatment

Responsive

NHS Gateshead Health NHS Foundation Trust

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

RTT Long Waiters (at month end)

Waiters at month end		Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Trend
Total Waiters	Actual	12715	12593	12753	12864	12880	13389	13381	13725	13527	13487	13834	13904	
52w waiters	Plan	15	10	5	2	0	100	90	80	70	60	50	42	
	Actual	95	99	84	70	86	98	145	196	236	237	293	274	
General Surgery	Actual	13	16	8	2	8	14	13	21	25	26	34	36	
Gynaecology	Actual	1	0	1	0	4	2	2	2	3	6	7	5	
Trauma & Orthopaedics	Actual	16	16	9	11	8	10	22	25	34	45	47	43	
Urology	Actual	1	1	1	4	2	4	9	10	10	9	6	2	
Paediatrics	Actual	32	30	42	33	45	44	70	82	104	92	110	119	
Cardiology	Actual	1	5	7	7	1	2	0	1	0	1	1	0	
Gastroenterology	Actual	3	5	1	1	1	3	1	6	2	0	2	6	
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	1	0	0	0	0	
Respiratory Medicine	Actual	14	16	2	2	1	0	0	0	0	0	0	0	
Rheumatology	Actual	0	0	1	0	0	0	0	0	0	0	0	0	
Other	Actual	14	10	12	10	16	19	28	48	58	58	86	63	
65 week waiters	Plan						59	52	45	38	31	24	17	
	Actual						6	4	14	17	45	52	76	
78 week waiters	Plan	0	0	0	0	0	0	0	0	0	0	0	0	
	Actual	3	2	0	0	0	0	0	0	0	0	0	1	

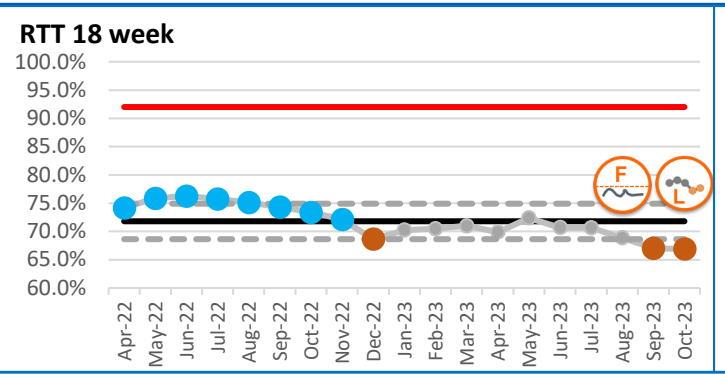
RTT % Within 18 weeks	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Monthly Trend
Trust (92%)	72.1%	68.7%	70.2%	70.5%	71.0%	69.9%	72.4%	70.7%	70.6%	68.9%	67.0%	66.9%	
General Surgery (92%)	78.6%	73.0%	71.7%	69.7%	68.9%	67.6%	69.6%	68.3%	67.2%	67.4%	67.1%	68.6%	
Gynaecology (92%)	78.8%	77.2%	72.8%	70.4%	72.5%	68.1%	68.4%	66.3%	67.3%	65.9%	63.6%	61.2%	
Trauma & Orthopaedics (92%)	61.7%	57.6%	58.6%	60.4%	59.3%	55.4%	57.4%	57.4%	58.3%	57.1%	55.9%	55.0%	
Urology (92%)	75.2%	69.9%	68.1%	74.5%	75.4%	70.5%	73.7%	69.4%	64.0%	67.6%	68.5%	68.7%	
Paediatrics (92%)	68.1%	67.1%	67.8%	69.0%	67.8%	65.4%	67.6%	65.7%	64.8%	60.4%	61.3%	59.8%	
Cardiology (92%)	71.6%	70.3%	73.8%	75.7%	75.2%	79.1%	82.6%	79.2%	73.7%	70.2%	65.9%	64.3%	
Gastroenterology (92%)	71.5%	67.1%	72.6%	72.1%	77.4%	79.1%	87.0%	83.2%	81.2%	78.2%	77.2%	79.7%	
General Medicine (92%)	88.9%	81.8%	91.8%	95.5%	94.2%	94.3%	90.7%	96.2%	93.1%	83.0%	88.1%	83.3%	
Geriatric Medicine (92%)	83.4%	78.2%	81.9%	84.0%	79.7%	79.5%	78.4%	76.1%	80.5%	81.2%	73.3%	75.4%	
Respiratory Medicine (92%)	66.8%	65.3%	79.4%	79.1%	76.9%	79.4%	88.5%	89.2%	88.5%	83.3%	78.6%	79.6%	
Rheumatology (92%)	78.9%	75.9%	87.4%	93.3%	91.5%	90.8%	94.2%	94.3%	92.6%	93.0%	86.8%	82.6%	
Other (92%)	67.2%	65.4%	66.8%	67.8%	68.4%	68.1%	69.4%	68.1%	71.5%	67.6%	65.1%	64.1%	

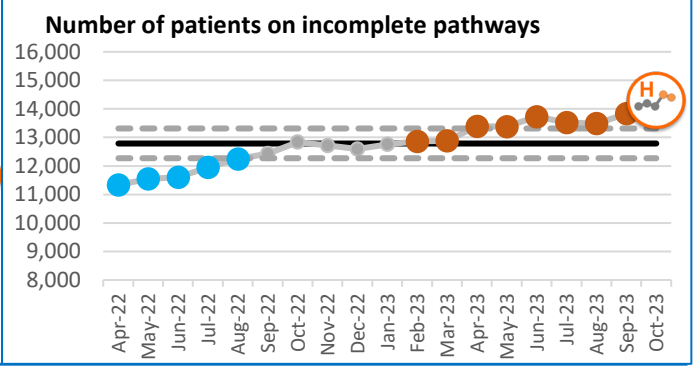
Trust RTT performance

- Octobers Trust performance 66.9%, just below September's figure of 67.0%, and the lowest monthly figure of the year so far.
- At 66.9% Trust performance is better than the latest national average 57.6% (Sep 23), but is below the ICB average of 70.1% (Sep 23)
- The Trusts total waiting list increased to 13,904 in October, an increase of 70 patients or 0.5% on September's position.
- 1 patient was now waiting more than 78 weeks, in General Surgery. The first 78 week wait since December 2022. And the number waiting more than 65 weeks increased from 52 to 76. which now 59 above planned for levels for the month.
- The number patients waiting 52 weeks fell in October to 274, a reduction of 19 from September but remains high at 232 above planned for levels in October.
- 274 is 232 patients above planned levels of 42 for October. Plans and subsequently the projections for end of year numbers of 52-week waiters are being revisited as part of the weekly Access and Performance meetings, with an aim to have 0 - 52 week waiters by the 31st March.

Main Risks – 52w+ waiters

- **Paediatrics** – pressures continue, best case projections based on current cohort indicate by the end of November number are expected to be around 125 waiters, which would be similar to the end of October, however, will increase further longer term. Paediatric long waiters are exclusively children aged 0-4 awaiting an autism assessment. Discussions continue around the Pathways for these children to align them to guidance.
- **Pain** –projections based on current cohort indicate by the end of November there will be circa 29 over 52-week waiters, around half the current volume. Plans are now in place for the pain specialities, which includes new staff starting in posts. As a result, the service has revisited the projections of their long waiters and expects to have 0 52-week waiters by the end of March 24. Currently the service is on target to meet this trajectory.
- **Trauma and Orthopaedics – P**rojections based on current cohort indicate by the end of November there will be circa 40 over 52-week waiters, broadly in line with the latest monthly values. A range of proposals are being address the challenges in T&O, with trajectories being revised with an aim to reduce these further. These are being overseen by the Access and Performance meeting.
- **General Surgery** – challenges in capacity indicate that general surgery will maintain at current levels of 52-week breaches in November of around 32. A business case for increasing capacity is due at November's business case review group.





Cancer Standards - 2 Week Waits

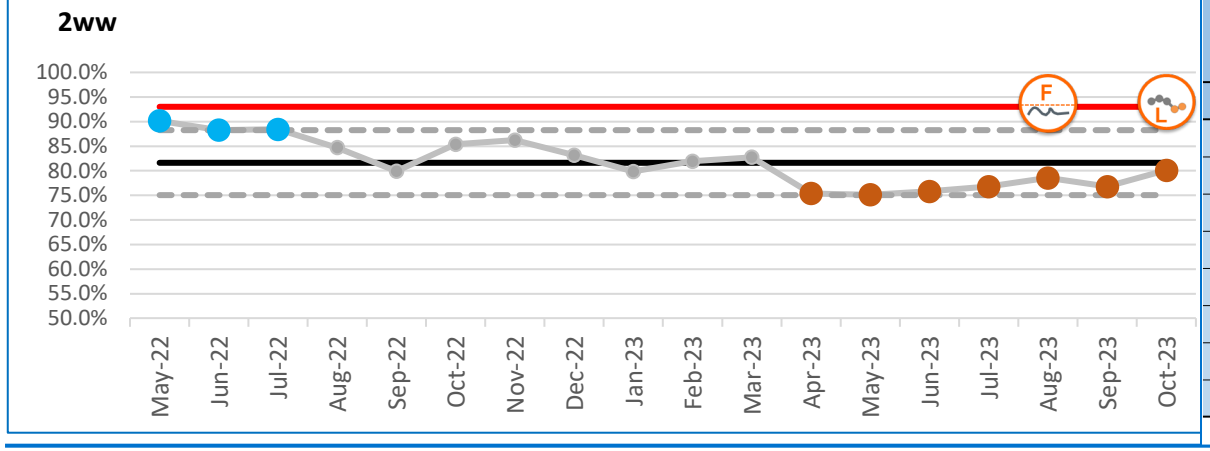
Responsive

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	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Monthly Trend
Trust (93%)	86.6%	83.3%	79.8%	82.3%	82.7%	75.4%	75.2%	75.8%	76.7%	78.4%	76.8%	80.4%	
Breast (93%)	94.8%	88.0%	94.4%	96.7%	94.9%	90.4%	94.8%	96.6%	96.5%	94.7%	96.6%	96.2%	
Gynae (93%)	79.4%	93.7%	90.9%	91.1%	90.7%	70.4%	30.0%	7.2%	8.9%	26.9%	16.3%	56.2%	
Lower GI (93%)	40.2%	44.9%	37.5%	25.5%	35.6%	25.6%	34.9%	33.3%	43.3%	37.7%	45.3%	41.7%	
Testicular (93%)	100.0%	83.3%	100.0%	100.0%	100.0%	75.0%	75.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Urology (93%)	94.1%	86.5%	69.0%	86.0%	82.5%	79.7%	89.7%	91.2%	88.9%	94.3%	69.7%	68.9%	
Haematology (93%)	100.0%	100.0%	85.7%	91.7%	100.0%	75.0%	85.7%	100.0%	100.0%	100.0%	100.0%	100.0%	
Lung (93%)	88.6%	90.0%	90.8%	91.3%	79.3%	96.8%	94.0%	96.4%	94.4%	91.2%	91.2%	92.7%	
Upper GI (93%)	88.9%	85.5%	45.5%	62.0%	73.1%	44.7%	45.9%	59.9%	73.5%	74.2%	81.7%	71.8%	
												Indicative	
Symptomatic Breast (93%)	89.7%	100.0%	100.0%	100.0%	97.2%	91.2%	100.0%	100.0%	98.0%	100.0%	100.0%	97.2%	



Trust 2 week wait Cancer performance

- Trust performance for stood at 76.8% against the 93% target in September
- 76.8% is above the latest England average at 74.0% (Sept 23) but slightly below the NENC average of 79.4% (Sept 23)
- The overall 2 week wait performance has not achieved the expected level in any month of the year so far.
- Previous pressures noted in the year, while still present in September have eased in October particularly in Gynaecology where indicative performance stands at 56.2% in October, a significant improvement from 16.3% in September.
- As a result, indicative performance for October has also improved to 80.4%.

Tumour site update:

- In September 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 October also.
- Gynae has improved significantly in October and is no longer the most significant risk area with overall performance at 56.2% in October.
- In September both Upper GI and Lower 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	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
Trust (100%)	121%	113%	121%	122%	146%	111%	112%	136%	116%	151%	115%	122%
Breast (100%)	128%	113%	119%	128%	155%	118%	119%	161%	133%	182%	138%	124%
Gynae (100%)	155%	151%	134%	135%	139%	120%	125%	177%	128%	181%	136%	165%
Lower GI (100%)	83%	85%	96%	107%	153%	105%	119%	75%	83%	96%	90%	84%
Testicular (100%)	20%	150%	140%	67%	50%	160%	50%	88%	120%	50%	43%	100%
Urology (100%)	128%	150%	155%	131%	106%	94%	100%	100%	77%	125%	97%	153%
Haematology (100%)	140%	100%	100%	240%	89%	300%	78%	157%	186%	86%	91%	113%
Lung (100%)	175%	113%	224%	157%	208%	144%	138%	181%	166%	140%	73%	65%
Upper GI (100%)	103%	96%	98%	90%	120%	76%	74%	117%	77%	92%	75%	121%
												Indicativ

Cancer Standards – 28 day Faster Diagnosis

Responsive

NHS Gateshead Health NHS Foundation Trust

Trust 28 day Faster Diagnosis performance:

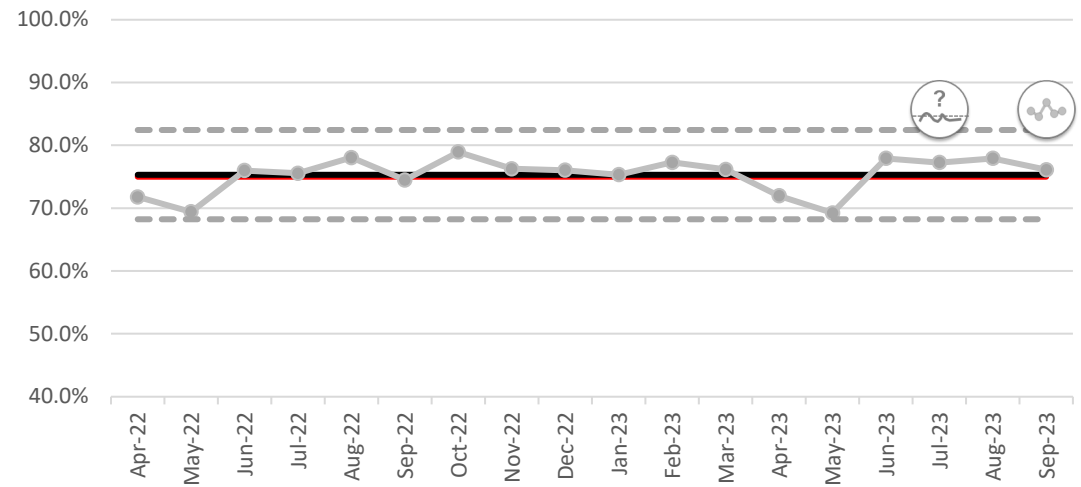
- Trust has achieved 75% target in most months since June 22, with the exception of May
- September's reporting showed performance at 77.7%, continuing to exceed the latest national average 69.7% (Sept 23), and this month also above the latest NENC average 75.2% (Sept 23)
- In February for the first 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 October shows a futher slight improvement to 81.7% 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 has improved and continued to achieve the target consistently since January to the latest validated month of September. Lung fell just below standard in September, having achieved it the month before.
- While Trust wide performance generally achieves the standard, performance risks continue across a number specialties - Particular consistently challenged specialties Gynae (both Gynae and Gynaecology, although Gynae is notably higher than gynaeoncology), Lower GI, Urology, Haematology and Upper GI.

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	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Monthly Trend
Trust (75%)	79.1%	78.7%	75.6%	78.0%	77.6%	75.3%	72.0%	78.7%	77.0%	78.4%	77.7%	81.7%	
Breast (75%)	96.6%	98.1%	94.7%	96.6%	97.4%	97.2%	98.6%	98.2%	98.2%	96.7%	96.5%	98.6%	
Gynae and GynaeOnc Combined (75%)	50.8%	44.6%	51.0%	51.2%	66.1%	57.1%	47.2%	56.7%	44.4%	55.7%	56.7%	69.2%	
Gynae (75%)	50.0%	44.8%	50.5%	51.3%	66.7%	59.3%	48.7%	60.9%	47.8%	58.1%	59.0%	71.4%	
Gynaeoncology (75%)	54.5%	42.9%	57.1%	50.0%	60.0%	0.0%	25.0%	25.0%	25.0%	37.5%	30.0%	28.6%	
Lower GI (75%)	51.6%	57.7%	38.1%	47.0%	36.9%	30.1%	33.3%	36.4%	53.3%	47.2%	56.3%	50.7%	
Testicular (75%)	100.0%	100.0%	100.0%	75.0%	83.3%	100.0%	75.0%	100.0%	100.0%	80.0%	100.0%	100.0%	
Urology (75%)	64.5%	66.3%	50.6%	67.6%	57.0%	35.1%	21.6%	36.7%	33.3%	53.2%	36.5%	57.6%	
Haematology (75%)	45.5%	71.4%	20.0%	66.7%	63.6%	70.0%	50.0%	71.4%	54.5%	50.0%	66.7%	28.6%	
Lung (75%)	85.3%	69.2%	80.7%	77.5%	84.5%	78.7%	83.1%	82.1%	88.5%	76.1%	70.0%	81.1%	
Upper GI (75%)	52.0%	56.4%	55.1%	55.2%	51.6%	52.7%	42.0%	64.3%	63.9%	59.8%	59.8%	59.0%	
												Indicative	
Sympt. Breast (75%)	100.0%	95.5%	100.0%	96.0%	97.3%	100.0%	100.0%	100.0%	98.1%	100.0%	100.0%	100.0%	

Cancer Standards - 31 Day Waits

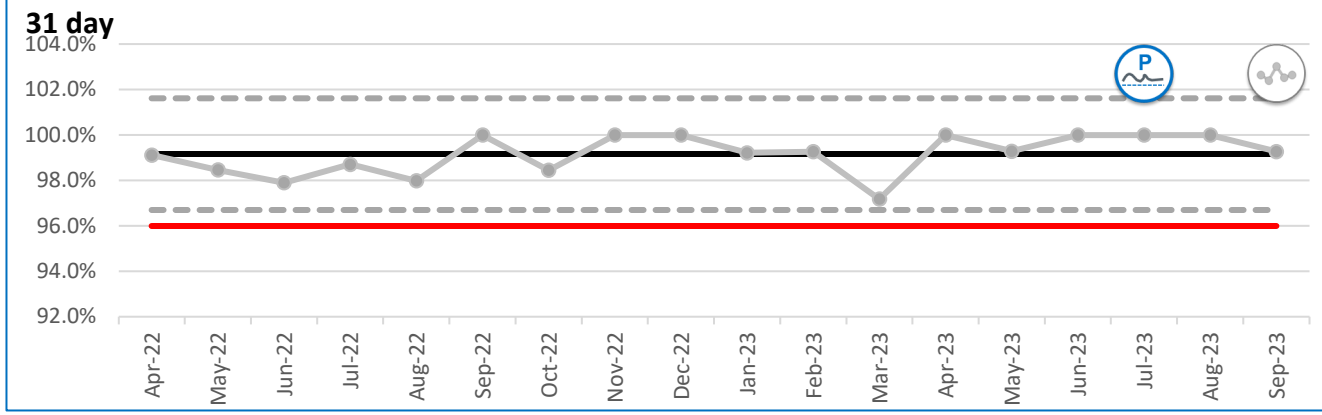
Responsive

Gateshead Health NHS Foundation Trust

NHSI SOF Operational Performance & National Operational Standard

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

31 day performance	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Monthly Trend
Trust (96%)	100.0%	100.0%	99.2%	100.0%	97.2%	100.0%	99.3%	100.0%	100.0%	100.0%	99.5%	97.6%	
Breast (96%)	100.0%	100.0%	98.1%	100.0%	98.4%	100.0%	98.4%	100.0%	100.0%	100.0%	100.0%	100.0%	
Gynae and GynaeOnc Combined (96%)	100.0%	100.0%	100.0%	100.0%	90.9%	100.0%	100.0%	100.0%	100.0%	100.0%	97.2%	97.1%	
Gynae (96%)	100.0%	NA	100.0%	100.0%	80.0%	NA	100.0%	100.0%	NA	100.0%	100.0%	100.0%	
Gynaeoncology (96%)	100.0%	100.0%	100.0%	100.0%	92.3%	100.0%	100.0%	100.0%	100.0%	100.0%	97.0%	96.8%	
Lower GI (96%)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	83.3%	
Urology (96%)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Haematology (96%)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	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%	100.0%	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	**Nov-22**	**Dec-22**	**Jan-23**	**Feb-23**	**Mar-23**	**Apr-23**	**May-23**	**Jun-23**	**Jul-23**	**Aug-23**	**Sep-23**	**Oct-23**	
Surgery (96%)	100.0%	100.0%	99.0%	100.0%	96.7%	100.0%	99.2%	100.0%	100.0%	95.2%	100.0%	100.0%	
Drug (98%)	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	



Trust 31 day cancer performance:

- The Trust continues to exceed the 31-day standard for September
- Trust performance for September stood at 99.5%, with both the subsequent treatments for Surgery and Drugs at 100%
- The Trust continues to exceed the latest national average of 89.7% (Sep23) and the NENC average 90.8% (Sep23)
- Octobers indicative position is 97.6%, so continues to be above target and comparator averages
- Volumes of 31-day activity have fluctuated against 19/20 baselines for some tumour sites over the past 6 months of this current financial year, 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, All sites with the exception of Gynaeonology were 100% in the latest validated month.

Risks

- Capacity / shared pathways, Theatre workforce pressures

Volumes as a % of 2019/20 Activity	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
Trust (100%)	125.4%	103.3%	95.5%	141.9%	65.2%	78.0%	108.5%	111.3%	75.0%	109.6%	105.5%	58.2%
Breast (100%)	125.9%	101.7%	100.0%	190.6%	76.7%	69.4%	124.0%	129.3%	68.6%	141.7%	110.2%	50.0%
Gynae (100%)	147.4%	133.3%	129.4%	100.0%	92.0%	56.0%	83.3%	79.2%	66.7%	71.4%	108.3%	55.6%
Lower GI (100%)	125.0%	122.2%	45.0%	88.9%	18.2%	128.6%	66.7%	69.2%	42.9%	84.6%	57.1%	35.3%
Urology (100%)	233.3%	216.7%	111.8%	166.7%	75.0%	200.0%	200.0%	191.7%	130.8%	83.3%	210.0%	233.3%
Haematology (100%)	180.0%	166.7%	80.0%	225.0%	38.0%	71.4%	85.7%	83.3%	133.3%	140.0%	71.4%	14.3%
Lung (100%)	92.3%	13.3%	42.9%	70.0%	50.0%	86.7%	140.0%	83.3%	56.3%	92.9%	58.3%	50.0%
Upper GI (100%)	27.3%	116.7%	225.0%	166.7%	42.9%	33.3%	66.7%	100.0%	66.7%	200.0%	150.0%	30.0%
												Indicative

Cancer Standards - 62 Day 2ww pathways

Responsive

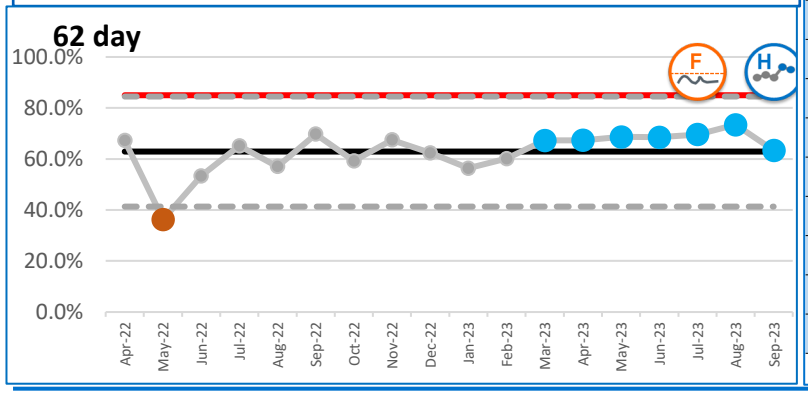
NHS Gateshead Health NHS Foundation Trust

Trust 62-day 2ww cancer performance

- Performance for September stood at 70.8%, above the latest national average 59.3% (Sept23) and NENC average 61.9% (Sep 23).
- **The Trust reported 58 patients waiting over 62 days on a 2ww classic pathway (7.6% of the total waiters on a 62 day 2ww classic pathway) (94 on all pathways (9.5% of total waiters)).**
- Within the operational guidance 'Systems are being asked to plan to reduce >62-day backlogs, the Trust submitted a plan of 60 for October 2023, reporting 58 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 October had decreased to 5 patients (0.7% of total waiters on a 62 day 2ww classic pathway) (12 on all pathways (1.2% of total waiters).
- Indicative performance for October stands at 65.6%, and while a reduction, it remains above both comparator averages.

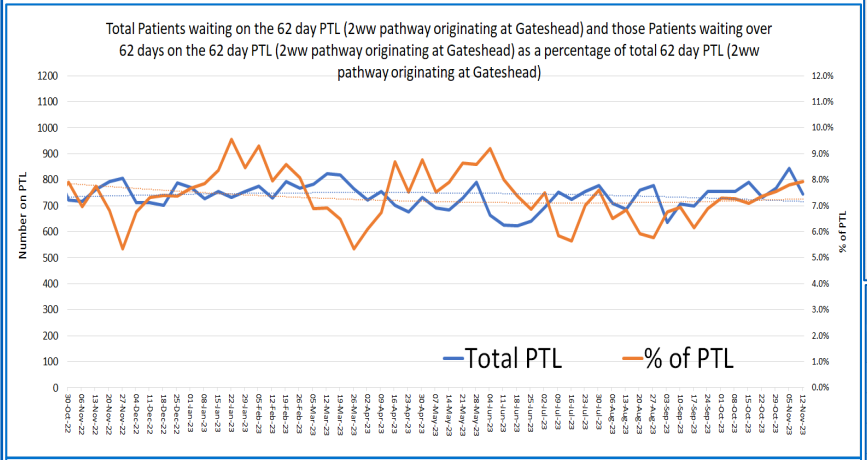
Tumour site update:

- 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 oncology, Lower GI, Urology. With other specialities more variable such as Lung and Upper GI. Upper GI having achived the target in September and in November to date.



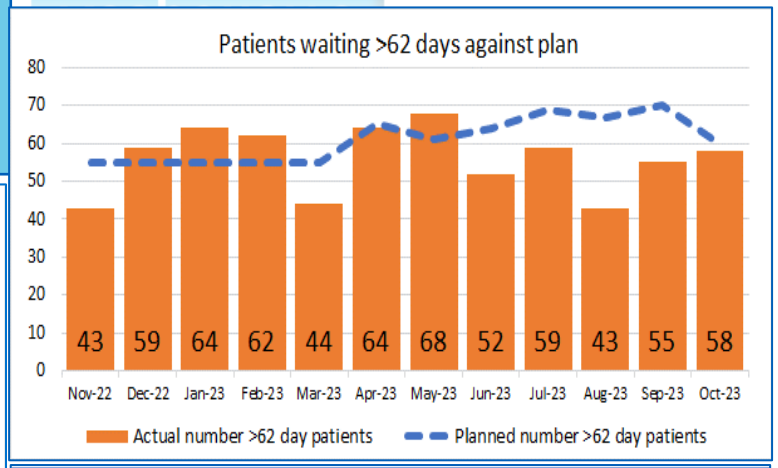
NHSI SOF Operational Performance & National Operational Standard

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	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Monthly Trend
Trust (85%)	67.9%	61.7%	56.5%	60.4%	66.9%	67.3%	69.4%	68.4%	68.5%	74.2%	70.8%	65.6%	
Breast (85%)	81.0%	76.0%	75.6%	93.2%	94.1%	100.0%	93.8%	87.8%	85.1%	94.7%	88.0%	90.7%	
Gynae and GynaeOnc Combined (85%)	52.2%	55.0%	25.0%	26.3%	56.3%	70.0%	60.0%	50.0%	55.0%	43.5%	37.0%	60.0%	
Gynae (85%)	50.0%	NA	NA	33.3%	45.5%	NA	NA	0.0%	NA	66.7%	100.0%	60.0%	
Gynaeoncology (85%)	52.6%	57.9%	25.0%	23.1%	60.0%	70.0%	60.0%	58.3%	57.9%	35.3%	32.0%	60.0%	
Lower GI (85%)	20.0%	0.0%	60.0%	100.0%	40.0%	50.0%	75.0%	100.0%	66.7%	52.2%	66.7%	44.0%	
Urology (85%)	62.2%	40.0%	41.0%	21.4%	15.4%	57.1%	18.9%	33.3%	48.3%	26.1%	36.4%	71.4%	
Haematology (85%)	83.3%	NA	100.0%	60.0%	100.0%	33.3%	100.0%	0.0%	76.5%	75.0%	100.0%	100.0%	
Lung (85%)	90.0%	60.0%	80.0%	33.3%	60.0%	62.5%	60.0%	66.7%	55.6%	72.7%	46.7%	46.4%	
Upper GI (85%)	33.3%	100.0%	50.0%	25.0%	54.5%	0.0%	40.0%	50.0%	88.9%	44.4%	100.0%	100.0%	

Indicative



Cancer - Patients waiting more than 62 days												
63 to 104 days	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sep	Oct
Breast	2	3	4	3	2	2	3	2	2	1	3	1
Gynaecology	12	17	18	9	5	13	6	8	13	15	12	5
Haematology	1	0	0	0	1	1	1	0	0	0	0	0
Lower Gastrointestinal	5	7	5	11	10	9	19	12	11	7	7	15
Lung	5	4	6	2	3	3	3	1	4	2	3	2
Upper Gastrointestinal	5	8	7	12	10	14	6	5	10	3	11	9
Urological	4	8	12	15	6	11	19	15	13	6	8	21
Other	0	1	0	1	0	0	0	0	0	0	0	0
63 to 104 days total	34	48	52	53	37	53	57	43	53	34	44	53

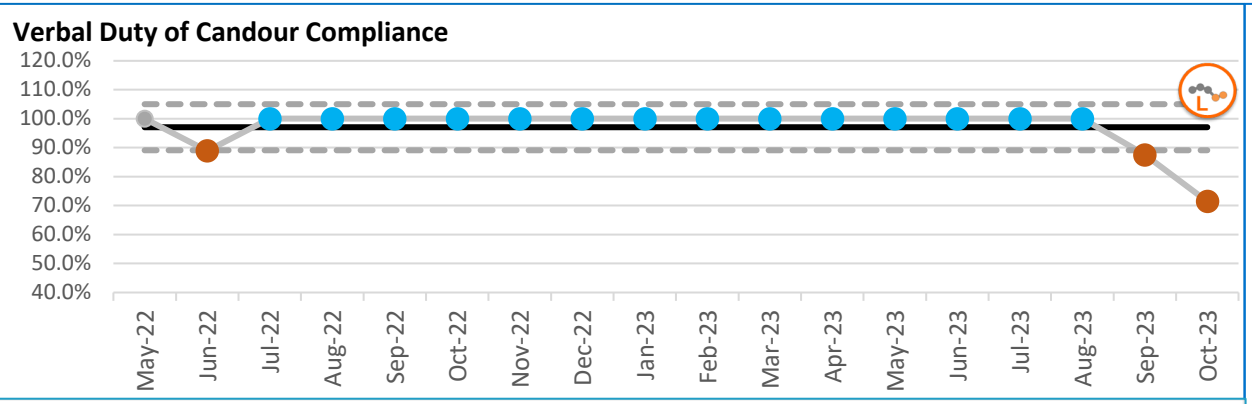
Over 104 days	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sep	Oct
Breast	0	0	0	0	0	0	1	0	0	0	0	0
Gynaecology	3	2	3	3	0	1	1	3	2	5	4	1
Haematology	0	1	0	0	0	0	0	0	0	0	0	0
Lower Gastrointestinal	1	2	5	2	2	5	4	0	2	0	3	0
Lung	3	0	1	1	0	0	1	2	0	1	1	0
Upper Gastrointestinal	1	4	2	1	2	2	2	2	1	2	1	2
Urological	1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

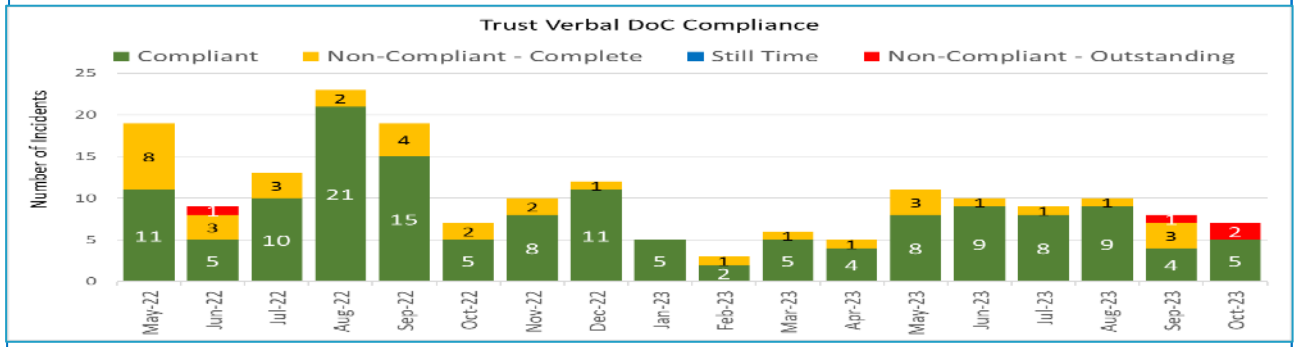
Report by exception: Responsive – Duty of Candour Compliance

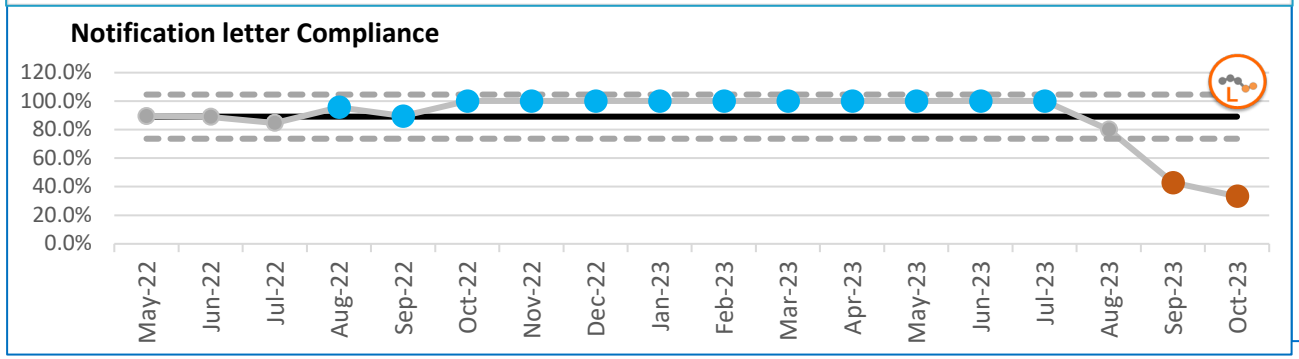
Responsive

Gateshead Health NHS Foundation Trust

Detail on this measure is included as special cause variation is observed.







Situation

Verbal Duty of Candour compliance is displaying special cause variation for concern in October 2023. Notification letter compliance displaying special cause variation for concern in October 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 as 71.4% for the month of October 2023. There are 2 incidents showing as non-compliant in relation to verbal enactment (308 and 624). These incidents have been followed up by the Legal team with the relevant handler / investigator and assistance offered where possible to enable the verbal duty is enacted. It has been confirmed that in relation to Incident 624, multiple specialities are involved and a decision is to be made as to which speciality undertakes Duty of Candour.

In relation to compliance for Notification letters, the report shows 2 letters outstanding and 1 incident is still within the timeframe for completion following agreed severity of harm at STG in October 2023 (incident numbers 147, 308 and 624) Verbal Duty of Candour has been enacted for incident 147. The Legal team have contacted the relevant handlers/investigators and provided the template notification letters to ensure these letters are sent. Once the letters have been sent a copy will be provided to the Legal Services team who will update the Incident reporting system.

Actions

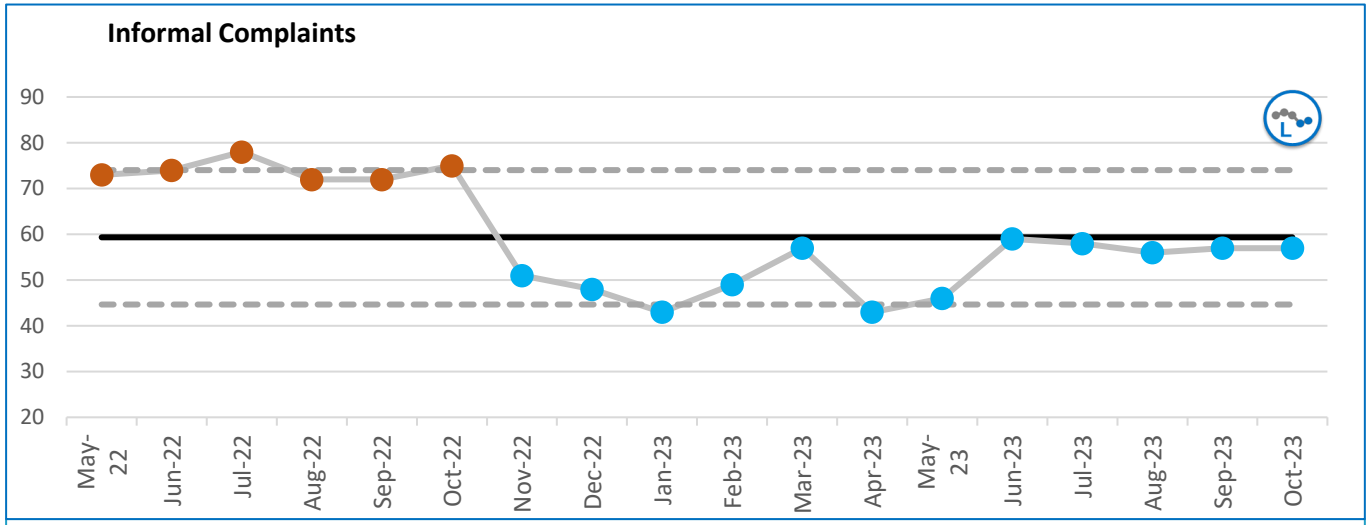
Currently, a manual review of incidents to establish those which have been formally signed off is being undertaken, so that we can provide definitive figures and assurances as to how many Findings letters are now due/ outstanding.

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 to June, the number of informal complaints continues to achieve special cause variation and remain low, below numbers seen earlier in the year and has been relatively static the past 4 months, bween 56-60 per month between June and October. The focus of informal complaints continues to vary and remain very broad. Analysis of informal complaints (November 2022 to July 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 July (baseline), 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 and length of telephone waits.

Facilities complaints - Car parking issues continue to be the most significant issue, the number of these type of complaints, increasing month on month. Complaints around inconsiderate parking in the local neighbourhood had reduced but are now the most significant group of complaints in the past 3 months.

Communications complaints by volume	Nov22 - Jul 23	Aug-23	Sep-23	Oct-23
Electronic - Length of wait (telephone)	41	1	4	2
Verbal - Poor communication	60	10	11	8
Written - Incorrect information	10	5	1	1
Written - Poor communication	24	3	4	
Verbal - Delay in diagnosis	3			1
Verbal - Poor staff attitude	4	2		1
Written - Breach of confidentiality	3			
Verbal - discharge	1	1	1	
Written - Poor / incorrect signposting	1			
Verbal - Incorrect diagnosis	3			
Verbal - Delay in Treatment	15			4
Electronic - Poor communication	1	1		
General - Interpreter not available	5	1		1
Verbal - Lack of community service communications	1			
Verbal - Misunderstanding	2			2
Verbal - proceedure / process error	3	1		
General - Lost Mail	1			
Verbal - Language barrier	1		2	
Grand Total	**179**	**25**	**23**	**20**

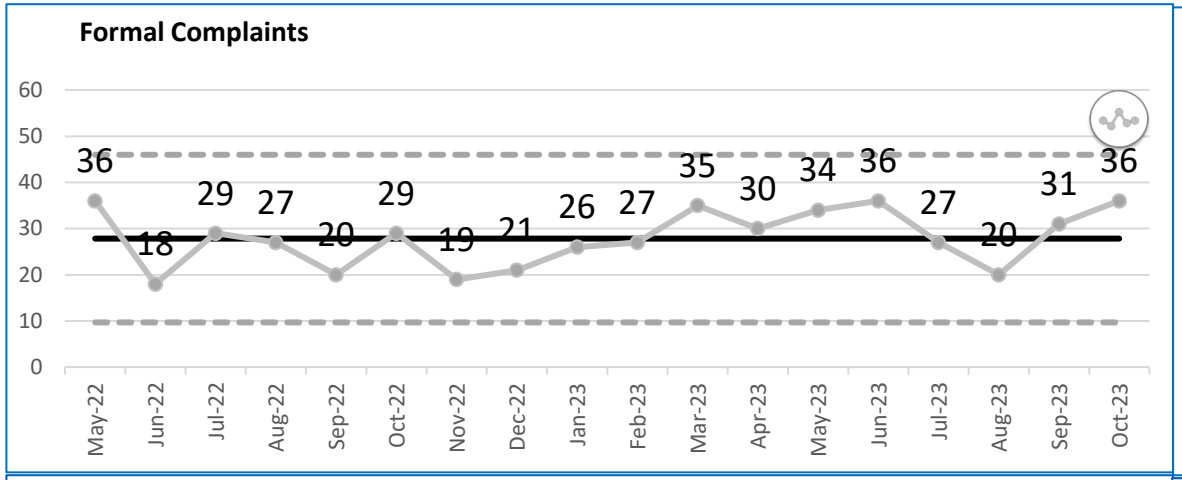
Facilities complaints by volume	Nov22 - Jul 23	Aug-23	Sep-23	Oct-23
General - Car parking	25		1	2
Car Parking - Parking Charge Notice (PCN)	22	7	6	1
Car parking - Issues with blue badge registration	10			2
Car parking - inconsiderate parking (neighbourhood)	7	6	6	7
Lack of resources - No ward bed (Not ITU/CCU/HDU)	1			
Facilities - Incomplete maintenance works	2			
General - Lack of adequate facilities/equiptment	1			
Facilities - Temperature Control	4			1
Grand Total	**72**	**13**	**13**	**13**

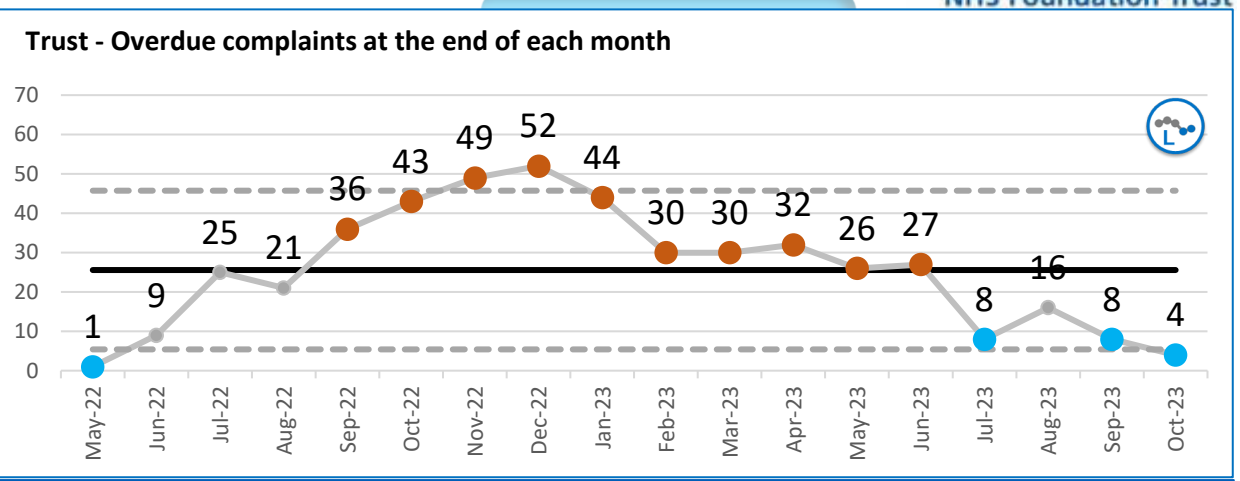
Report by exception: Formal Complaints

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

Responsive

NHS Gateshead Health NHS Foundation Trust





Analysis – The number of formal complaints received continues to demonstrate common cause variation and be within expected levels based on past trends. However, has increased month on month for the past 2 months, with the 36 received in October, the highest since June 23. The number of overdue complaints at the end of October continues to triggering special cause variation and demonstrates significant improvement, falling again in October, the joint lowest since May 2022. 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 4 overdue complaints remaining open at the end of October a fall from 8 in September. 3 sat with the Medicine Business Unit the other one in Nursing, Midwifery & Quality – Cancer Services.

Friends and family test results - identify the following themes for patients whose experience was rated as 'Poor' or Very Poor' these related to long waiting times, pain relief whilst waiting, poor care and staff attitude

Clinical Treatment Complaints - by location (Nov-22 to Oct-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 Orthopedics	Blaydon Urgent Treatment Centre	Gastroentorlogy - No specific Dept	General Surgery	Gynaecology	Delivery Suite (Maternity)	Cardiology (Specialty of) - No specific dept	Clinical Haematology (Specialty of) - No specific dept	CT (Radiology)	Obstetrics	Breast Screening	Paediatrics (outpatient)	PeaPod (Paediatric Emergency Assessment)	PIU Day Unit
Actions - Actions not carried out	47	2	1										1			2	1		1	3	3				1	1	2	4	
General - Inadequate/Inappropriate nursing care	1		3	1	2	3	6	3	2	1	3	2		4	5														1
General - Inadequate/Inappropriate medical care				2	1	1			1		1				2	6		1	2	1		5	1	1				1	
Total	48	2	4	3	3	4	6	3	3	1	4	2	1	4	7	8	1	1	3	4	3	5	1	1	1	1	2	5	1

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

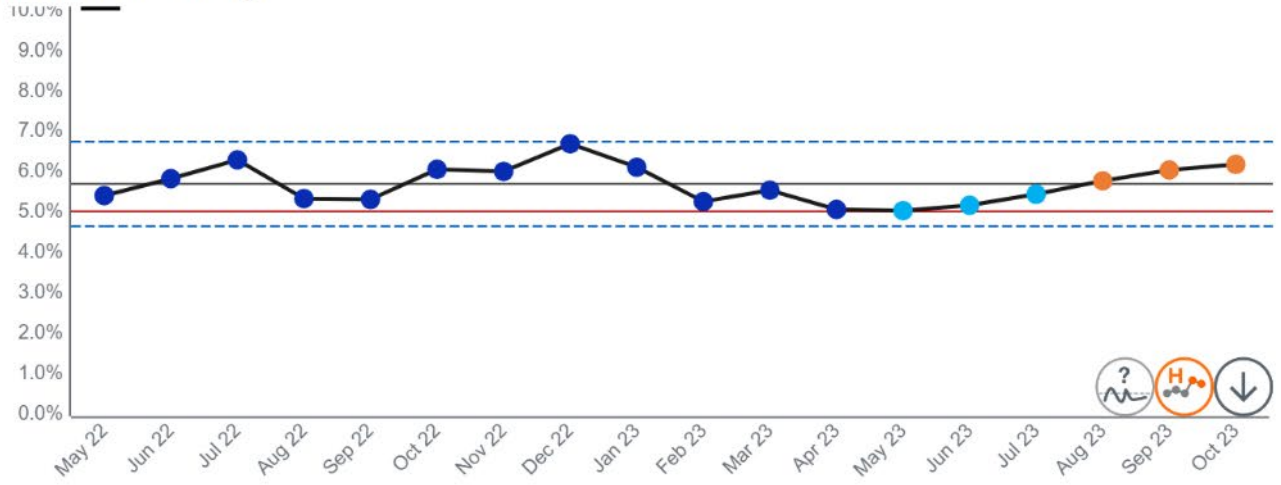
	Accident and Emergency	Same Day Emergency Care (SDEC)	Emergency Admissions Unit	Ward 9 (Respiratory)	Ward 12	Ward 14a (Trauma and Orthopaedics)	Trauma and Orthopaedics (Medical)	T27 (General Surgery)	General Surgery (Medical)	Gastroentorology	Gynaecology (Medical)	Pain Clinic	Children's Community Nursing	Breast Screening	Discharge Liason Team	Pregnancy Assesment Unit	Outpatients	CT (Radiology	Community Midwives (Maternity)	Rapid Response Team	Community Stroke
Grand Total	10	1	4	3	1	2	1	2	3	1	2	1	1	2	1	2	3	1	1	3	1

Sickness Absence

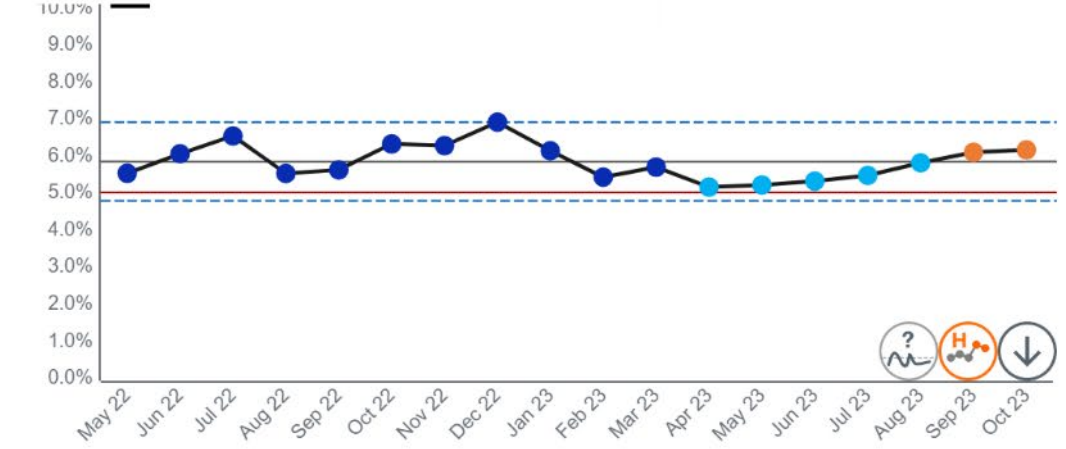
Well Led

NHS Gateshead Health NHS Foundation Trust

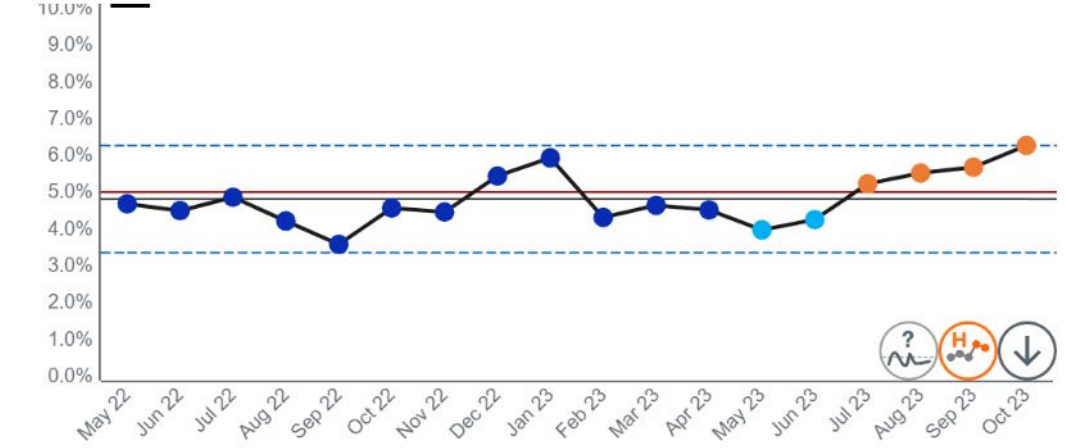
Sickness % - Group



Sickness % - Trust



Sickness % - QEF



What is the data telling us?

- There is a 0.2% increase from last month and absence is 0.2% higher than the same period last year. Rolling 12m sickness remains at 5.7%.
- We have seen an increase since the summer in absences of 28 days – 6 months duration.

What is our plan and expected impact?

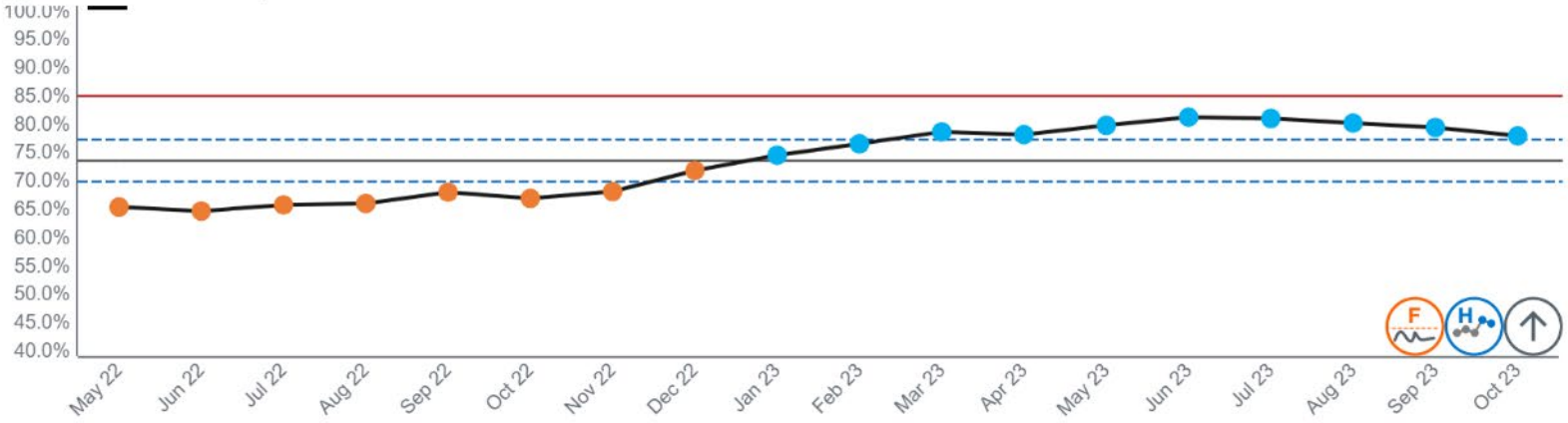
- Local management of sickness absence and POD oversight continues.
- The collective approach to managing absence despite the increase does show a positive variance in absence within the Business Units.
- Case management is reviewed monthly.
- The collective approach remains focused.
- Monthly LTS clinics within the Business Units are active.
- Bitesize Promoting and Supporting Attendance training is now live for all people managers.
- Promotion of wellbeing check-ins with managers.

Appraisals

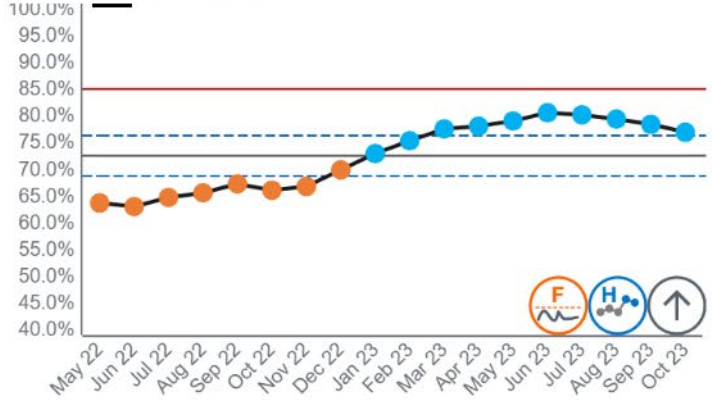
Well Led

NHS Gateshead Health NHS Foundation Trust

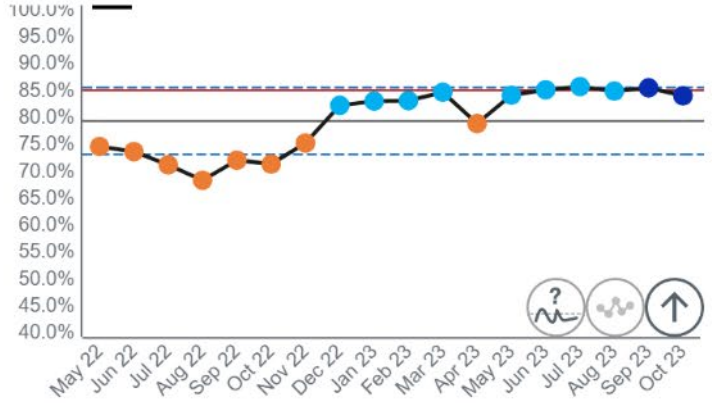
Appraisal % - Group



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 further decrease to 78% for the group. There has been a sustained improvement since May 2022 however this is the fourth consecutive drop in compliance. QEF has seen a decrease in compliance this month to 84% with the Trust dropping slightly to 76.9% . Significant work has been undertaken to achieve the current levels however further work required to improve the position as a group.
- 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?

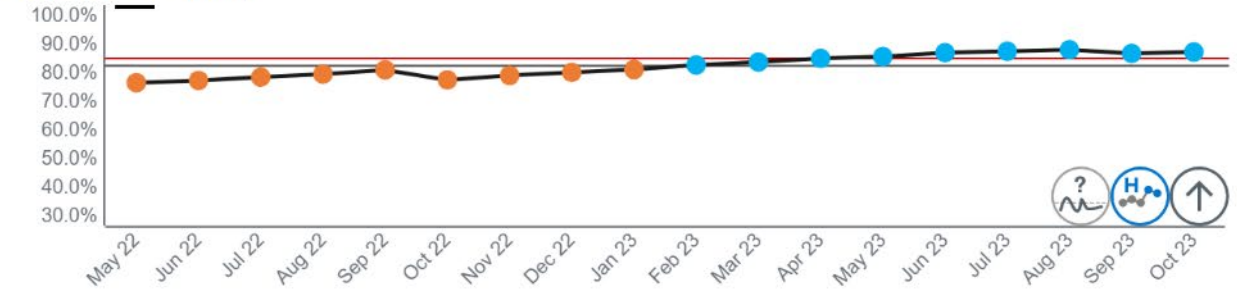
- The People and OD (POD) Leads are working with each business unit, directorates and teams to identify actions required to reach the required compliance levels. Additional training is being provided in areas as requested, for new appraisers and refresher training to ensure people are comfortable with the current process. The 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

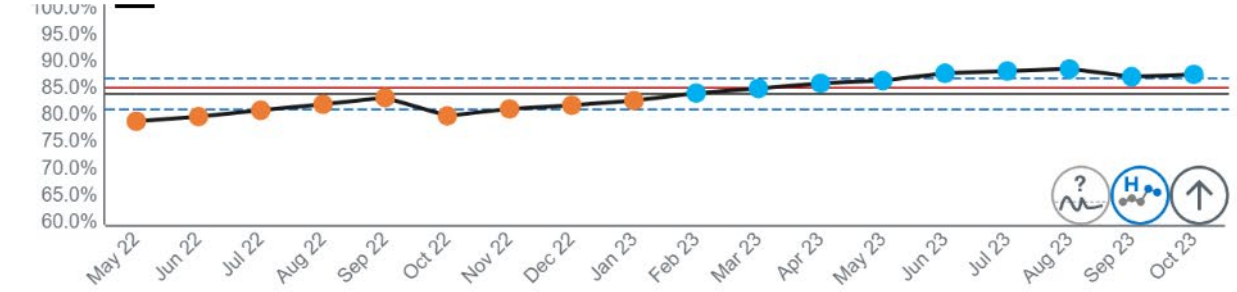
Well Led

NHS Gateshead Health NHS Foundation Trust

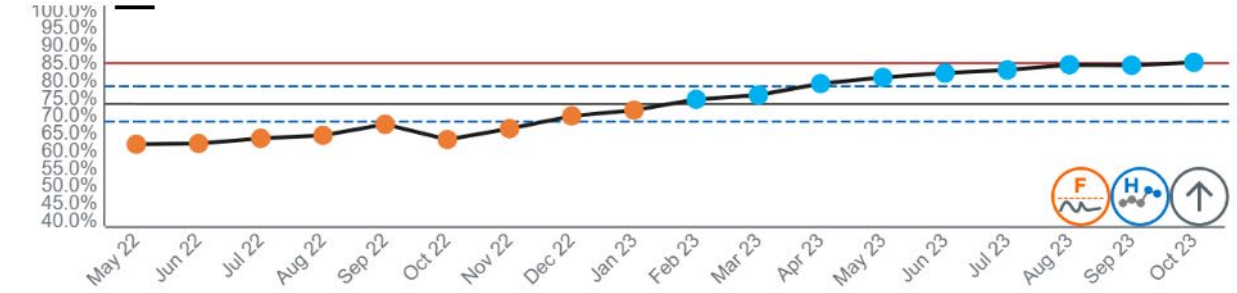
Core Skills % - Group



Core Skills % - Trust



Core Skills % - QEF



What is the data telling us?

- An increase in compliance of 0.5% with a whole group compliance figure of 87.2% against an 85% target.
- QEF currently have a compliance level of 85.2% against the 85% target, which is a positive increase that takes them to target. The additional space for QEF staff for training is available and this continues to see an increase compliance.
- The Trust has increased to 87.5% 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. These remain a risk within the overall compliance target.
- PMVA training will remain a risk until further staff have completed the training. 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?

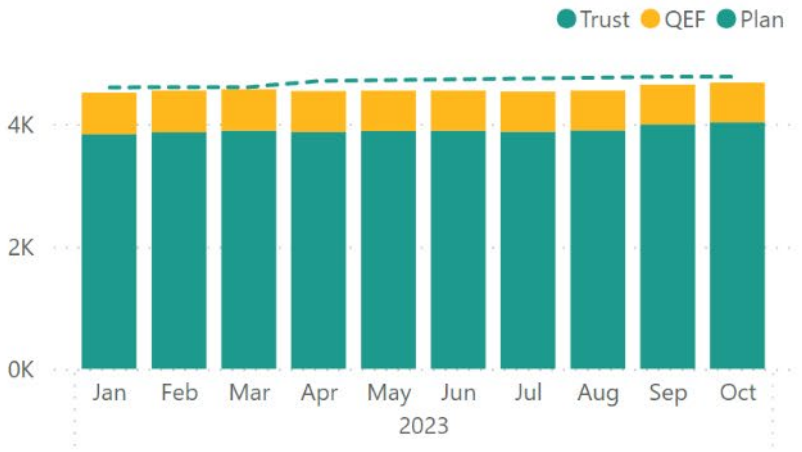
- Core skills compliance has been discussed at SMT, escalated to Executive Team and discussed at recent oversight meetings with business units. The addition of a couple of the topics which saw an initial reduction in overall compliance, until the staff complete the training is now paused while a full 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

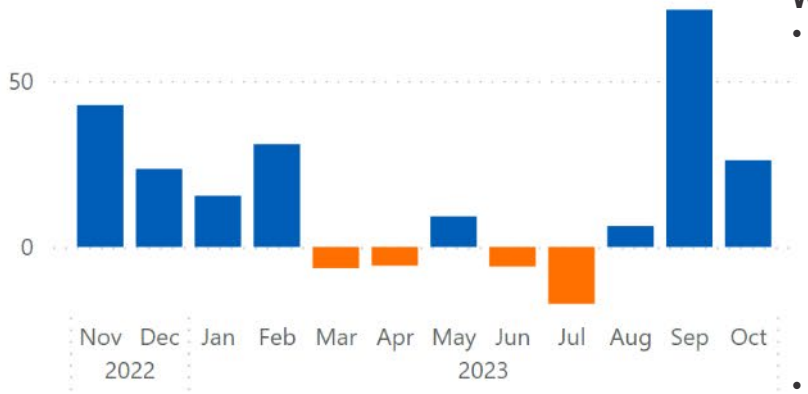
Well Led

NHS Gateshead Health NHS Foundation Trust

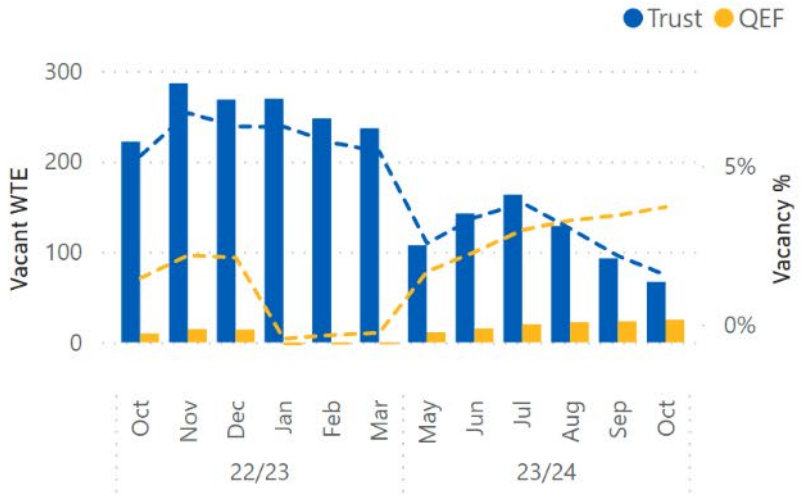
Plan vs Contracted SIP



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 month on month since July with a slight increase in October. The team continue to focus efforts on clearances for all candidates in offer stage . 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 1.6% as of Oct23, a 0.6%, 25.8 WTE decrease since Sep23. QEF vacancy rate is 3.7%, a 0.3%, 1.8 WTE increase since Sep23. Staff in post at the end of October was 4,030 WTE for the Trust and 647.6 WTE for QEF.

What is our plan and expected impact?

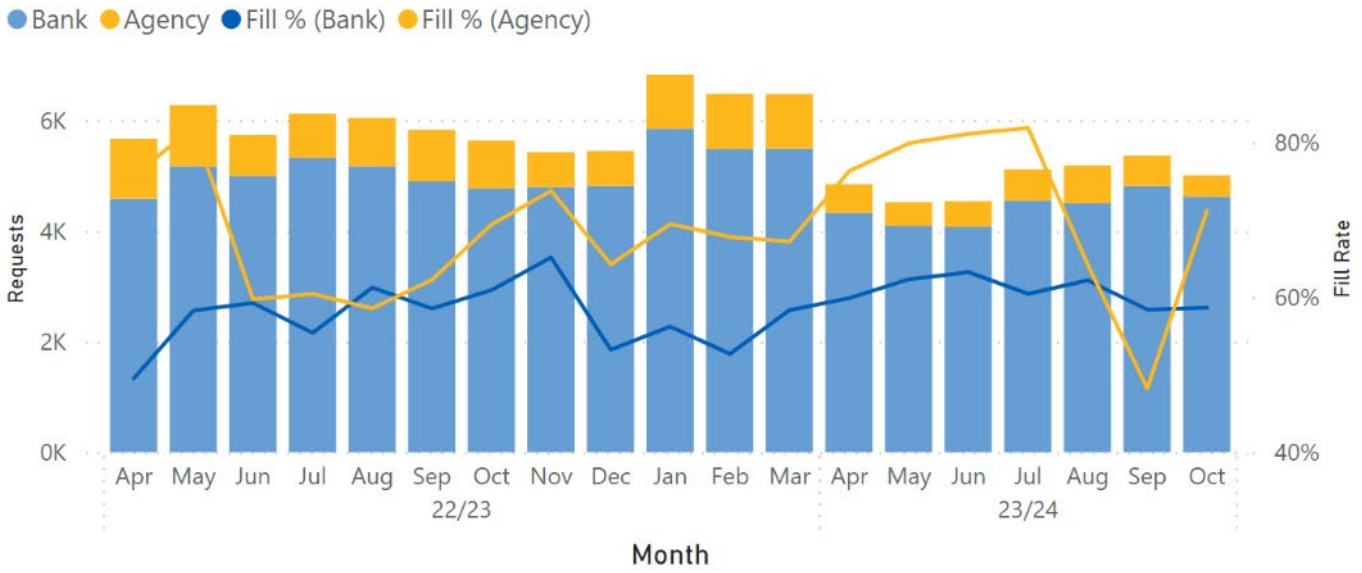
- Given the variety of posts included, there are factors that can impact on this metric for various roles. For example, Medical posts are advertised for 4 weeks, which is longer than non-medical posts which typically are advertised for 1-2 weeks. This metric does not include the time taken to authorise 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

Well Led

NHS Gateshead Health NHS Foundation Trust

Temporary staffing fill rate and requests



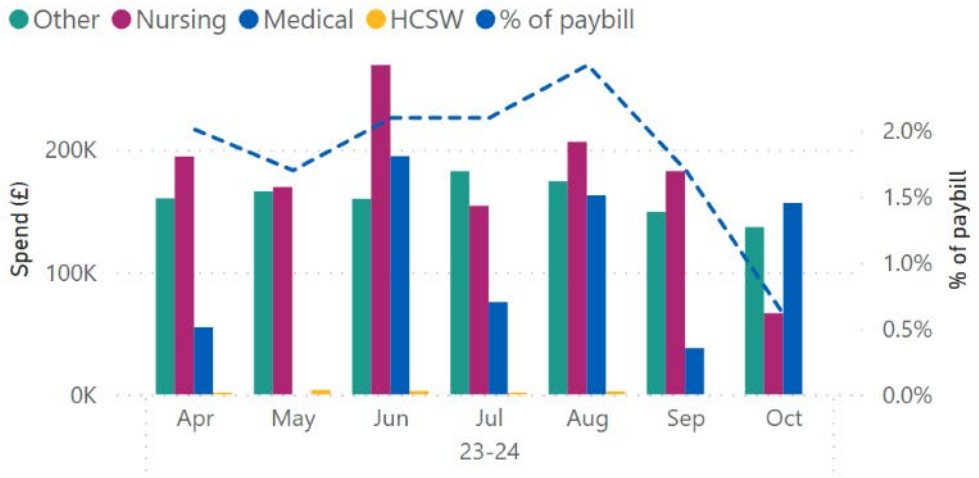
What is the data telling us? *Bank requests include all requests via Health Roster

- The month of October saw a decrease in both bank and agency requests. Fill rates for bank shifts remains constant, where agency fill rates have increased significantly. Total Agency spend has reduced across nursing and other workforce groups, with medical workforce demonstrating an increase. Overall percentage of the pay bill continues on a decline. Bank spend in the registered and non registered nursing workforce has increased from the previous month.

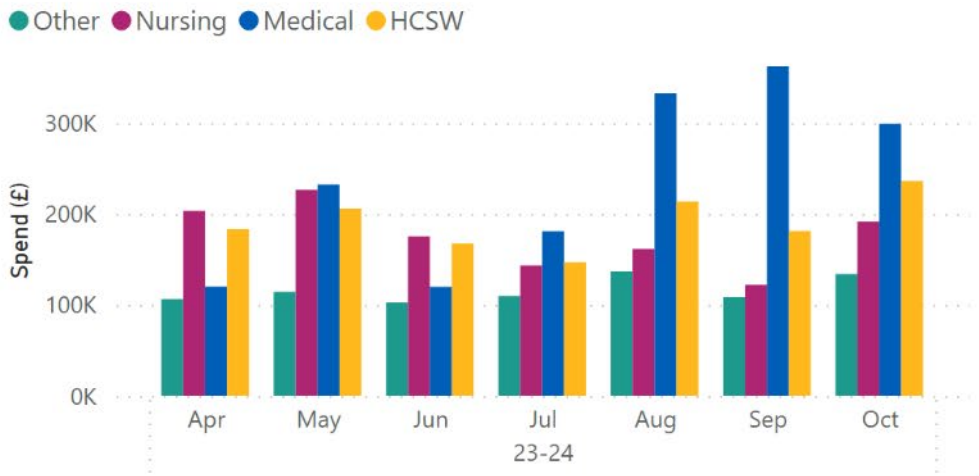
What is our plan and expected impact?

- Agency control procedures 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. Nursing off-framework agency shifts continue to decline.

Total Agency Spend (£)



Total Bank Spend (£)



Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 12ii

Report Title:	Leading Indicators			
Name of Meeting:	Board of Directors			
Date of Meeting:	29th November 2023			
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:** ☒
	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 October 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, • Amber: was on target or achieving trajectory, but off-track latest month (forecast possible risk) • Grey: target or trajectory to be agreed once baselines established In summary at the end of October: **We will improve productivity and efficiency of our operational services** • 4 of 4 Leading Indicators (LI's) RAG rated Red			

<table>
<tr><td>

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

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

- 1 of 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, 1/2 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

Having previously been RAG rated RED, in October transacted CRP is now above planned for levels in the month and also cumulative year to date meaning it has moved this month to GREEN.

While still not RAG rated RED, the trajectory for the number of CDIFF cases, and mortality in relation the HMSR value increasing are moving more toward this status. Future reports will cover the specifics of these indicators if they breach the RED status. However, detail for each is covered in the main leading indicator pack as usual with all metrics.

A more detailed summary for the metrics included in each outcome is provided in the full leading indicator pack. Each month indicator leads are asked to review their performance scorecard and provide supporting narrative, which is what is included in the main report and summarised below.

</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 recommendations to the Board are to receive this report, discuss the potential implications and note the improvement or challenge in key areas.</td></tr>
<tr><td rowspan="4">**Trust Strategic Aims that the report relates to:**</td><td>**Aim 1**
☒</td><td>We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>**Aim 2**
☒</td><td>We will be a great organisation with a highly engaged workforce</td></tr>
<tr><td>**Aim 3**
☒</td><td>We will enhance our productivity and efficiency to make the best use of resources</td></tr>
<tr><td>**Aim 4**
☒</td><td>We will be an effective partner and be ambitious in our commitment to improving health outcomes</td></tr>
</table>

	Aim 5 ☐	We will develop and expand our services within and beyond Gateshead			
Trust corporate objectives that the report relates to:	• Improving the productivity and efficiency of our operational services • Improving the quality and safety of our services for our patients • 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 – November 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 September position:

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: on target or achieving trajectory, (forecast not at risk)
Amber: was on target or achieving trajectory, but off track latest month (forecast possible 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

- **1 of 2** Leading Indicators RAG rated **Green**, **1 of 2** RAG rated **Amber** and 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 **Green**
- **2 of 2** BO's RAG rated **Red**

3. Strategic Aims & Objectives

3.1 This report was amended at the request of Finance and Performance committee in August to only focus 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. Performance at 9.11% in October, a fall from 9.51% in September. 9.11% is the lowest month figure since March. The average number of wards a patient experience fell slightly this month to the lowest value since November 2022, to 1.67 from 1.75 the previous month.

Casual factors affecting performance	Actions being taken
• Patients remaining in the bed base with no criteria to reside. • Reduced bed availability for acute admissions.	• Completion of the NOM programme (November 23). • Formal review of the patient flow form and function with amended information flows.

- 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.

- Programme to relaunch and engage the organisation in criteria to reside.
- New patient flow meeting format being piloted, which includes increased actions to improve flow and monitoring of 1-hour DTA to bed.
- Stranded patient meetings also restarted to reduce length of stay.
- Weekend discharge service in place to increase discharges on Saturday and Sundays.
- Winter ward opened start of November and move away from medically optimised wards which slow flow due to multiple moves of patients.

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 90 recorded between April and the end of October, of which 74 (82%) were in the last 2 months of September and October. In the same period last year, 438 were recorded, so current levels are however 80% lower than last year. The target of 65% of ambulance handovers within 15 minutes continues not to be met, with 41.7% achieved in October, a further reduction from 42.4% in September.

Casual factors affecting performance

- Estates work is continuing resulting in a temporary decant of wards (due to complete Nov 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

Actions being taken

- Completion of the NOM programme in late November. 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.

capacity and increasing delays within the Emergency Department.	• Review of the impact of SDEC being used as additional inpatient capacity.

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 40 patients recorded in October, the same as in September. While no actual target value has been set for the number of bed days lost each month, the plan is to reduce in this area. While September saw a significant reduction to 1818 (a 26% reduction on the previous month, and the lowest in the past 12 months), the number of days last in October have returned to previous levels, increasing to 2407 in October (a 32% increase on September).

Casual factors affecting performance	Actions being taken
• % of patients on P1-P3 remain a significant challenge • Referral to the discharge hub is the greatest pressure. • Out of area patients awaiting discharge on pathways 1-3 have seen a significant increase (but we are now seeing a reduction) • There remain challenges with patients being discharged to Sunderland.	• 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. • 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. • A weekly stranded patient review led by the Chief Matrons has been introduced to further ensure that patients are not remaining in hospital unnecessarily in addition to daily ward review processes.

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 -** Since May (having prior to May been generally improving) the overall length of stay has increased each month. In October the Trust saw the figure increase by the single biggest value so far, from 4.73 in September to 5.52 in October, now well above the 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 5.52, more than a day on average difference.

Casual factors affecting performance	Actions being taken
• Length of stay is Influenced by both internal (hospital/community) and external (system wide) factors. • 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.	• System wide resilience group established, creating opportunities to explore system wide solutions to 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 October the Trust had 274 patients who had been waiting more than 52 weeks. This is 232 above planned for levels at this point in the year, and an increase of 174 since in April. Projections at present are

for the number to reduce by the end of by the end of November to around 252 best case, however up to 327 worst case. The largest pressure specialities are Paediatrics, Pain, Trauma and Orthopaedics and General Surgery. Pain has an improvement trajectory where they expect to have 0 52-week waiters by March 24, and are currently on target to achieve this trajectory. However, for the other challenged specialities, projections are that they will not achieve 0 52-week waiters by the end of March.

Casual factors affecting performance	Actions being taken
• Below planned elective activity levels – but more recent indications of activity improving. • 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	• Recovery plans developed and agreed as part of weekly Access and Performance Meeting, focussing on the reduction of long waiter cohort. • Revised format of weekly Access and Performance Meeting on broader performance that may impact long waiters, such as diagnostics. • Weekly patient level review of long waiters as part of weekly meeting • Exploring digital mutual aid and use of the independent sector. • 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 –** The overall number of patients on the outpatient PTL increased again in October, from 10,580 in September to 10,601 in October. 10,601 remains below the 12-month high of 10,835, but also remains well above the local trajectories.

Casual factors affecting performance	Actions being taken
• Elective activity below plan, new outpatient below plan, follow activity above plan.	• Productivity opportunity by implementation pilot of partial booking.

- Previous periods of 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

- Activity plans discussed weekly through Access and Performance meeting, 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.
- Targeted validation work in progress across all specialties.
- Outpatients programme to look at further opportunities in draft.
- Job plan reviews underway.
- Scoping independent sector for potential additional capacity.

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** – There is no update this quarter to the engagement score, as October's value is sourced from the Annual Staff survey currently being undertaken. As such results will not be available until later in the year. 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. Response rates for the quarterly pulse survey are low, with July's survey results being based on a 2% response rate.

Casual factors affecting performance

- Individuals across the organisation experiencing 'survey fatigue' or feeling that their feedback is not acted upon.
- Low levels of engagement with both Annual and Pulse Survey Results (latest quarterly response rate for Julys results were circa 2%), bringing validity of measure into question.

Actions being taken

- Plans in place to encourage engagement, as well diversify engagement measurement tools to gain a more rounded picture.
- More targeted focus on the 3 elements of the Engagement Score i.e. Motivation, Involvement and Advocacy.
- Comms via the CEO messaging around the importance of completing staff survey and tangible

Trust Wide actions that have been taken as a result of this.

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. At 6.2% for the month of October, this is the fifth month In a row that sickness levels have risen, and the monthly figure now is the highest since January 2023. The 12 month rolling average sickness figure increased remained at from 5.7%, in the 12 months to the end of October.

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.	• 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. • Recruited recent vacancies within the POD team and on appointment anticipate again seeing the benefit of specialist support being involved from an early stage in the absence process.

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, overall financial plan.*

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: Green – Having previously been RAG rated RED, in October transacted CRP is now above planned for levels in the month and also cumulative year to date meaning it has moved this month to GREEN. In October

transacted CRP was £2,231m, £478k above planned levels for the month. The year-to-date variance for CRP improved to £309k above planned for levels at this point in the year.

3.4.2 **Status: Red –** Pay spend was £1,047m above plan in October, and £5,022m year to date overspend against plan. Non-pay spend was -£522k below plan in October, resulting in a £861k year to date overspend on this measure. This however is an improvement £1,383m overspend at the end of last month. Cumulative year to date with a planned deficit at the end of October of -£8,305m, the Trust stood at -£10,248m, £1,943m more than planned, and a slight increase from £1,705m more than planned at the end of September.

Casual factors affecting performance	Actions being taken
• Opening of non-funded escalation beds and acuity of patients requiring enhanced care contributing to overspend against delegated budgets. • Medical, Nursing and HCA staff pay budgets due to bank and agency spend. • Availability of resource to support project management of identified schemes included in the delivery oversight group. • Unscheduled care operational pressures and industrial action impacting the elective recovery programme contributing to reduced activity.	• Investment in admission avoidance and discharge schemes from external funding to support urgent & emergency care and virtual wards. Implementation of new operating model ward configuration. • Deep dive into Medicine Business Unit and production of financial recovery plan. • Finance workstream delivery oversight groups which includes back to basics and enhanced financial controls including: Team including minimising discretionary spend, criteria for the approval of waiting lists 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. • Coding & Counting review and elective care transformation programme.

NHS
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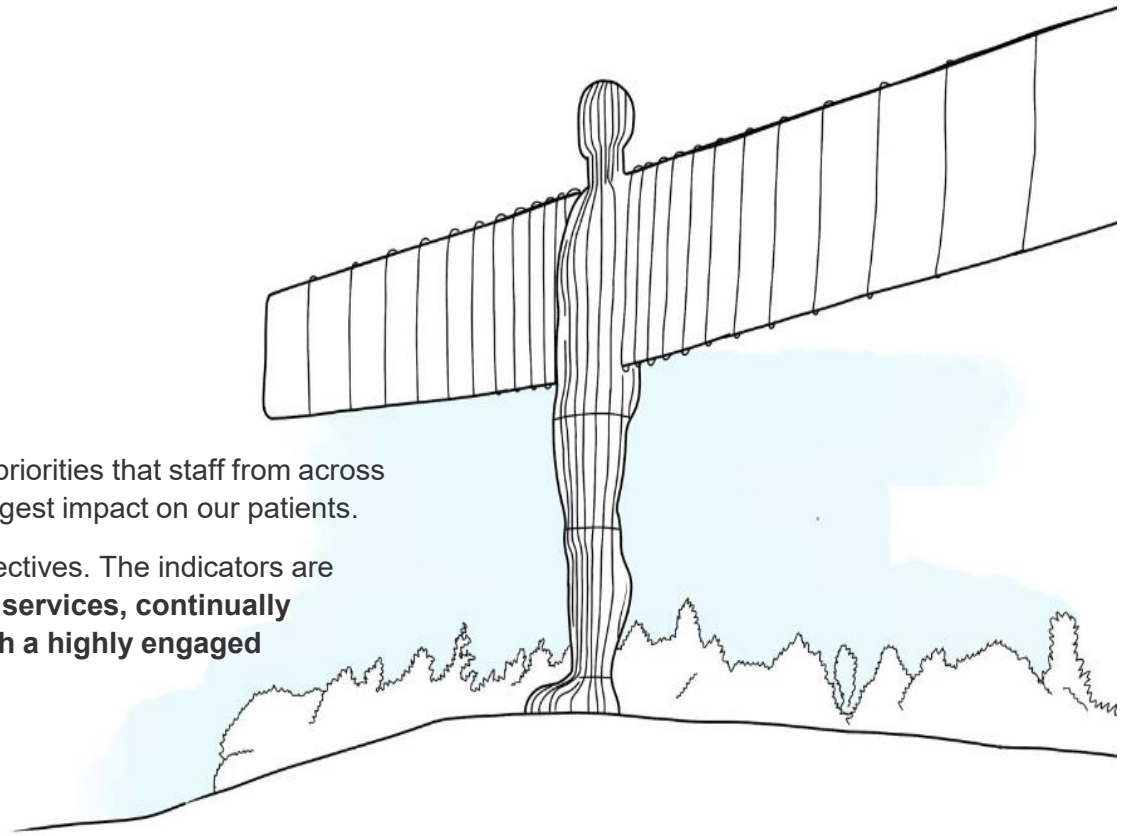
Leading Indicators

November 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**

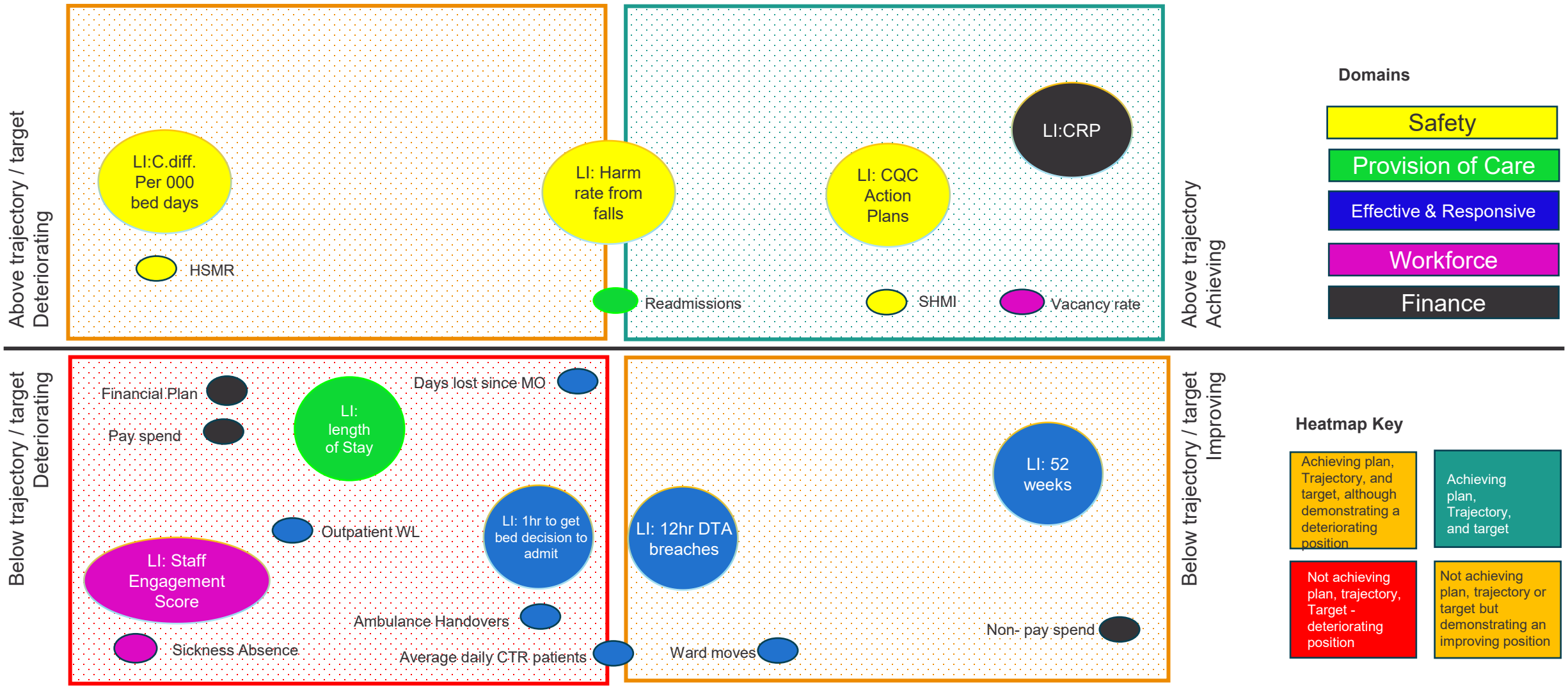
This pack is the fifth iteration of the metrics, which are continuing to be refined and developed.

THIS PACK IS BEST VIEWED ON SCREEN IN SLIDESHOW MODE

	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	7	
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	8	
Increase in the % of ambulance handovers within 15 minutes	BO		
Reduction in the time (days) between patients becoming medically optimised and discharge	BO	9	
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	10	
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	11	
A reduction in the RTT PTL outpatient waiting list	BO	12	
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	14	
Increase the proportion of closed actions in the CQC action plan, reported to SMT	LI	15	
Reduction in the harm rate per 1,000 bed days from patient falls	LI	16	
Summary Hospital-level Mortality Indicator (SHMI) within the expected range / <1	BO	17	
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	19	
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	21	
Pay spend no greater than £250m	BO		
Non-pay spend no greater than £132.5m	BO		

Metrics Explained: Overall Strategic Picture

Gateshead Health NHS Foundation Trust



Heatmap Narrative

Not Achieving & Deteriorating (prioritise & focus)

Length of Stay: Increased from 4.73 days to 5.52 days in month and can be impacted by an increase in poorly patients who need to stay longer in acute care as well as in hospital delays contributing to longer lengths of stay and external factors prohibiting or delaying patients going home. Patients on Pathways 1 – 3 remain a challenge however out of area discharges have improved in month. Internal delays and admission avoidance schemes are being managed within business as usual, with the Trust's Clinical Support Group are clinically leading on focused areas of work. There is work ongoing to support discharge and embed as business as usual. The System Resilience Group is focused on system wide solutions to support flow across the ICB.
There is a renewed national focus on better data collection to support discharge with a new 'discharge ready date' and further plans to improve the clarity around the reasons for delay. Gateshead Health is one of two Trusts in the region who are complaint with the ask, however our time between discharge ready and actual discharge has increased.
Timely access to a bed: Access to bed within 1 hour is not being achieved - with a deteriorating position over the winter months. Access to EAU as well as base-ward beds remains a challenging. Both EAU and SDEC are on the priority list for service improvement observations to understand the bottlenecks in support of an improvement plan and continuous improvement in the operating model.

Staff Engagement: Pulse staff engagement score remains at 5.92 (July data) with a 2% completion rate. This is the latest data available as we await the results of the staff survey to provide a more relevant engagement score. Enhanced communications across the Trust and releasing dedicated time for staff to complete the survey continues. Sickness absence rates continue to rise, our current rate is at 6.2%, above 5% threshold.
Finance: Our Trust Planned deficit at the end of October is £1.9m over planned for levels and our pay spend is £5m over planned for levels.

Not Achieving but Improving (watch and intervene)

12 Hour Decision to Admit (trolley waits): The position has improved in month with 24 patients waiting > 12 hr waits for a bed in October (from 50 last month) and 85 year to date. There are new patient flow standards in place and enhanced team actions to continually review and monitor and challenge the status of admissions and access to beds as well as rigour in monitoring ambulance arrivals to minimise delays, with a commitment to handing over ambulance conveyances within 15 minutes.

52 Week waiters: The position has improved from 293 to 274 over 52 week waiters in October, with further improvements will follow as risks surrounding long waiters are managed via the Access & Performance clinics and are aiming for zero long waits at year end.
Risks surrounding delivery of your year end targets are currently being managed by maximising productivity opportunities to increase capacity, reassigning lists to areas of greatest need – whilst prioritising our longest waits. Increased validation and improving data quality will support cleaner waiting lists whilst minimising re-work. Business unit plans are in place to meet 90% by the end of December.

Gateshead Health NHS Foundation Trust

Heatmap Narrative

Not Achieving but Improving (watch and intervene)

Non-pay: Is also over planned for levels £861k year to date, however the monthly position has improved with a £522 positive variance to plan.

Achieving but deteriorating (support)

C.Difficile per 100,000 bed days: Remains within expected range and is showing common cause variation. However, the challenging target of no more than 23 cases in 2023/24 is now flagging at risk, as 6 cases were reported in October bringing our cumulative year to date total to 20 cases. The current action plans are still very relevant with careful monitoring and learning from thematic reviews.

Achieving (maintain)

Harm rates from falls: Continues to be our leading patient safety event reported in the Trust. We have not set a threshold in this area as this is currently a watching leading indicator. The metric is within common cause variation – although a spike of 2.6 per 1000 bed days were reported in October. The learning from these falls will be reviewed through learning panels and feed into the Trust Falls Prevention Group.

CQC Improvement Plans : Completed actions remain the same as last month, actions are reviewed and updated bi-monthly.

CRP: Delivering £2.2m against a plan of £1.7m in October has improved the year to date position with a positive variance of £309k against plan.

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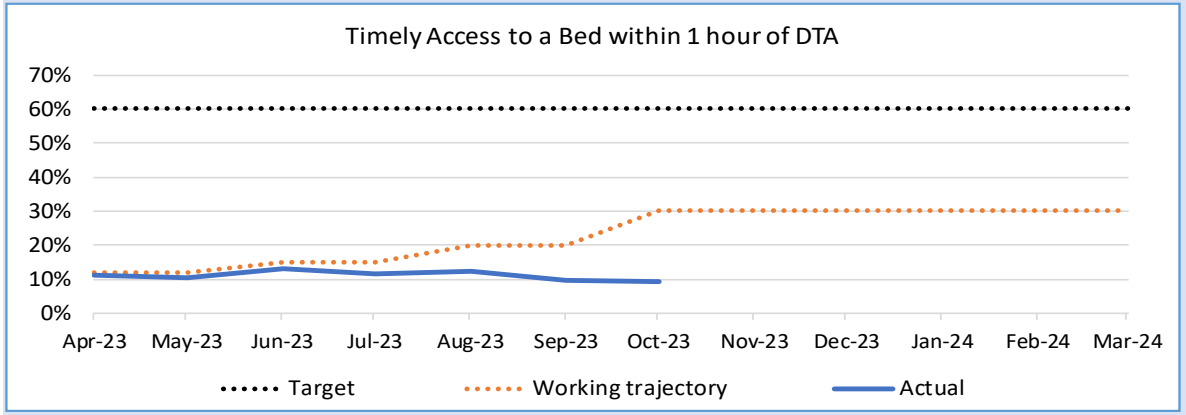
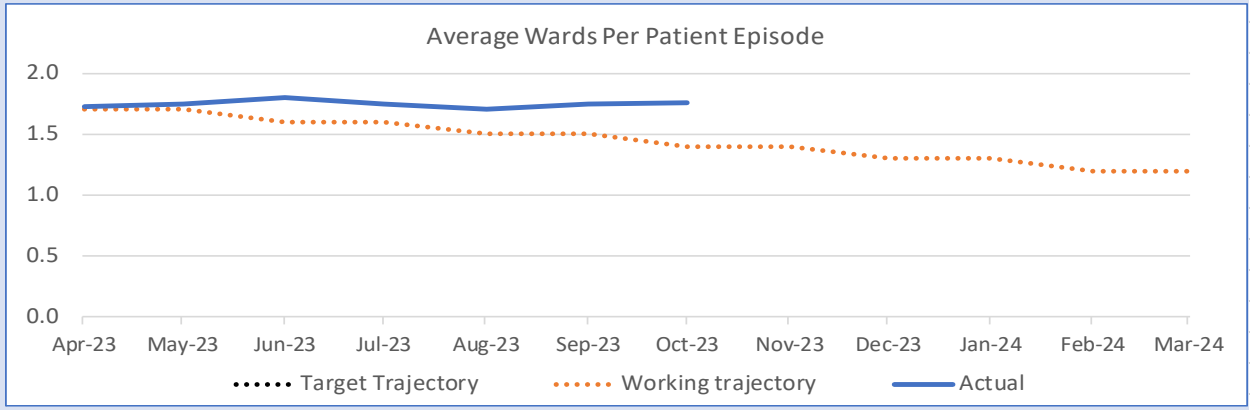
We will improve productivity and efficiency of our operational services

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	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Trend
Timely Access to a Bed within an Hour of DTA	LI	Oct-23	>60%	Loc	11.60%	7.77%	8.92%	7.49%	9.58%	11.01%	10.49%	12.92%	11.61%	12.22%	9.51%	9.11%	
Reduction in the average number of wards per patient episode	BO	Oct-23	TBA	Loc	1.69	1.71	1.74	1.77	1.81	1.73	1.75	1.80	1.75	1.76	1.75	1.67	
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 in late November. Formal review of the patient flow form and function with amended information flows. Programme to relaunched and engage the organisation in criteria to reside. Review of the BO metrics as part of the leading indicators to link to operational actions.

New patient flow meeting format being piloted, which includes increased actions to improve flow and monitoring of 1 hour DTA to bed. Stranded patient meetings also restarted to reduce length of stay.

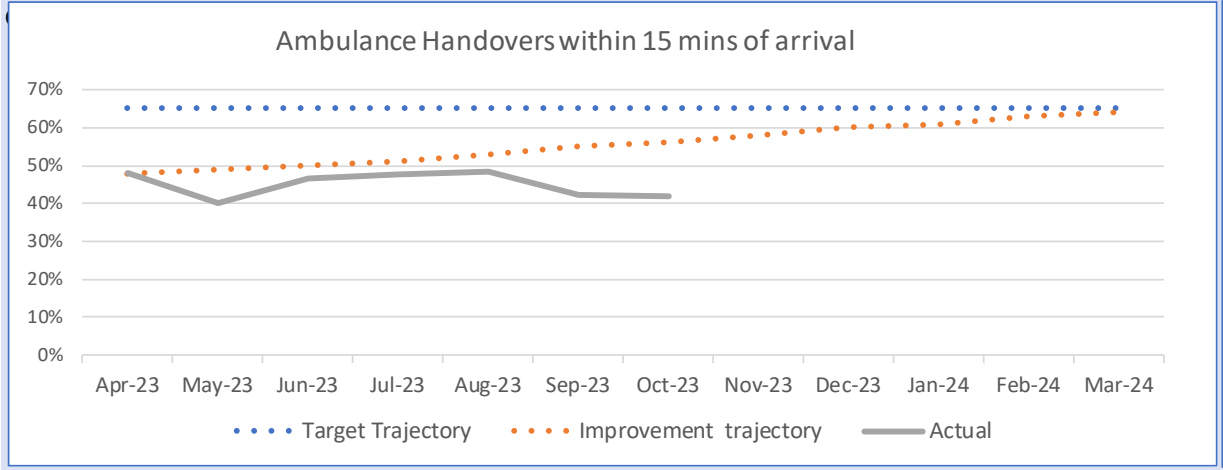
Weekend discharge service in place to increase discharges on Saturday and Sundays

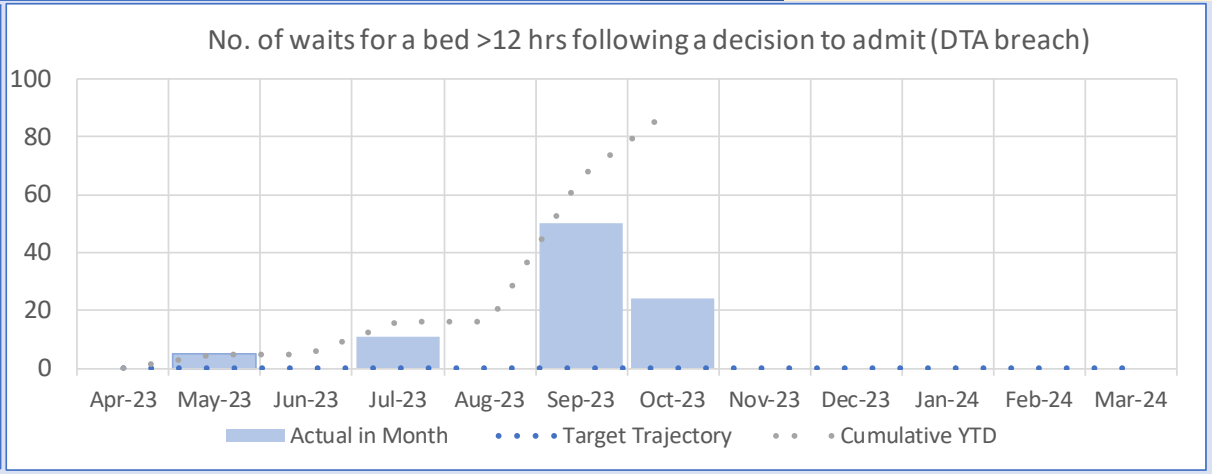
Winter ward opened 05/11/23 and move away from medically optimised wards which slow flow due to multiple moves of patients.

Gateshead Health NHS Foundation Trust

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	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Trend
Ambulance Handovers within 15 mins from arrival	BO	Oct-23	65%	Nat.	33.6%	24.7%	39.5%	48.6%	48.0%	48.0%	40.3%	46.6%	47.8%	48.3%	42.4%	41.7%	
Waits for a bed >12 hrs following a decision to admit (DTA breach)	LI	Oct-23	Zero	Nat.	172	538	320	40	80	0	5	0	11	0	50	24	

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 Nov 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 in late November. 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

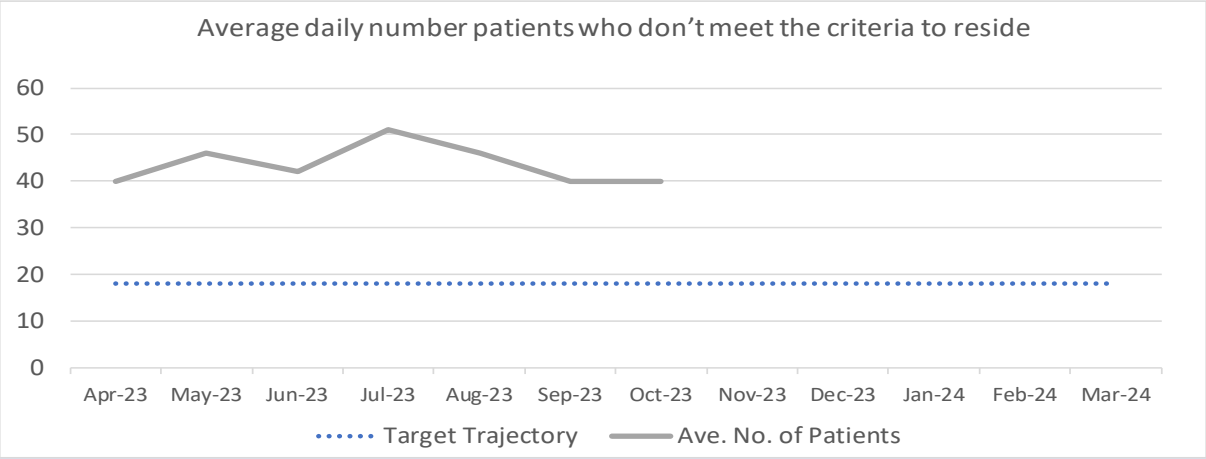
Action plan in place to improve performance

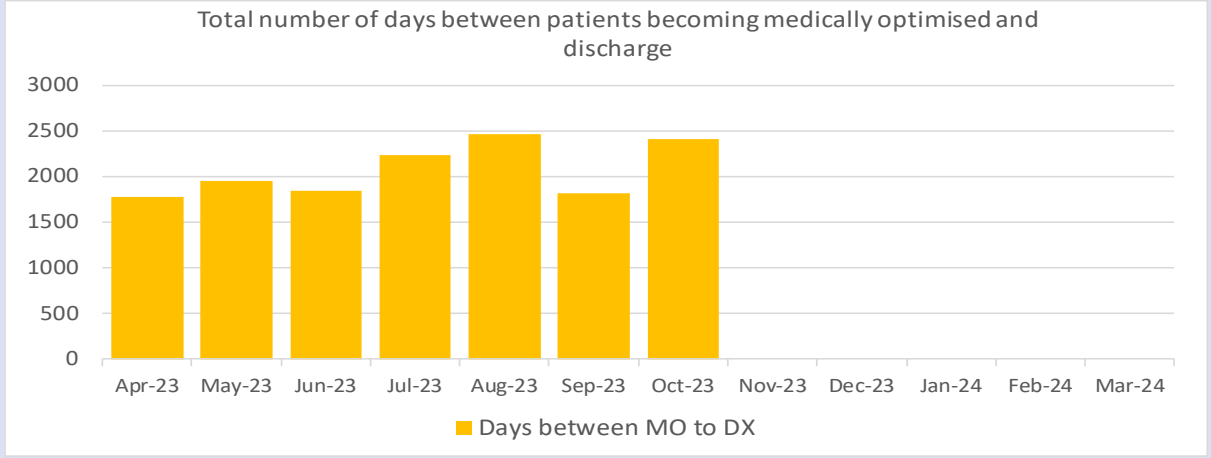
Gateshead Health NHS Foundation Trust

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:	Gareth Johnson
		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	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Trend
Average daily number patients who don't meet the criteria to reside	BO	Oct-23	≤18	Loc.	52	56	53	51	43	40	46	42	51	46	40	40	
Total days between patients becoming MO and discharged	BO	Oct-23	Monitor	Loc.	2175	2677	2259	2391	2798	1783	1952	1851	2236	2467	1818	2407	

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 a significant 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 remains challenges with patients being discharged to Sunderland.

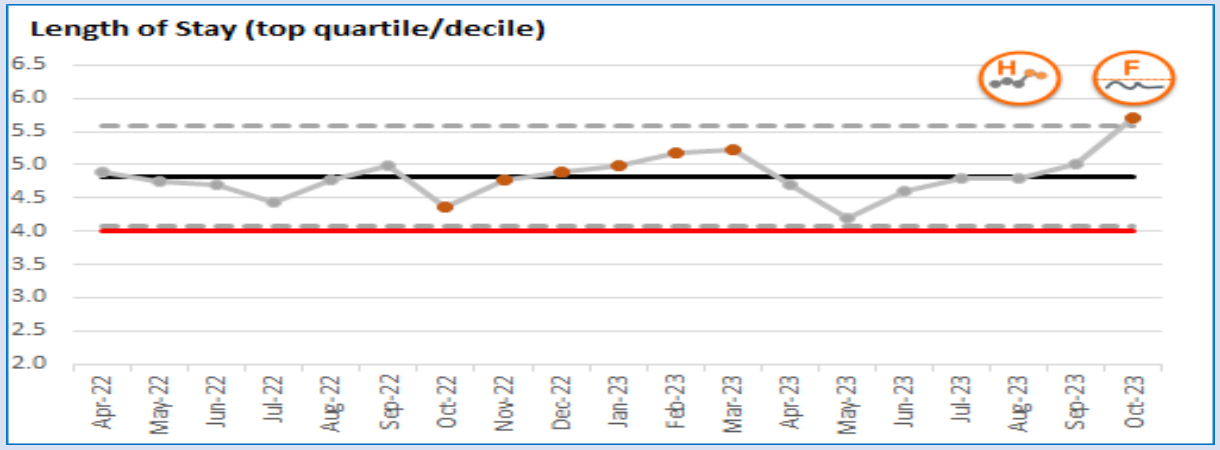
Actions being taken: Daily review of patients on list of patients who are medically optimised. Daily allocation of patients to appropriate out of hospital placements. Strategic planning with social care to identify and appropriately and commission system capacity to reduce pathway 1-3 delays.

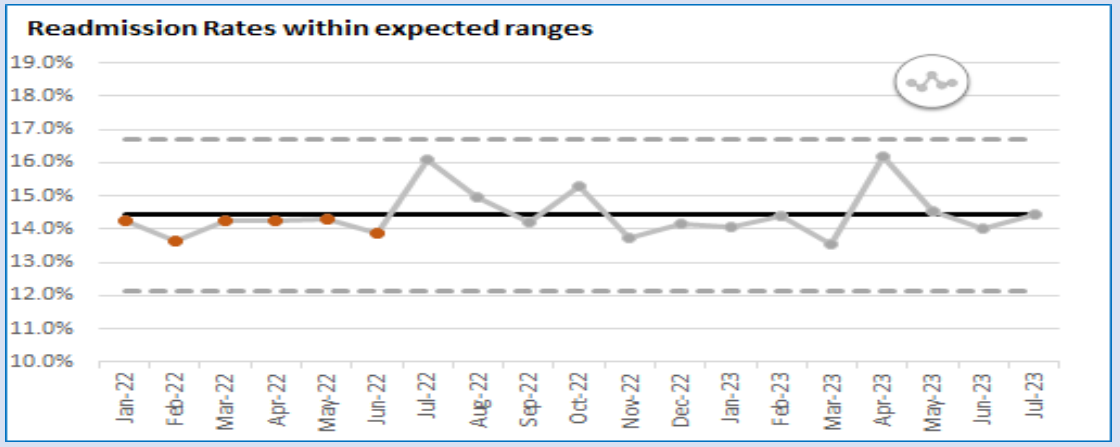
A weekly stranded patient review led by the Chief Matrons has been introduced to further ensure that patients are not remaining in hospital unnecessarily in addition to daily ward review processes.

Gateshead Health NHS Foundation 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:	
		Oversight:	Unscheduled Care Transformation





Indicator	Leading Indicator	Period	Target	Target Type	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Trend
Trust overall length of stay	LI	Oct-23	Top Quartile <4	Loc.	4.77	4.9	4.98	5.19	5.23	4.68	4.26	4.44	4.5	4.56	4.73	5.52	
Elective (exc. DC)		Oct-23	Monitor	Loc.	3.9	3.32	4.44	4.7	3.09	4.26	2.52	2.66	3.91	2.48	3.75	3.25	
Non Elective		Oct-23	Monitor	Loc.	4.88	5.05	5.04	5.24	5.45	4.72	4.43	4.6	4.55	4.66	4.83	5.79	
Readmission Rates	BO	Jul-23	Monitor	Loc.	13.8%	14.2%	14.1%	14.4%	13.5%	16.2%	14.5%	14.0%	14.5%				

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.

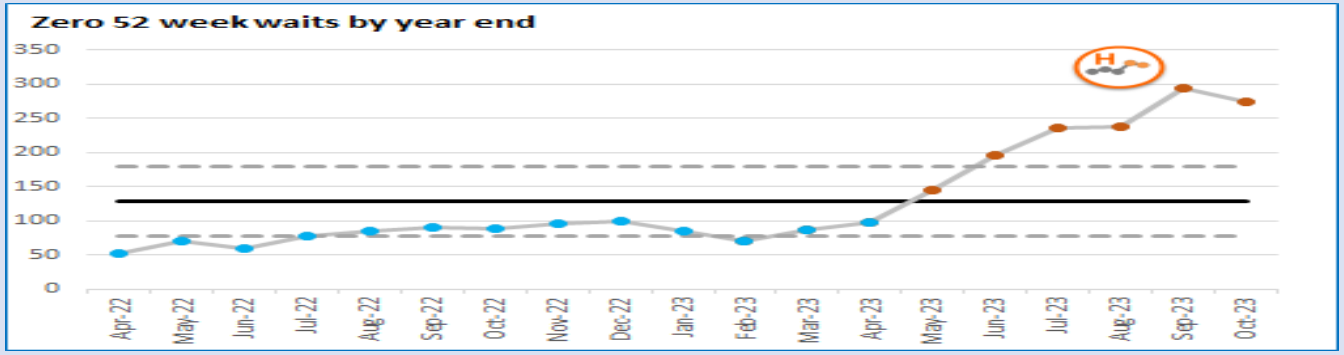
Re-admissions - Remodel SDEC Follow-ups, deduct from NEL to determine real rate, and continue to monitor. Develop integrated flow across the integrated care model.

NHS Gateshead Health NHS Foundation Trust

We will improve productivity and efficiency of our operational services

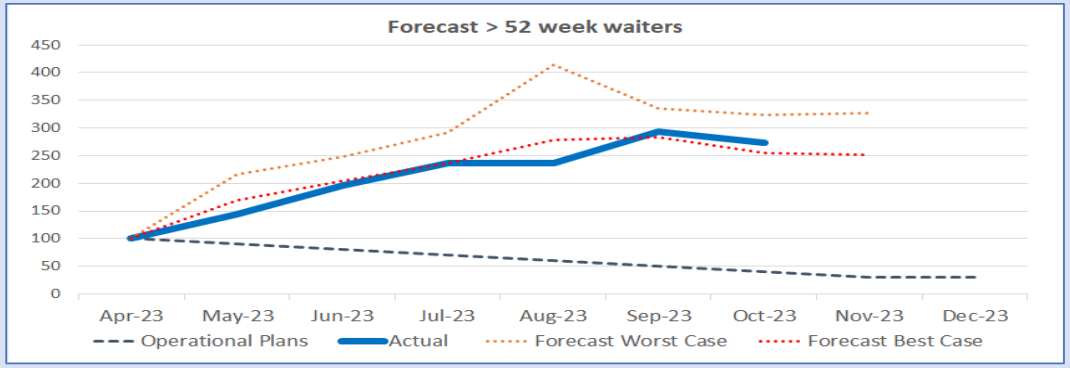
Status	Director:	Amy Muldoon
LI	Ops Lead:	Ross Peddie
	Oversight:	Elective Care Programme

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



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	293	274					
Forecast Worst Case	100	217	249	292	415	335	324	327				
Forecast Best Case	100	169	205	236	278	283	255	252				
Forcasted		02-May	05-Jun	17-Jul	17-Aug	19-Sep	19-Oct	19-Nov				

Specialty Forecast (best case)	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23
Paediatrics				104	93	112	103	125
Pain				67	77	79	59	30
Orthopaedics				29	49	42	44	41
General Surgery				18	26	27	31	31
Urology				8	9	8	5	5
Gynae				4	7	9	8	12
Gastro				2	2	3	4	4
Cardiology				0	0	1	1	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 Access and Performance meetings with all Business Units developed 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.

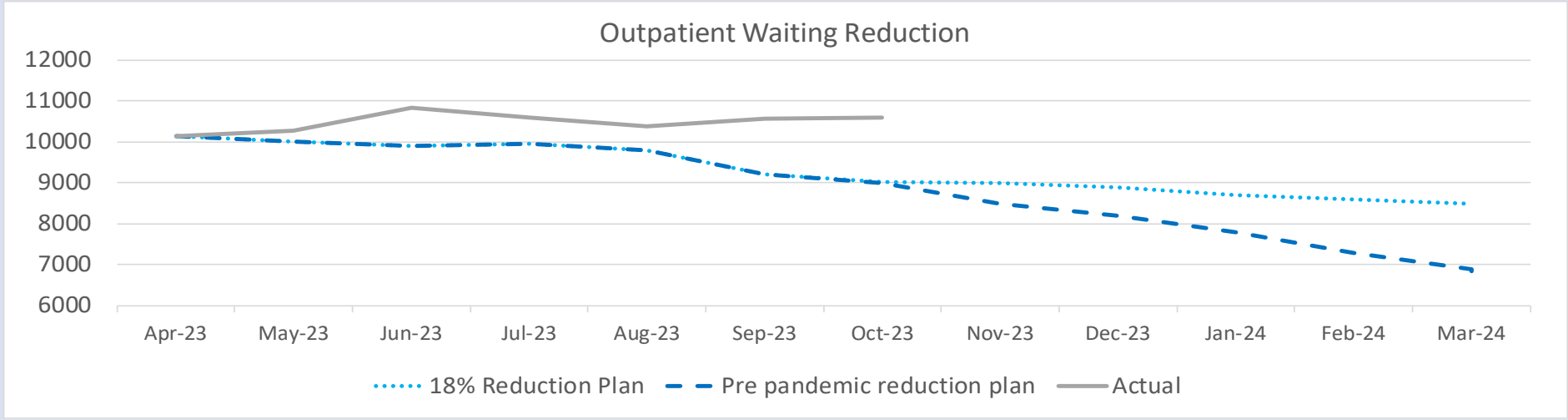
Causal Factors: Industrial action leading to cancellation of elective activity and site pressures resulting in the loss of elective beds and activity, with 17% of routine working days lost due to IA in 2023/24 financial year to date (September 2023). Data quality and inconsistency of practice in RTT 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 Access and Performance Meeting, focussing on the reduction of long waiter cohort. Revised format of weekly Access and Performance Meeting on broader performance that may impact long waiters, such as diagnostics. Weekly patient level review of long waiters as part of weekly meeting. Exploring digital mutual aid and use of the independent sector. 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.

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	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Trend
No of outpatient on the RTT waiting list	BO	Oct-23	7,500	Loc.	9607	9441	9558	9784	9643	10146	10283	10835	10584	10387	10580	10601	

Risks: Referrals are above 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 access & performance clinics to identify specialty level improvement plans led by Ops Director. Pathway reviews to understand bottle necks. Focussed pieces of work underway include a review of clinic template capacity by consultant/ specialty. Long waiting patients are closely monitored with appointments brought forward wherever possible. Reviewing long waits for 1st OP appointment by specialty to incorporate into specialty recovery plans

Causal Factors:
Elective activity below plan- IA and Staffing issues impacting position due to cancellation 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 Access and Performane meeting, 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. Targeted validation work in progress across all specialties. Outpatients programme to look at further opportunities in draft. Job plan reviews underway. Scoping independent sector for potential additional capacity

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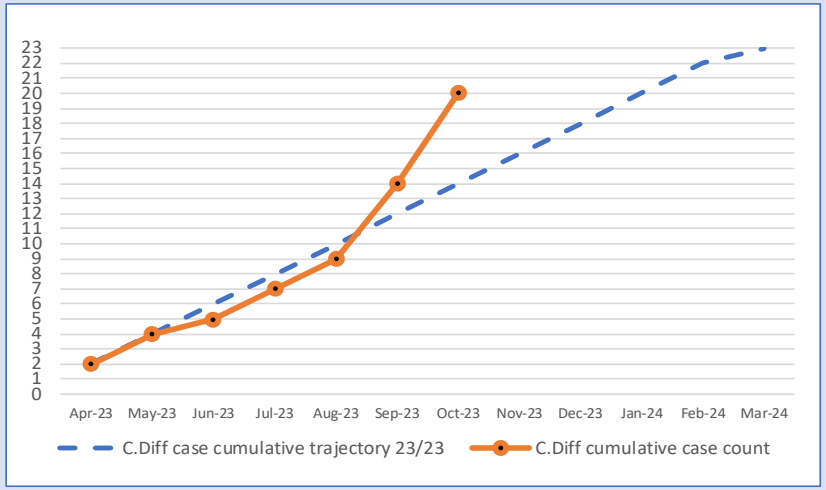
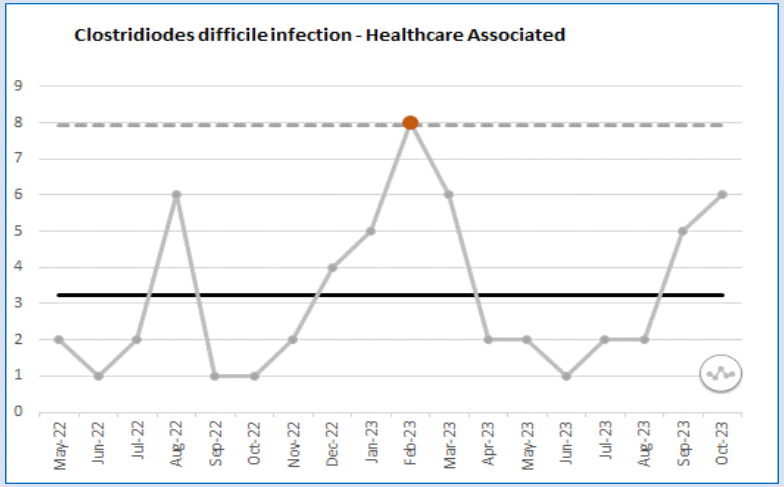
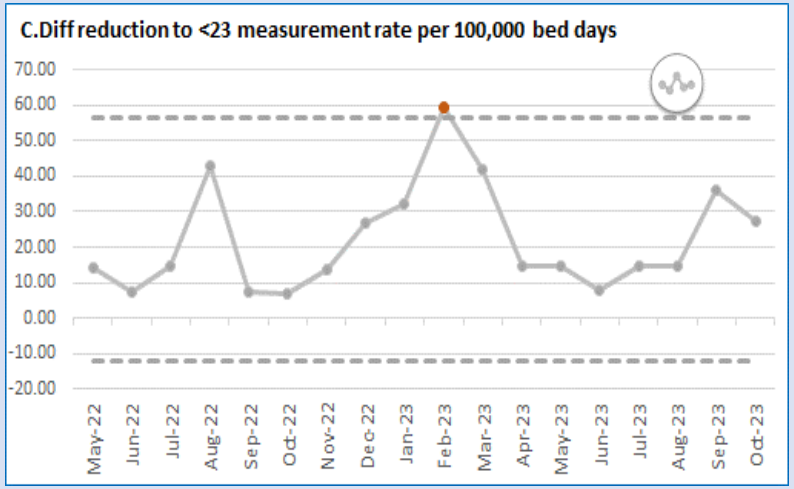
LI: Rate per 100,000 bed days below or inline with national objective

Status	Director:	Gill Findley
LI	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	5	6					
Total YTD	2	4	5	7	9	14	20					
Community Associated	2	0	0	0	2	2	0					

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. New RAG rated cleaning process implemented for environment where c-diff has occurred. Increased surveillance by the IPC team regarding CDI patients. Sporicidal wipes placed in all clinical areas for enhanced equipment cleaning. New posters planned for display across the organisation. 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. More virulent strain of C-diff identified by UKHSA. High level of antibiotic prescribing in some areas. High bed occupancy rate. De-escalation of IV to oral antibiotics. Documentation. Timeliness in faecal sampling. 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.

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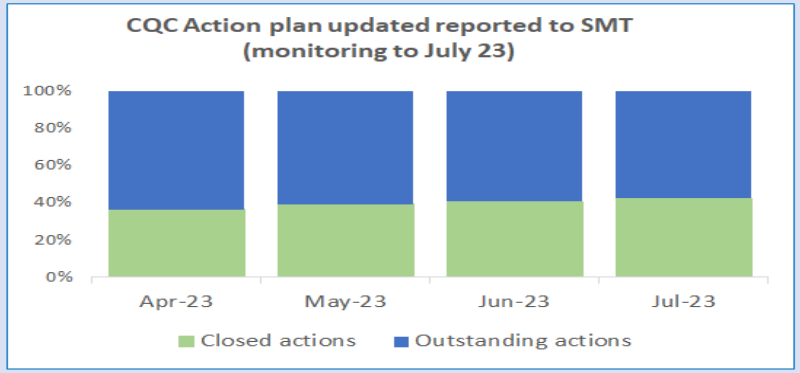
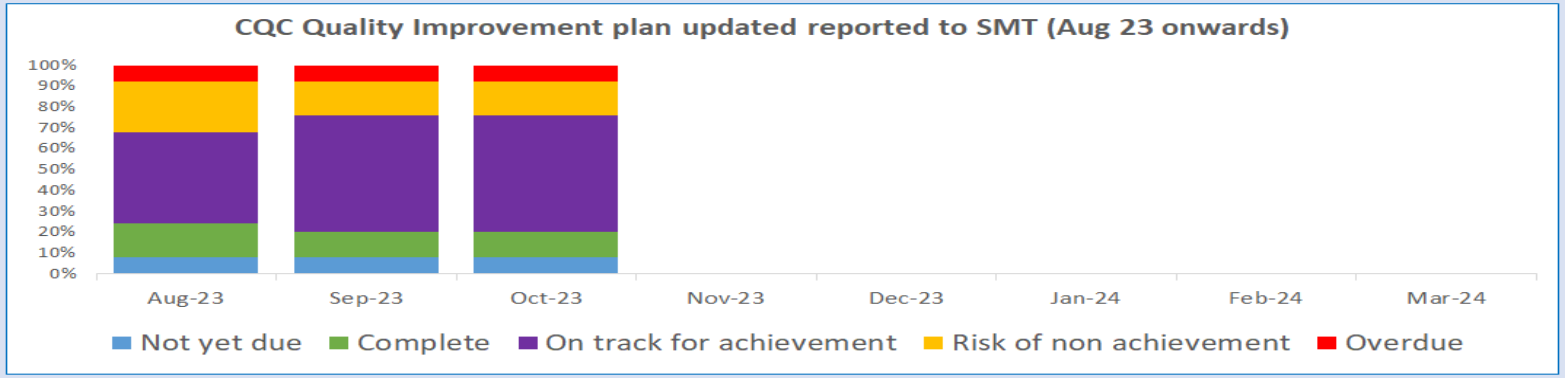
LI: Increase the proprtion of complete actions in the CQC Quality Improvement Plan, reported to SMT

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	2	2					
Risk of non achievement					6	4	4					
On track for achievement					11	14	14					
Not yet due					2	2	2					
Complete					4	3	3					

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.

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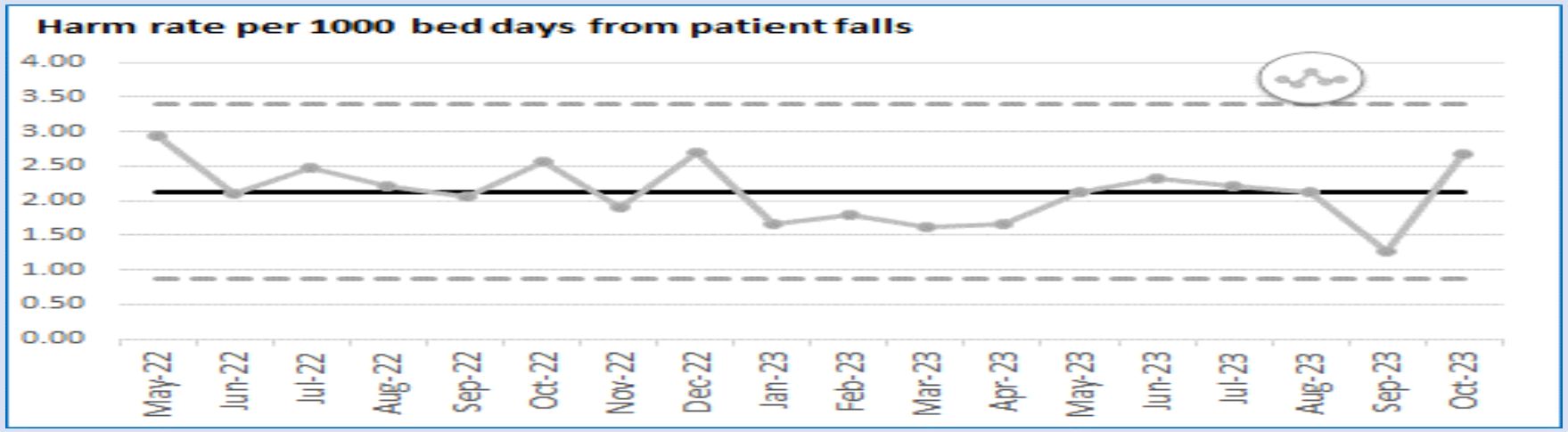
LI: Reduction in the harm rate per 1,000 bed days from patient falls

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	1.27	2.67					
Improvement Trajectory	TBA	TBA	TBA	TBA	TBA	NA	NA					

Risks: Inpatient falls continue to be a 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 below the median for the past three months suggesting targeted improvement work is continuing to be successful in preventing falls. It has to be acknowledged that the Trust went live with a new system which will mean that data for September will sit between two systems which may impact ease of reporting. Reassuringly falls reporting remains consistent and effectively managed within the new system.

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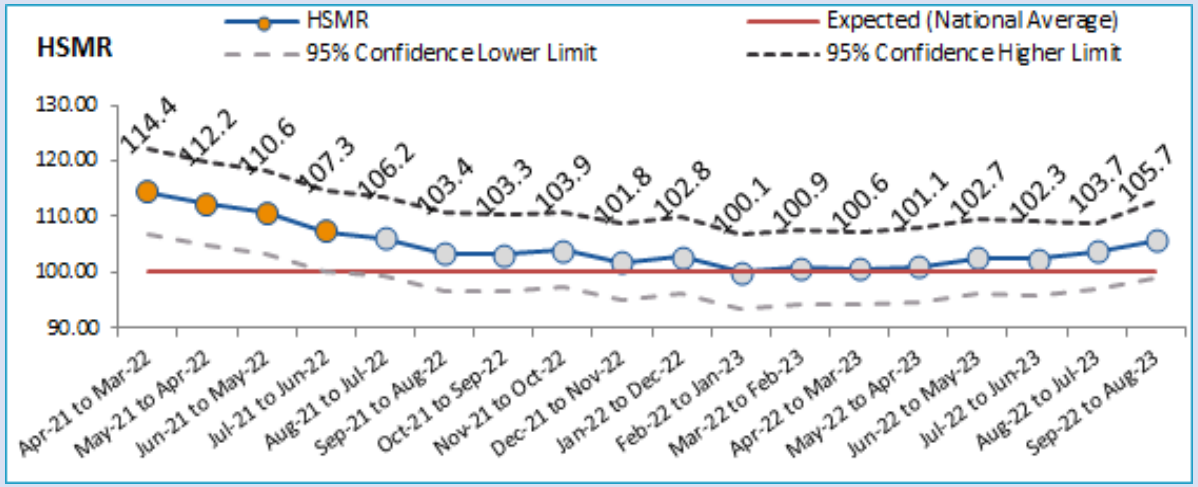
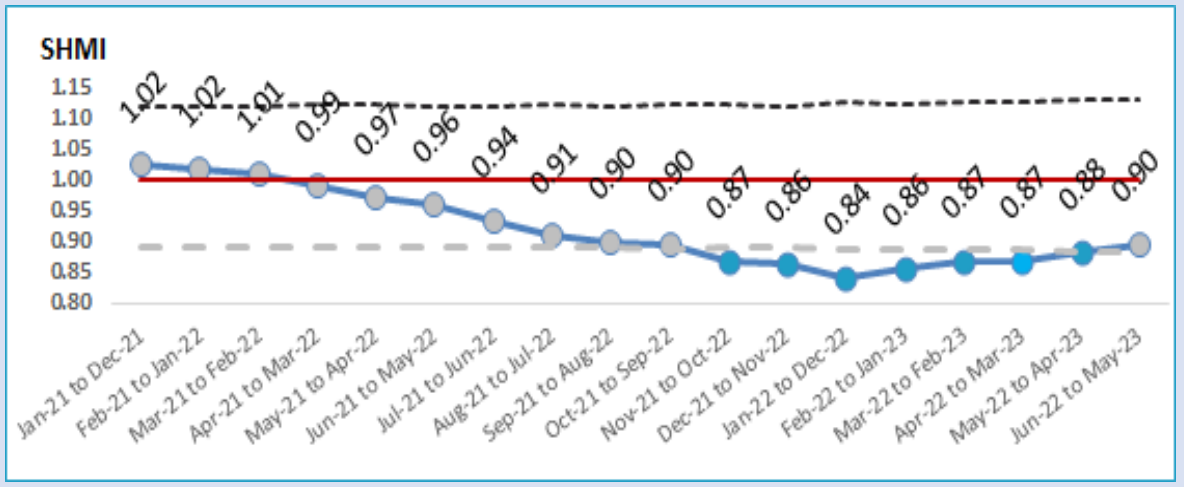
	Status		
BO: Summary Hospital-level Mortality Indicator (SHMI) within the expected range	BO	Director:	Andy Beeby
BO: Hospital Standardised Mortality Ratios (HSMR) within the expected range	BO	Ops Lead:	Wendy McFadden
		Oversight:	Quality Governance Committee





Indicator	Leading Indicator	Period	Target	Target Type	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Trend
Summary Hospital Mortaility Indicator (SHMI) (rolling 12 months)	BO	Jun-23	≤1	Nat.	0.87	0.86	0.84	0.86	0.87	0.87	0.88	0.9			
Hospital Standard Mortality Ratio (HSMR) (rolling 12 months)	BO	Aug-23	`	Nat.	101.8	102.8	100.1	100.9	100.6	101.1	102.7	102.3	103.7	105.7	

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. Following a recent upward trend this indicator is close to triggering more deaths than expected. 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 Patient Safety Learning 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 99.9% 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 featured 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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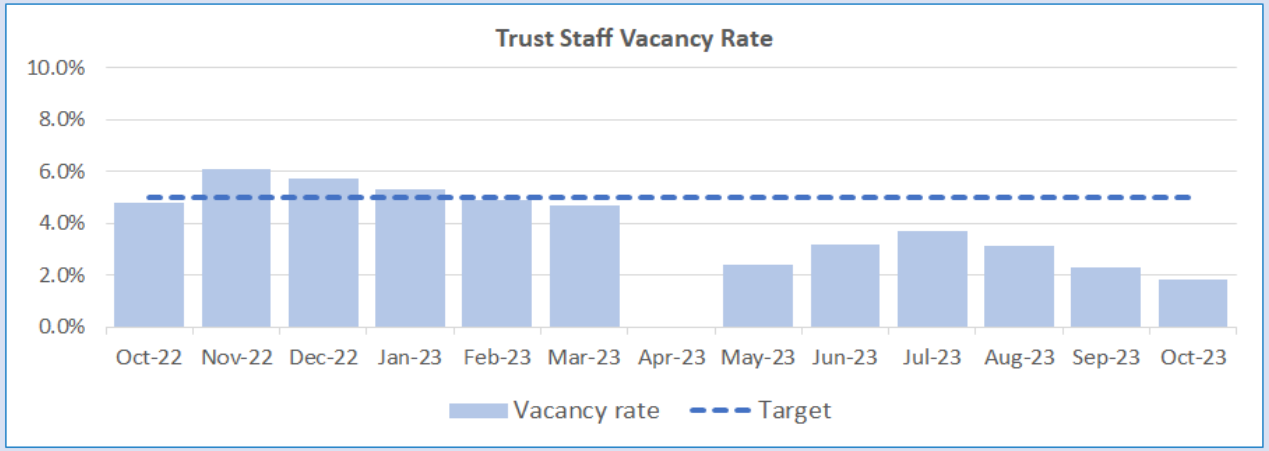
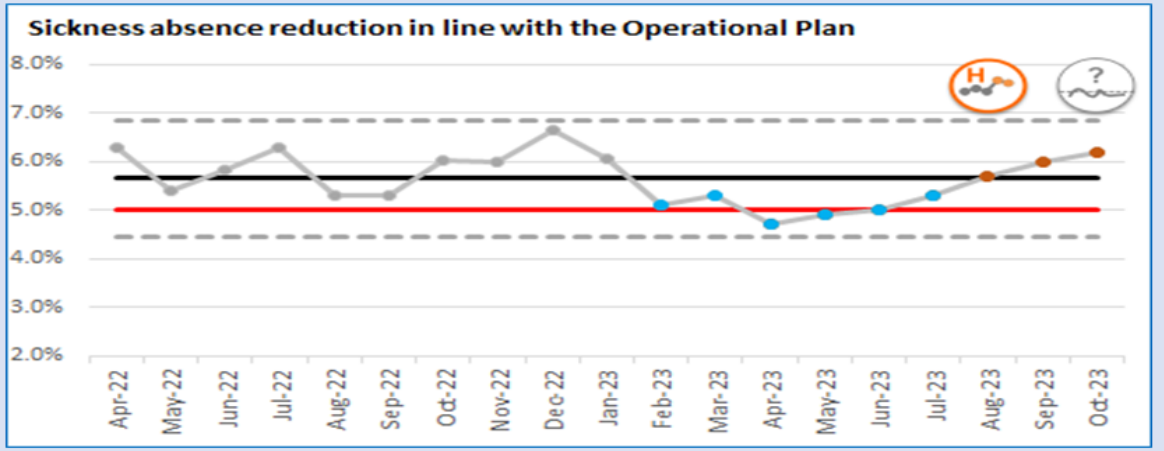
We will be a great organisation with a highly engaged workforce

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	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Trend
Trust Staff Survey rate - Engagement score	LI	Q1	SS: 6.9	Loc.		6.9	6.47			6.77			5.92			from staff survey	
Group Staff Vacancy rates	BO	Oct-23	≤5%	Loc.	6.1%	5.7%	5.3%	4.9%	4.7%	Not Available	2.6%	3.4%	3.7%	3.1%	2.3%	1.8%	
Group Sickness Absence	BO	Oct-23	≤5%	Loc.	6.0%	6.7%	6.1%	5.1%	5.30%	5.0%	4.9%	5.0%	5.3%	5.7%	6.0%	6.2%	

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:
Engagement Score: Individuals across the organisation experiencing 'survey fatigue' or feeling that their feedback is not acted upon. **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. Comms via the CEO messaging around the importance of completing staff survey and tangible Trust Wide actions that have been taken as a result of this. **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. Recruited recent vacancies within the POD team and on appointment anticipate again seeing the benefit of specialist support being involved from an early stage in the absence process.

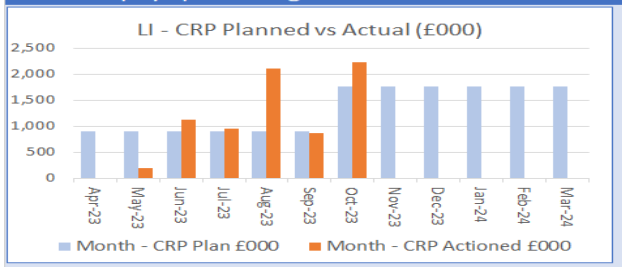
Gateshead Health NHS Foundation Trust

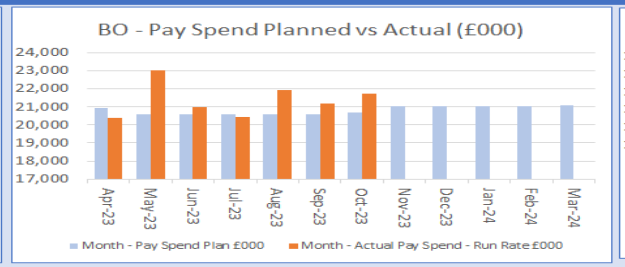
We will achieve financial sustainability

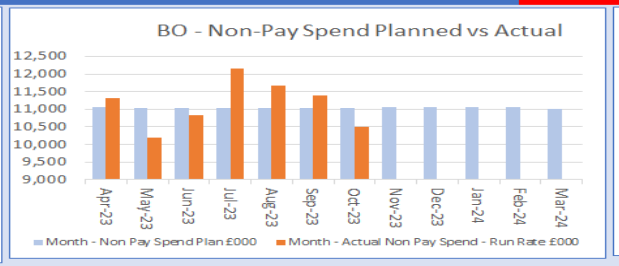
Gateshead Health NHS Foundation Trust

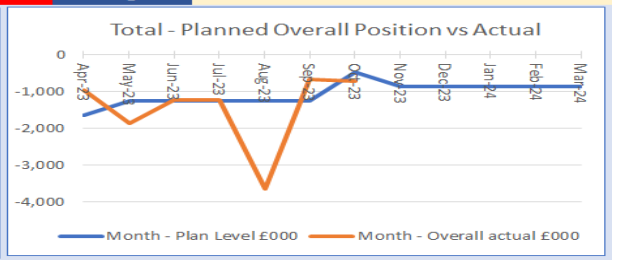
We will achieve financial sustainability

	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						15,900
Month - CRP Actioned £000		0	191	1,116	949	2,096	861	2,231						7,444
Month - Variance £000		-897	-706	219	52	1,199	-36	478						-8,456
YTD - CRP Plan £000		897	1,794	2,691	3,588	4,485	5,382	7,135						
YTD - CRP Actioned £000		0	191	1,307	2,256	4,352	5,213	7,444						
YTD - Variance £000		-897	-1,603	-1,384	-1,332	-133	-169	309						
Month - Pay Spend Plan £000	BO	20,953	20,593	20,593	20,593	20,593	20,593	20,677						249,811
Month - Actual Pay Spend - Run Rate £000		20,379	23,002	20,994	20,451	21,913	21,154	21,724						149,617
Month - Variance £000		-574	2,409	401	-142	1,320	561	1,047						-100,194
YTD - Pay Spend Plan £000		20,953	41,546	62,139	82,732	103,325	123,918	144,595						
YTD - Actual Pay Spend - Run Rate £000		20,379	43,381	64,375	84,826	106,739	127,893	149,617						
YTD - Variance £000		-574	1,835	2,236	2,094	3,414	3,975	5,022						
Month - Non Pay Spend Plan £000	BO	11,051	11,025	11,025	11,025	11,025	11,025	11,027						132,424
Month - Actual Non Pay Spend - Run Rate £000		11,311	10,203	10,823	12,152	11,681	11,388	10,505						78,064
Month - Variance £000		260	-822	-202	1,127	656	363	-522						-54,360
YTD - Non Pay Spend Plan £000		11,051	22,076	33,101	44,126	55,151	66,176	77,203						
YTD - Actual Non Pay Spend - Run Rate £000		11,311	21,514	32,337	44,489	56,170	67,559	78,064						
YTD - Variance £000		260	-562	-764	363	1,019	1,383	861						
		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						-12,588
Month - Overall actual £000		-954	-1866	-1211	-1216	-3625	-666	-710						-10,248
Month - Variance £000		674	-624	29	26	-2,383	573	-238						2,340
YTD - - Plan Level £000		-1,628	-2,870	-4,110	-5,352	-6,594	-7,833	-8,305						
YTD - Overall actual £000		-954	-2,820	-4,031	-5,247	-8,872	-9,538	-10,248						
YTD - Variance £000		674	50	79	105	-2,278	-1,705	-1,943						

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 monthly oversight meetings. Weekly activity performance dashboards and introduction of new financial controls limiting discretionary spend, authorisation of waiting list payments and use of agency staff.

Causal Factrors: Opening of non-funded escalation beds and acuity of patients requiring enhanced care contributing to overspend against delegated budgets. Medical, Nursing and HCA staff pay budgets due to bank and agency spend. Availability of resource to support project management of identified schemes included in the delivery oversight group. Unscheduled care operational pressures and industrial action impacting the elective recovery programme contributing to reduced activity.

Actions being taken: Investment in admission avoidance and discharge schemes from external funding to support urgent & emergency care and virtual wards. Implementation of new operating model ward configuration. Deep dive into Medicine Business Unit and production of financial recovery plan. Finance workstream delivery oversight groups which includes back to basics and enhanced financial controls including: Team including minimising discretionary spend, criteria for the approval of waiting lists 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. Coding & Counting review and elective care transformation programme.

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 13i

Report Title:	**Nursing Staffing Exception Report**			
Name of Meeting:	Board of Governors			
Date of Meeting:	29 November 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:	Gillian Findley, Chief Nurse and Professional Lead for Midwifery and AHP's			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☒
	This report is to provide assurance to the Board that staffing establishments are being monitored on a shift-to-shift basis.			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☐ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by:				
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 October 2023. October has demonstrated some staffing challenges relating to vacancies and short term sickness absence alongside ward movements to accommodate maintenance across the Trust. Within October we continued to experience periods of increased patient activity with surge pressure resulting in escalation areas. This has impacted on staffing resource and the clinical operating model, which is supportive of maintaining elective recovery. There is continued focused work around the recruitment and retention of staff and managing staff attendance. Wards where staffing fell below 75% of the funded establishment are shown within the paper. Detailed context and actions taken to mitigate risk are documented. A staffing escalation protocol is now in operation across all areas within the organisation and assurance of this operating as expected, is provided by the number of			

<table>
<tr><td></td><td colspan="5">staffing incident reports raised through the incident reporting system.</td></tr>
<tr><td>Recommended actions for this meeting:</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 12 staffing incidences raised via datix throughout the trust during the month of October 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
October 2023

1. Introduction

This report details the staffing exceptions for Gateshead Health NHS Foundation Trust during the month of October 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 October are presented in Table 1. Whole Trust wards staffing are presented within this report in appendix 1, broken down into each ward areas staffing. In addition, the Trust submit monthly care hours per patient day (CHPPD) as a national requirement to NHS Digital.

Table 1: Whole Trust wards staffing October 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 (%)**
96.1%	128.2%	101.1%	105.0%

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 23 currently have 3.11 wte Registered nurse combined with elevated levels of sickness absence throughout October. There were 3 red flags raised to highlight concerns over safe staffing, with only one documented within the on call resilience bulletin. Ward 25 currently have 2.92 wte RN vacancies and a surplus of 3.15 Healthcare Support Worker posts, however they have experienced high levels of sickness absence within the workforce group for October. There were two red flags raised by the ward area, one of which was in relation to a shortfall in Healthcare support workers, and this was escalated to the senior team and a staffing plan was implemented.

The exceptions to report for October are as below:

October 2023	
Registered Nurse Days	**%**
Ward 23	74.6%
Registered Nurse Nights	**%**
N/a	
Healthcare Support Worker Days	**%**
N/a	
Healthcare Support Worker Nights	**%**
Ward 25	70.1%

In October, the Trust worked to the agreed clinical operational model, which meant at times some wards listed above had lower patient occupancy and staff were redeployed appropriately to areas with the greatest clinical need. Throughout October, areas of deficit were escalated as per staffing policy and mitigations were put in place by the Matron teams using professional judgement as to the acuity and demand in each area, which included:

- Redeployments of Registered Nurses and HealthCare assistants on a daily and at times hourly basis between wards according to patient acuity and demand.
- Concentrated support from the Matrons and the People and Organisational Development team to address the sickness absence levels within the divisions and to recruit to vacant posts.

3. Care Hours Per Patient Day (CHPPD)

Following the Lord Carter Cole report, it was recommended that all trusts start to report on CHPPD this is to provide a single consistent way of recording and reporting deployment of staff working on inpatient wards/units. It is calculated by adding the hours of registered nurses to the hours of support workers and dividing the total by every 24 hours of inpatient admissions. CHPPD is relatively stable month on month, but they can show variation due to a number of factors including:

- Patient acuity and dependency
- Patients required enhanced care and support
- Bed occupancy (activity)

Ward level CHPPD is outlined in Appendix 1. For the month of October, the Trust total CHPPD was 8.6. This compares 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 12 staffing incidents raised via the incident reporting system. From these incidences, none of which related to the two areas highlighted in the staffing exception report.

5. Nursing Red Flags

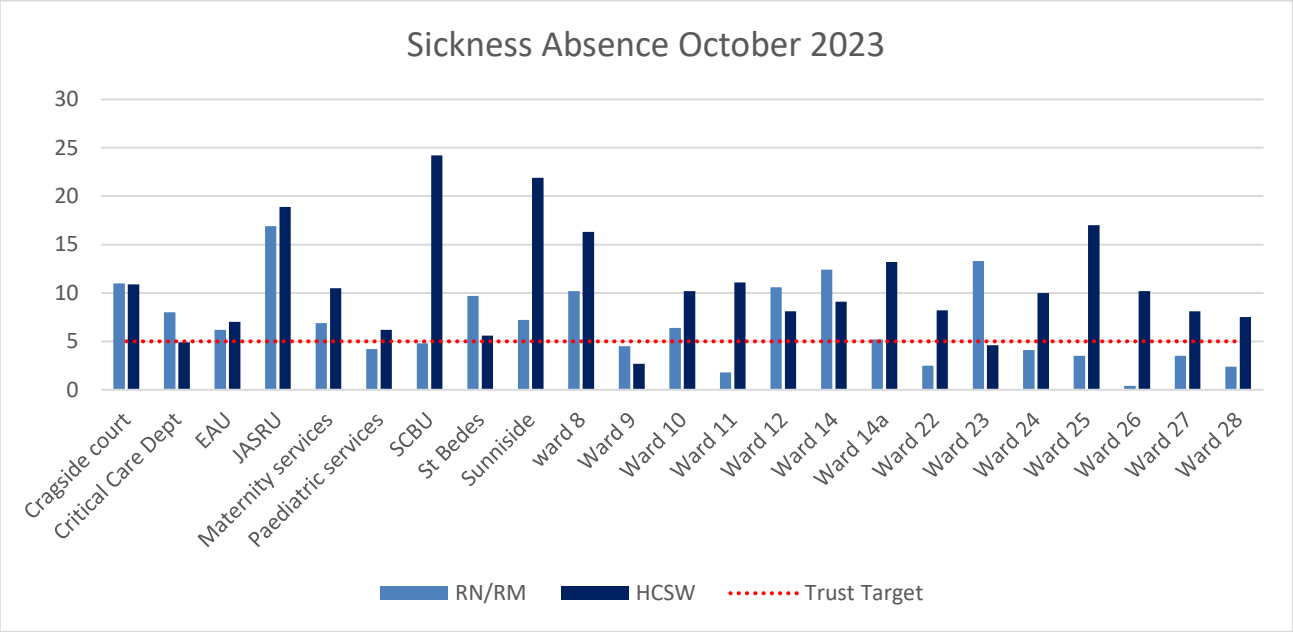
The National Institute for Health and Care Excellence (NICE) guideline for Safe Staffing for nursing in adult inpatient wards in acute hospitals (2014) recommend the use of nursing Red Flag reporting. A Nursing red flag can be raised directly as a result of rostering practice/shortfall in staffing or 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 October there were 23 nursing red flags reported. Of those 23 Red flags, there were 5 raised in areas highlighted in this paper that planned staffing levels fell below 75%.

Date	Shift type	Ward	Flag Type	Narrative
05/10/2023	Night	Ward 23	Shortfall in RN time	No details provided
05/10/2023 13:14 pm	Day	Ward 23	Shortfall in RN time	staffing deteriorates for late shift
05/10/2023 13:08 pm	Day	Ward 25	Shortfall in RN time	escalation beds open, working 1:12 ratio
08/10/2023	Day	Ward 23	Less than 2 RNs on shift	x3 WTE qualified vacancies. x2 LT qualified sickness. Unable to produce a safe effective roster due to this. Shifts out to both bank and agency.
14/10/2023	Night	Ward 25	Missed 'intentional rounding'	Currently on 3 Q and 1 HCA on nights- plan to support from ward 3 Qualified.

Of the above recorded red flags, only two were 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 October. 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 October 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 October 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	84.8%	99.5%	101.8%	107.4%	289	6.4	6.9	13.3
Critical Care Dept	79.9%	144.8%	84.5%	79.1%	194	36.1	8.6	44.8
Emergency Care Centre - EAU	95.4%	132.9%	78.1%	126.9%	1404	6.1	4.5	10.7
JASRU	81.4%	94.5%	100.7%	139.2%	611	3.1	4.6	7.7
Maternity Unit	110.2%	123.1%	108.8%	96.0%	632	13.9	4.8	18.7
Paediatrics	133.8%	85.9%	107.1%		71	36.1	6.9	43.0
Special Care Baby Unit	100.4%	116.8%	110.1%	90.5%	231	8.2	2.7	10.9
St. Bedes	87.4%	107.2%	102.8%	99.4%	272	5.4	4.6	10.0
Sunniside Unit	81.2%	149.2%	106.6%	98.9%	314	4.9	4.2	9.1
Ward 08	105.1%	138.4%	121.2%	100.8%	632	3.8	3.6	7.4
Ward 09	104.5%	145.2%	107.4%	100.2%	761	3.0	3.1	6.1
Ward 10	104.7%	130.7%	104.6%	113.2%	672	3.4	3.4	6.8

	Day		Night		Care Hours Per Patient Per Day (CHPPD)			
Ward	**Average fill rate - nurses/midwives (%)**	**Average fill rate - care staff (%)**	**Average fill rate - nurses/midwives (%)**	**Average fill rate - care staff (%)**	**Cumulative patient count over the month**	**Registered midwives / nurses**	**Care Staff**	**Overall**
Ward 11	106.7%	136.1%	108.4%	133.5%	867	2.7	3.3	5.9
Ward 12	76.1%	120.0%	100.9%	102.1%	717	2.5	3.3	5.9
Ward 14 Medicine	114.8%	119.7%	111.6%	115.1%	729	3.4	3.1	6.5
Ward 14A Trauma	108.9%	139.7%	109.6%	100.0%	750	3.3	3.9	7.1
Ward 22	79.6%	139.8%	109.9%	90.8%	909	2.3	3.7	6.0
Ward 23	74.6%	157.2%	105.2%	96.3%	715	2.3	4.4	6.7
Ward 24	93.9%	111.3%	111.6%	93.7%	903	2.6	3.3	5.8
Ward 25	112.3%	134.7%	143.2%	70.1%	950	3.0	3.2	6.2
Ward 26	89.8%	130.8%	140.1%	118.8%	825	3.1	3.7	6.7
Ward 27	101.4%	150.3%	131.3%	117.5%	838	3.2	4.0	7.2
Ward 28	82.8%	124.6%	101.4%	84.7%	232	6.1	5.8	12.0
QUEEN ELIZABETH HOSPITAL - RR7EN	**96.1%**	**128.2%**	**101.1%**	**105.0%**	**14518**	4.6	3.9	8.6

Gateshead Health
NHS Foundation Trust

Safe Staffing – Bi Annual

Inpatient Safer Nursing Care Staffing Report

October 2023

Nursing, Midwifery & Quality
Published: October 2023
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Introduction

The need to recruit and retain a suitable health workforce has been described as the greatest challenge currently facing the NHS. Care Quality Commission's State of Care report for 2018/19 stated that workforce problems are having a direct impact on care. Having the right number of nurses, with the right mix of skills and experience is essential if organisations are to provide safe, high-quality care for patients.

The purpose of this paper is to provide the board with continual assurance that the nursing workforce at Gateshead Health is safe, competent, and compliant with National Institute for Clinical Excellence (NICE), National Quality Board (NQB) and NHSI Safer Staffing guidelines and standards at a time when nationally nursing is facing the greatest recruitment and retention challenges.

This paper provides an overview of the Safer Nursing Staffing review undertaken in July 2023. Key observations, mitigations, and where appropriate establishment recommendations are also highlighted.

National context

Nursing continues to face significant challenges with recruiting and retaining nurses, with a reported 43,000 vacant nursing posts in England in August 2023 and a significant increase in nurses leaving the NHS, with two thirds of these being under the age of 45.

Ensuring that we continue to have the right number of nurses, with the right mix of skills and experience is essential. This is increasingly important with the changing needs of patients, and treatment advances meaning that those admitted to hospital tend to have more complex care needs than in the past.
The Government has also made several pledges relating to the nursing workforce, including an additional 50,000 nurses in the NHS by 2024/2025, introducing a nursing grant and devising a fast-track visa for NHS workers including nurses. The NHS continues to look outside the European Union to try and replace the number of European nurses who left due to Brexit. International recruitment has been made increasingly difficult since the pandemic, which is delaying recruitment pipelines.

Analysis of Gateshead Health Safer Staffing Nursing Review July 2023

As recommended by NHSI (2018), Gateshead Health uses a triangulated approach when reviewing the nursing workforce (refer to Figure 1 below). This includes using evidence-based tools where available including Safer Nursing Care tool (SNCT) Care Hours per Patient Day (CHPPD) together with quality and safety metrics linked to nursing care. Together with professional judgment these measures support nurse leaders to make staffing decisions to ensure that Gateshead Health continues to deliver safe, high-quality care based on patients' acuity and dependency. This bi-annual approach supports workforce planning and ensures effective utilisation of staff to ensure we continue to have the right person in the right place with the right skills.

Throughout July-September 2023, the safer staffing review process has been led by the Deputy Chief Nurse alongside the Safe Staffing Nurse Lead and senior representatives from workforce and finance who met with every Ward Manager, Matron, Chief Matron, Service Line Manage of inpatient, and Emergency Department. The Mental Health in-patient services will be reviewed as a separate paper.

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Figure 1. Triangulated approach used to ensure safe staffing.

Evidence based tools

Safer Nursing Care tool (SNCT) – All inpatient wards use the SNCT to record patient acuity and dependency, The tool is easy to use by frontline nursing staff but must be applied correctly and consistently for data to be valid, and to allow benchmarking against agreed standards. It should be combined with nurses' professional judgement and account for local factors.

Mental Health Optimal Staffing Tool (MHOST) – In 2022, Gateshead health used the MHOST tool for the first time to review acuity and dependency across our inpatient mental health services. Like SNCT, the development of the MHOST was commissioned and funded by Health Education England (HEE). The tool is based on five acuity and dependency levels for each mental health inpatient specialty. Each acuity and dependency level has an associated descriptor to enable clinical staff to score patients receiving care in their ward.

The MHOST embraces all the principles that should be considered when evaluating/implementing decision support tools described in 'Safe, sustainable, and productive staffing: An improvement resource for mental health (NHSI, 2018)

- How acuity and dependency are measured in mental health settings
- How to ensure that accurate data can be collected.
- What quality metrics should be allied to acuity and dependency measurement to enhance staffing decision making
- How to use staffing multipliers to support professional judgement in reviewing and setting clinical workforce establishments

To note both SNCT and MHOST as designed to record acuity and dependency for inpatient units with a bed base greater than 16 beds. Therefore, further consideration for professional judgement is required for units with a smaller inpatient bed base.

Emergency Department Safe Nursing Care Tool (EDSNCT) - The Emergency Department Safer Nursing Care Tool (EDSNCT) calculates nurse staffing requirements for emergency departments based on patients' needs acuity and dependency. Together with professional judgement, the tool looks at numbers and the acuity of patients at a specific point in the day for a 24-hour period covering the whole day. Gateshead health introduced the tool in 2022. There has been more than two data collections completed, allowing us to review the data and make recommendations.

SNCT Audit – The SNCT audit is required to be presented Bi – annually to board. The report presented in May can be found here

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Gateshead Health - SNCT report May 202

Care Hours per Patient Day (CHPPD)
CHPPD is a recognised standard of measurement for calculating staffing requirement on inpatient wards. It does not reflect patient acuity, staff skills or size of the ward. The Trust CHPPD (target range 10-12) remains at 9.0 in July 2023 compared with 8.2 in July 2022. Although reduced Gateshead health benchmarks well with other regional trusts with NCL (8.5) CDDFT (7.9) and NUH (7.1).

Monthly Fill Rates
Each month the Senior leadership team and Board are presented with The Nursing Staffing Exception report. This report highlights the monthly fill rates broken down by ward area in line with Safer staffing. Overall fill varies depending on vacancies, gaps in rosters and number of patients. Between September 2022 and September 2023 Gateshead health has averaged 88.7% fill rate for registered nursing and 127% fill rate for care staff. The increased fill rate for care staff is largely attributable to the over recruitment which is noted to support with additional enhanced care needs along with the inclusive capture of support staff as per national guidance. This is comparable to regional trusts who also see a similar ratio of fill rate for registered nurses vs health care assistants.

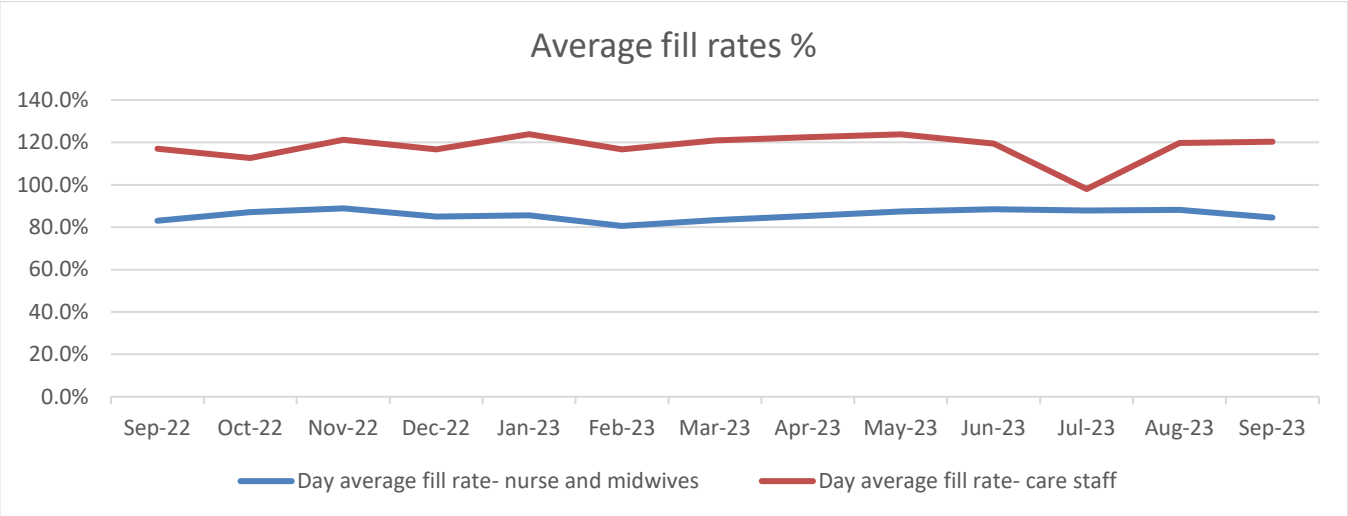

Figure 2: monthly fill rate

Red Flags
Red flags are raised using the safer staffing tool, these are used by staff when staffing levels have been identified as impacting safety on the ward either by reduced staff numbers, skill shortfall or delay to care. Between July and September 2023 the main key themes recorded are:

- Shortfall in Registered Nurse time (23)
- Missed 'intentional' rounding (7)
- Less than 2 Registered Nurses on shift (7)

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It is important to note that whilst red flag reporting has implemented, it needs further work with the ward teams to empower usage, low reporting is likely linked to staff being too busy to raise a red flag. Matrons will now be working with areas to support red flag reporting to ensure accurate documentation.

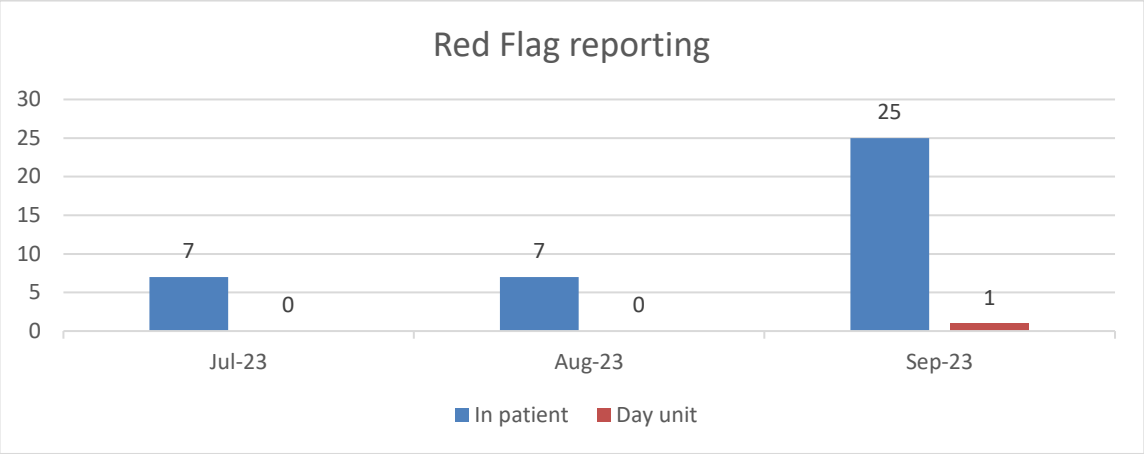

Figure 3: Red Flags

Right staff

Recruitment and retention

Recruitment and retention remain a key priority for Gateshead Health, with a current vacancy rate of 4.7% for nursing against the Trust target of 8%; the lowest vacancy rate the Trust has seen over past 12 months. Rolling recruitment campaigns continue to focus on attracting newly qualified nurses alongside specialist areas such as Critical Care unit (CCU) and Paediatrics. The recruitment and retention group are working with the marketing team to review and refresh the nurse recruitment and looking at how it uses social media in a more targeted way.

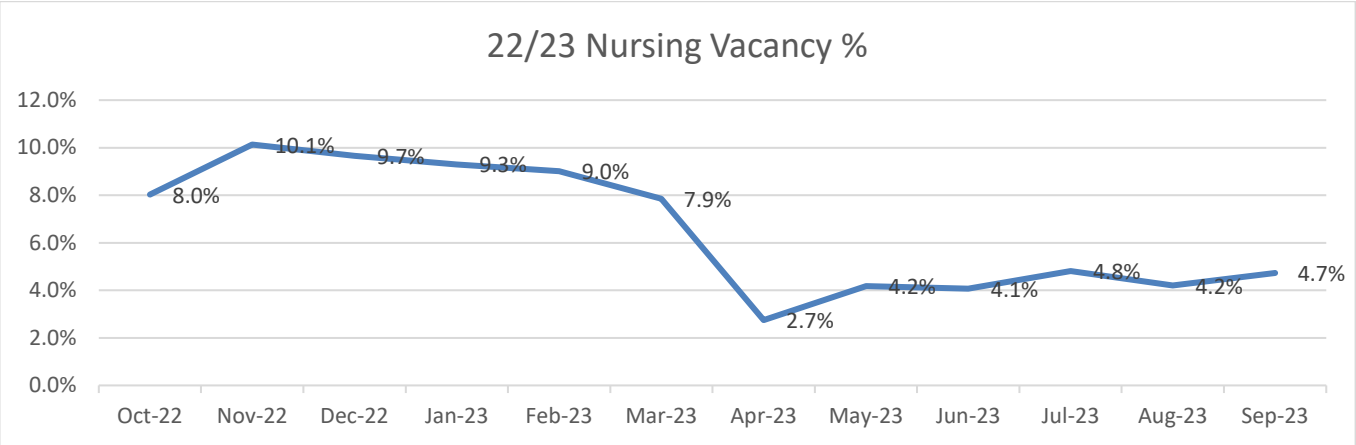

Figure 4: Trust nursing vacancy rate%

International recruitment

Gateshead continues to proactively recruit internationally with 65 nursing recruits having passed their Objective Structured Clinical Examination (OSCE) since January 2022. A further 40 are currently working through the OSCE at present which will take us to capacity within the international recruitment process. Through the international recruitment process we have been able to recruit some experienced nurses with a variation of skills and knowledge, over coming months following consolidation we will working with our

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Practice Development team to commence career progression discussions to support further recognition of their skills and experience.

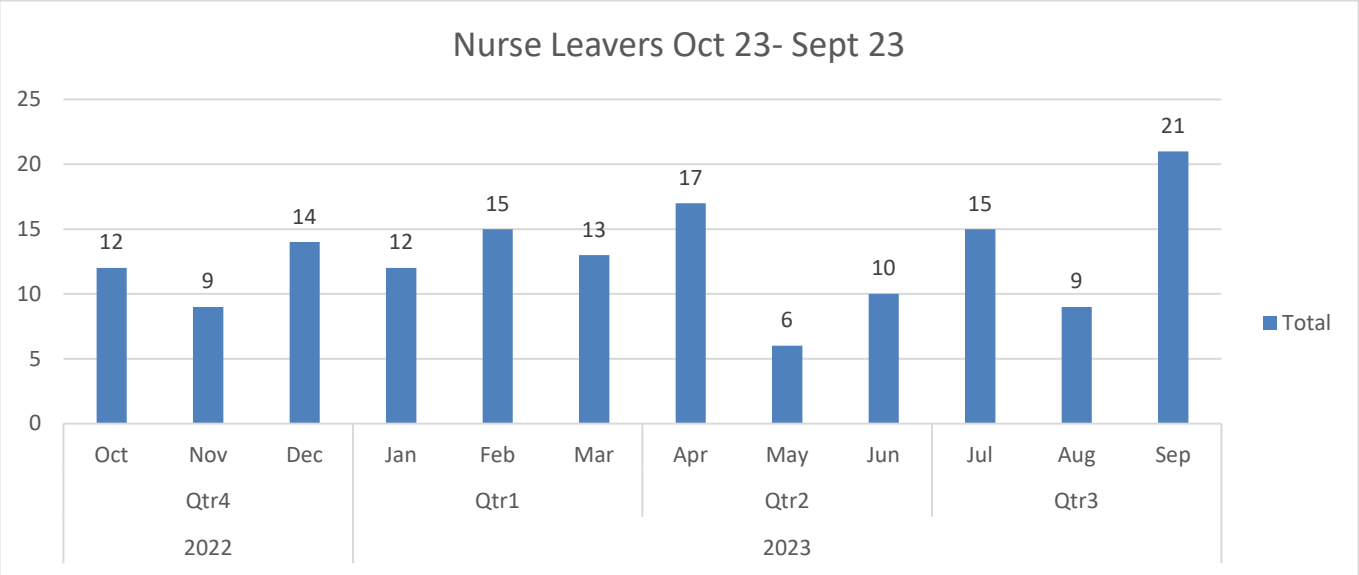
Gateshead Health has also agreed to be part of cohort 6 supporting NHS England's Refugee programme, with 5 places for nurses who require refuge in the UK due to arrive in January. Once recruited they will be working clinically on the wards as healthcare support workers (HCSW) with planned study days to support them with English language preparation to enable them to take the Occupational English Language test (OET). Prior to then commencing on the OSCE.

Despite the success of this pipeline to date, it is important to note that it has become increasingly challenging to recruit internationally educated nurses as the UK demand outweighs the supply. Consideration of sustainable domestic pipelines, including growing our own Nursing Degree Apprenticeships will be key.

Nursing Turnover

Regionally, Gateshead has been highlighted as having one of the highest nursing turnover rates including those leaving the NHS, with this at 10.4% for September 2023, however this has reduced since the previous staffing review (13.7% in January 2023). There were 153 nurse leavers from October 2022 to September 2023, which equates to 12% of registered nursing workforce (total RNs = 1266 WTE).

A deep dive into registered nurses leaving the trust showed that 17% (n= 28) of all leavers retired from the health services. 5% (n = 10) left the NHS to work in the private sector. 18% (n = 32) relocated outside of the north east and Yorkshire ICB and 16% (N = 27) left to do a promotion or development opportunity. Band 5 remains the highest band to leave the trust during this period.



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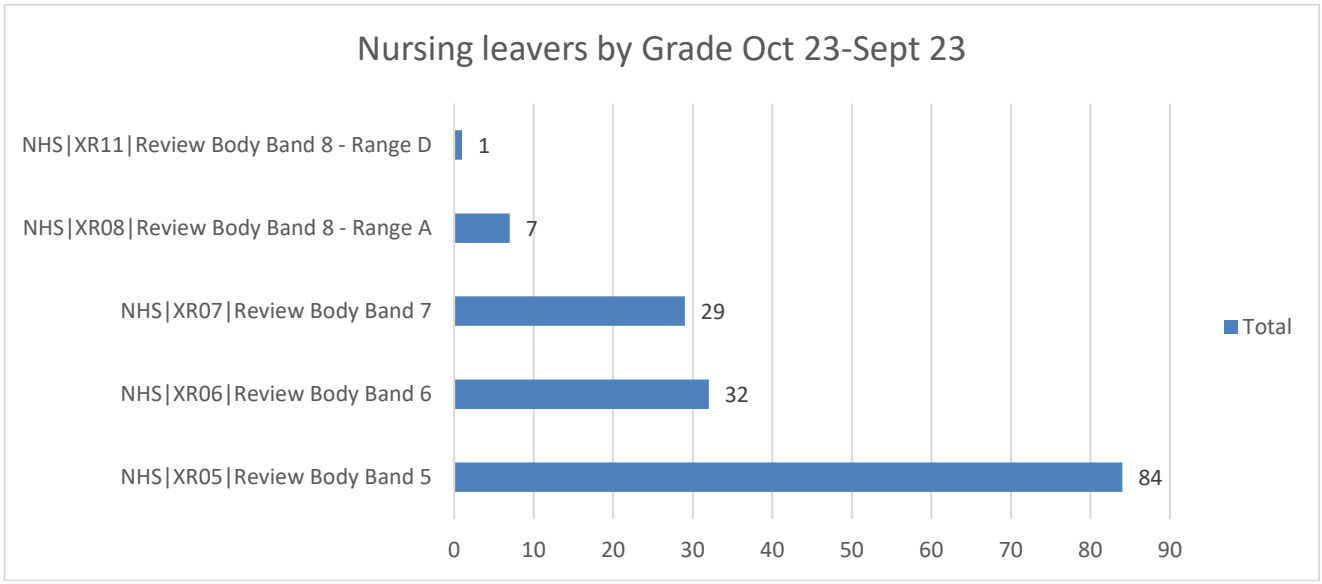

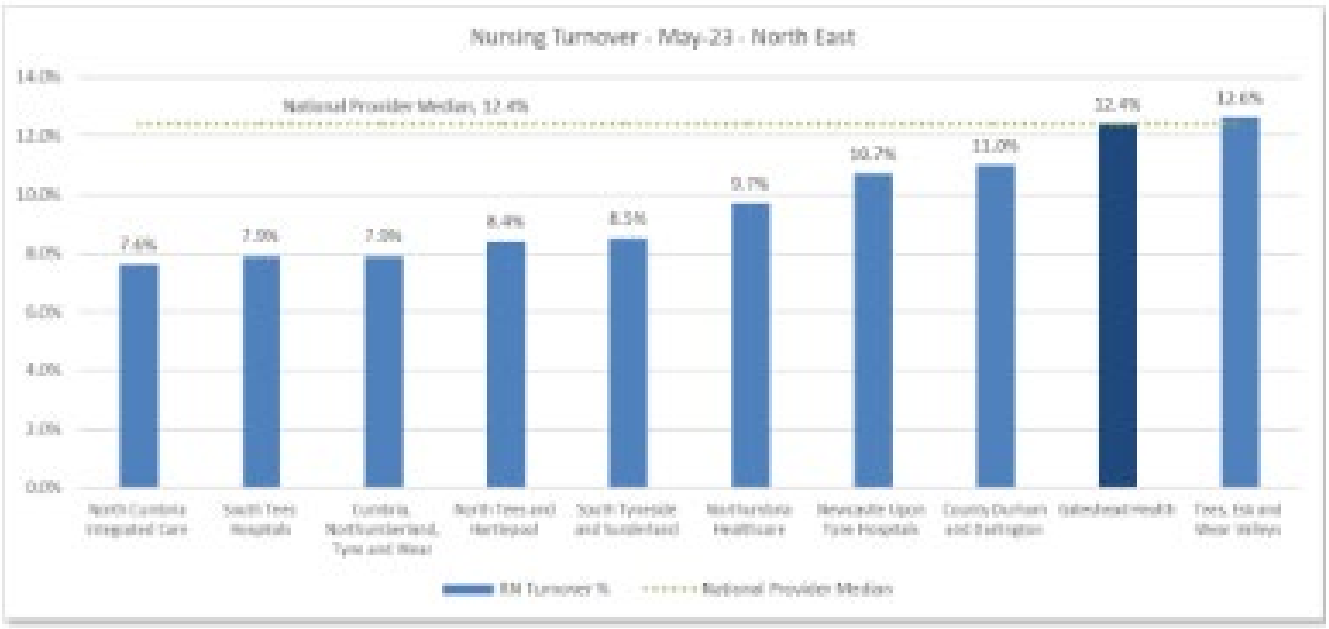

Figure 5,6,7: Regional Turnover position and trust Nurse leaver

NHSE in collaboration with Gateshead Health are due to commence a review of our workforce reporting structures and services.

Unavailability – sickness/staff absence

Sickness levels within nursing remain high and above the NHS target of 5% however, throughout the year there has been an overall decrease in % absence, averaging at 7.07% combined in July. Work continues with POD to review sickness and absence reasons and work with staff to support them to return to work safely.

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Unavailability - Annual leave
Annual leave remains to be monitored monthly by the Matron team, Ward managers have worked hard trying to facilitate 12% of leave for the workforce per quarter while balancing vacancies and ensuring safe staffing levels on the wards to ensure that staff will be able to attend training and be available to be clinical shifts.

Right skills

Core Skills (CS): across the workforce CS is compliant at 86.53% in September 2023. Business units are working together with ward teams to facilitate time for staff to complete all core skills training.
With several new recruits and nurses there are shifts with the right staff numbers; however, may be missing key nursing skills. Where these occur, the senior nursing team are supporting clinical areas and staff may be redeployed to ensure care is not compromised. All new starters are being supported by ward teams and practice educators to obtain key skills applicable to their clinical area and care of the deteriorating patient.

Leadership: There have been several appointments into ward manager and matron leadership roles within the organisation, through both internal promotion and external appointments. Currently at Gateshead health ward leaders are not budgeted for allocated management time or clinical supervisory time to support ward staff. In line with national guidance, throughout December – February 2023, wards 25 and 26 have been trialling a period of 100% supervisory time for ward mangers to facilitate time to improve ward metrics, ensure Mandatory training compliance is monitored and provide clinical supervisory support for the ward team and patients.
This trial has been successful in seeing a marked improvement in ward metrics as well as seeing improved staff rostering compliance and a reduction in bank and agency spend during this period. The Matrons are due to present the outcome of the trial to the trust's senior management time.


Supervisory B7
Presentation April 2

Healthcare support workers (HCSW): National guidance around the differentiation between band 2 and 3 HCSW and skills requires Gateshead Health to review this role and each clinical area requirement, which may require re-banding of some posts in the coming months. This work is underway. In 2022 due to increased registered nursing vacancies the trust approved over recruitment into HCSW posts to backfill support to clinical areas currently we remain with an overall increased number of HCSW across the trust with 68.8 WTE above funded establishments across the trust. As the nursing vacancy position has improved, work is underway to review placement of each of the over established HCSW to ensure pipeline recruitment is levelled off across the trust. It is also important to note that the internationally educated nurses are aligned to the HCSW establishments during the training phase and will move into the registered nursing establishment when their registration is achieved. Gateshead Health are currently awaiting a revised Job description for the band 3 HCSW, prior to job evaluation panel in November 2023.

Right place, right time

Redeployment: Staffing is reviewed daily by the senior nursing team and staff are redeployed to the areas of greatest need whilst maintaining patient safety throughout the Trust. Providing oversight and supporting the decision-making process is the use of safe care, which provides a live update of staffing and acuity levels on the ward. Staff continue to be flexible and supportive of being redeployed; however, this has led to increase in anxiety and concerns over the frequency it can occur especially on nights.

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Notably, redeployment from staff from EAU, Critical Care and theatres has been particularly challenging for staff in those areas, both of which are specialist areas being moved to support surgical and medical wards.

Shift status- Fill %: A RAG rating system is being introduced to assist with the redeployment of staff throughout both inpatients and day areas. The RAG rating is:

- Green: Rostered staff hours are greater than or up to 5% less than required hours. Skills on shift meet the needs of the current patient mix.
- Amber: Rostered staff hours 5-15% shortfall from required hours and/or missing key skills
- Red: Rostered staff hours are 15% or less than required for the current requirements and/or missing key skills.

Headroom
Gateshead Health headroom is currently calculated at 21%, which is broken down by annual leave 12%, Study leave & training 5% and Sickness absence 4%. This is less than the national recommended headroom of 22%. It is recognised that some clinical areas will have a requirement for additional training and study leave which is not factored into budgeted establishments. Areas such as Critical Care, Emergency Department and theatres have additional training needs along with national training requirements before being competent to complete the role independently.

Bank/agency use: There continues to be an ongoing reliance on bank and an ongoing need for nurses via agencies over the past 6 months; including the need to cover shifts using high-cost agencies. The use of enhanced care (1:1s) continues to rise. Gateshead has managed to secure some agency nurses working lines of work and has been able to be upskill them, which allows them to support day units and administration of intravenous medications; however, it has been challenging to incentivise the agency nurses to join the nurse bank pool due to the inability to meet the current benefits they receive via the agency. The Senior management team has commissioned an Agency review group that is looking at overall agency spend and rationalisation across all staff groups. The Deputy Chief Nurse and the Workforce lead are working with Pulse to scope out a master vendor relationship to eradicate the need to use high cost off framework agencies and improve patient safety.

Whilst increasing numbers of Gateshead health staff are working bank, on many occasions this has used enhanced rates. Furthermore, it has been increasingly challenging to fill HCA shifts on day shifts in week using bank, in part thought to be attributable to the rising cost of living, incentivising HCAs to opt for unsocial hours.

Though November 2022 – April 2023, the Trust approved an enhanced payment rate for registered nurses working bank shifts at time + 70%. This was monitored and saw an initial improvement in the uptake of bank shifts, resulting in a reduction in agency spend but as months progressed this initial uptake reduced. This incentive was stopped in April 2023 with little impact on uptake of bank shifts noted.

Gateshead health spent £3,344,325 on temporary staffing expenditure between Sept 22 and Aug 2023, with £1,946,852k on agency staff (table 1).

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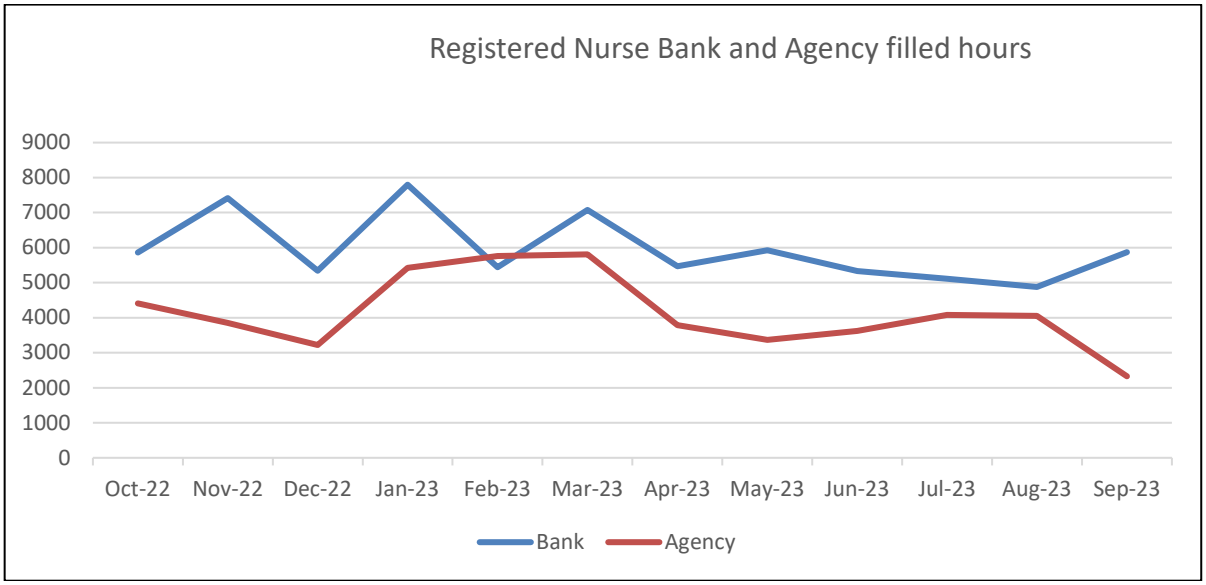

Figure 8 Registered Nurse Bank and Agency Filled hours 22/23

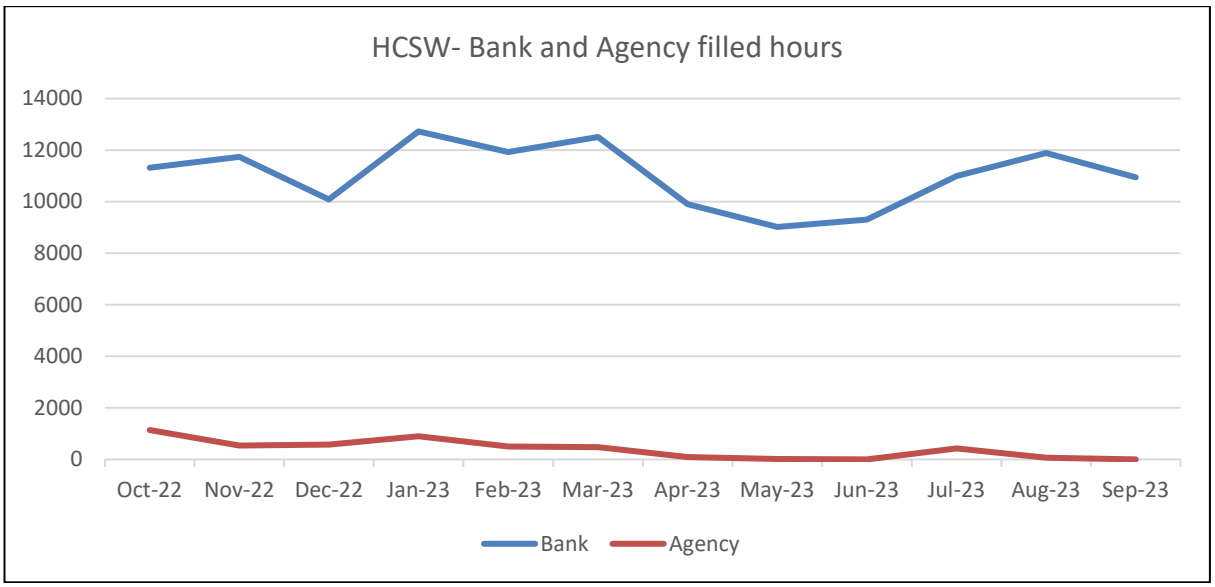

Figure 9 HCSW Bank and Agency filled hours in 2022/23.

Temporary staff	Sept 22 – Dec 22	Jan 23 – April 23	May 23- Aug 23	Grand Total
Agency expenditure £	£1,043,888	£1,038,872	£799,082	£1,946,852
Bank expenditure £	£617,950	£72,828	£706,695	£1,397,473
Grand Total £	**£1,661,838**	**£1,111,700**	**£1,505,777**	**£3,344,325**

Table 1: Temporary staff expenditure

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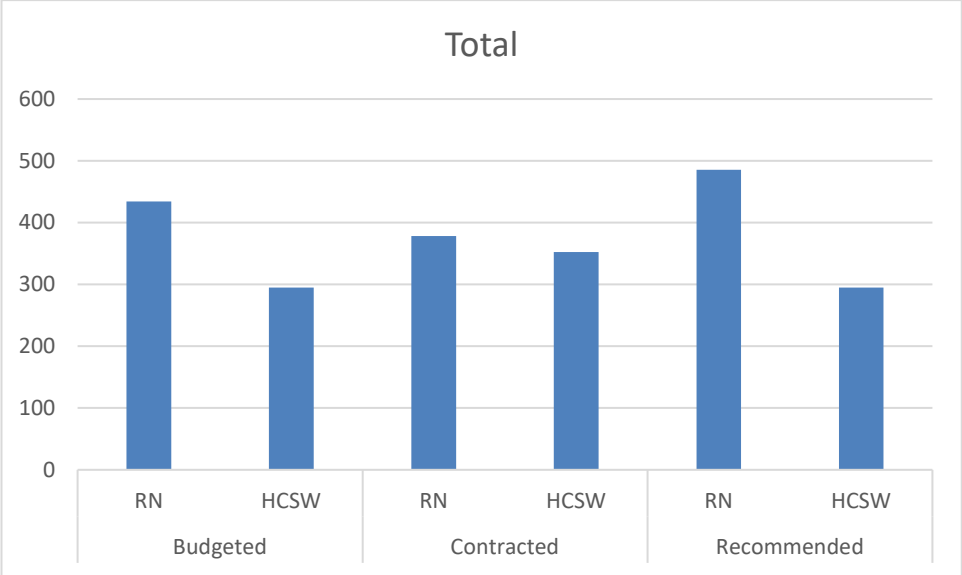
SNCT Staffing Review Results:

RN & HCA funded establishment against actual WTE in post against SNCT recommended WTE (excluding ED)

The financial ledger for 2023/24 month 4 was used to identify both the funded and actual establishments across the audited areas.

The comparison includes a recommended supervisor post 1.0 WTE for each inpatient area and an uplift of RN numbers to comply with safe staffing on a night shift. Current practice in Gateshead Health is to staff ward areas with 2 registered nurses. This is outside of the recommended guidance for 1 registered healthcare per 10 patients at night, therefore the recommended registered nursing numbers includes an uplift in areas to comply with at 1:10 ratio for safe staffing levels at night.



Conclusion:

The Trust continues to closely monitor staffing levels and comply with National recommendations on safer staffing. However, it must be acknowledged that sustained demand and capacity issues presents significant challenges with regards to ensuring safe staffing across all areas. Consideration should be given to the overall global shortage of healthcare workforce and the strategies that Gateshead Health will require to build a sustainable nursing workforce model that provides competent and skilled staff to meet the needs of all our patients. There is no magic bullet for addressing workforce shortages, it requires consistent and concerted effort across all areas of pay, training, retention, and job security.

Recommendations:

- Recommendation to support the uplift of registered nurses to enable safe staffing numbers for night shifts across inpatient ward areas.

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- Recommendation to support the uplift of Registered nurses to support a supervisory 1.0WTE for each clinical areas.

- Recommendation to further review Medicine Service Line 1 to understand safe staffing levels within the Emergency department and EAU to identify shortfall in WTE due to patient activity and acuity and dependency level.

- Recommendation to review 21% allocated headroom as currently not aligned nationally or with Trust Sickness absence target of 5%.

Actions:

- To produce a business case to support the shortfall in WTE across all identified in patient areas, incorporating the additional WTE on nightshift and supervisory role.
- To further review and align with National Guidance on staffing recommendations for ED, EAU, Critical Care Department and Theatres.
- Ongoing monitoring of acuity and occupancy over next 6 months to determine whether establishment modifications are required in line with the current increasing acuity.
- Matrons to support inpatient and day unit areas to raise red flags to ensure these are being accurately recorded.
- Workforce and CN Office and POD to implement retention strategies with a focus on:
    - Nurses leaving within 3 years.
    - Flexible working.
    - Rewards and benefits.
    - Sustainable accommodation and travel.
    - Leadership programmes to support new leaders

References

NHSI: (2018) Developing workforce safeguards.
NQB: (2016) Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time.
The Kings Fund (2022) The NHS nursing workforce – have the flood guards opened.
Shelford Group: (2014) Safer Nursing Care Tool.

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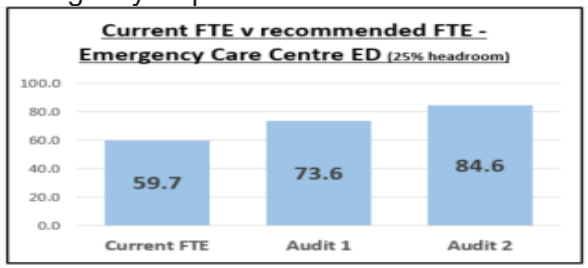
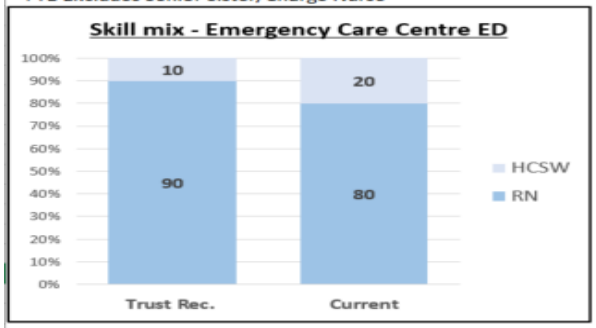
Appendix 1: SNCT Data Analysis:

Medical Service Line 1
Emergency Department



* FTE Excludes Senior Sister/Charge Nurse



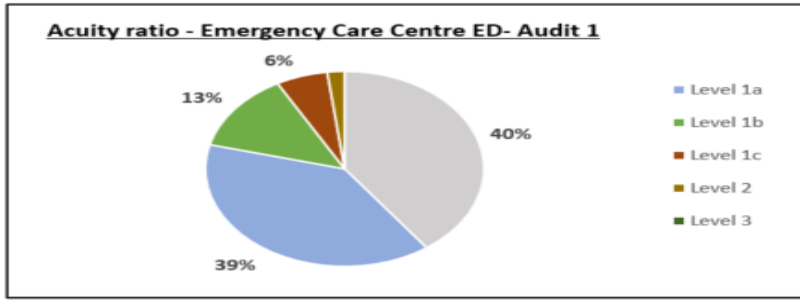
Emergency Care Centre ED SNCT results 2023

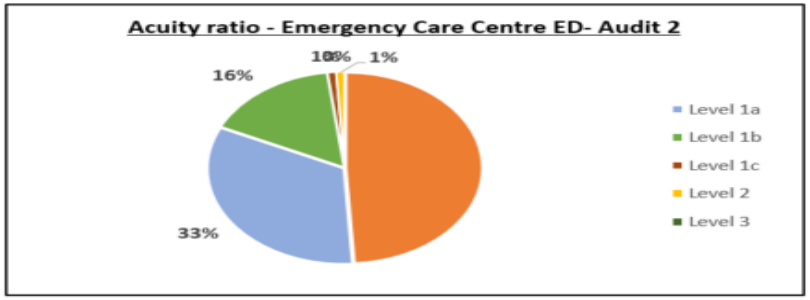
Top Graph on the left:
Demonstrates the comparison between the budgeted staffing, the recommended staffing according to the SNCT in Audit 1 and Audit 2.

Bottom graph on the left:
Compares the current and Trust recommended skill mix required.

Graphs on the Right:
Show the % of each level of care for the patients during the audit identified. Level 0 = Patients requiring hospital admission but can be cared for within normal duties, 1a = acutely ill patients who have the potential to deteriorate, 1b = stable patients with increased nursing support needs i.e. assistance with feeding, toileting, at risk of harm due to confusion/mobility, 2= High dependency patients requiring intensive clinical monitoring due to clinical instability, 3 = Patients needing advanced respiratory support and / or therapeutic support of multiple organs.

Table below:
Shows the data compliance, variance between the current funded establishment and the recommended establishment alongside the patient outcomes, patient experience and staff outcomes.





Nursing & Midwifery Care Quality Indicators

			input staffing	Input - process of care		Outcome - Incidence of harm			Outcome - Patient Experience	Outcome-Staff Experience					
Ward	Division	Audit	data compliance	Hand Hygiene	Observations on time	inpatient falls with harm	Hosp. acquired pressure ulcers	Reportable Medication errors	Friends and family test	Safer Staffing red flags	No. vacancies	% AL used	% sickness	CHPPD	Peer CHPPD
Emergency Care Centre ED	Medicine	Audit 1	100.00%	98.50%	0.00%	10	0	11	93.00%	0		8.30%	1.80%	0	
		Audit 2	100.00%	100.00%	0.00%	6	0	42	80.70%	0	21.56	12.70%	5.00%	0	

The recommended establishment for Emergency Care Centre ED requires further review.

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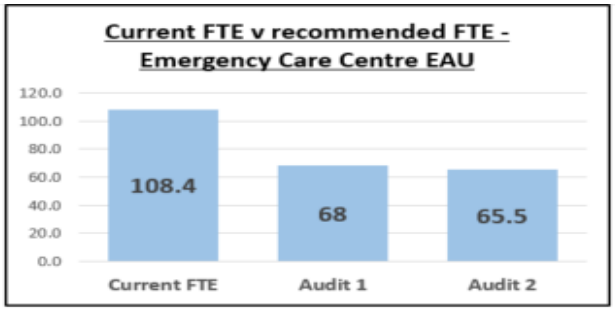
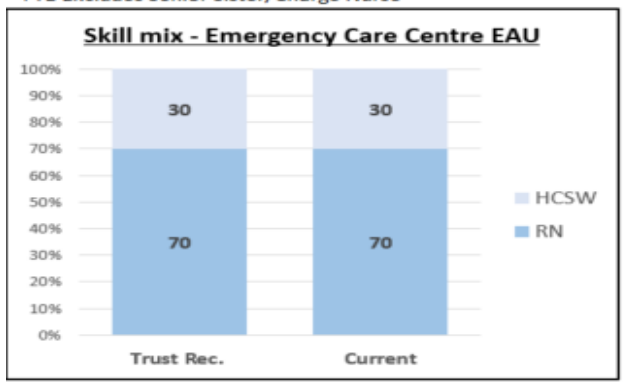
EAU



* FTE Excludes Senior Sister/Charge Nurse



Emergency Care Centre EAU SNCT results 2023

Top Graph on the left:
Demonstrates the comparison between the budgeted staffing, the recommended staffing according to the SNCT in Audit 1 and Audit 2.

Bottom graph on the left:
Compares the current and Trust recommended skill mix required.

Graphs on the Right:
Show the % of each level of care for the patients during the audit identified. Level 0 = Patients requiring hospital admission but can be cared for within normal duties, 1a = acutely ill patients who have the potential to deteriorate, 1b = stable patients with increased nursing support needs i.e. assistance with feeding, toileting, at risk of harm due to confusion/mobility, 2= High dependency patients requiring intensive clinical monitoring due to clinical instability, 3 = Patients needing advanced respiratory support and / or therapeutic support of multiple organs.

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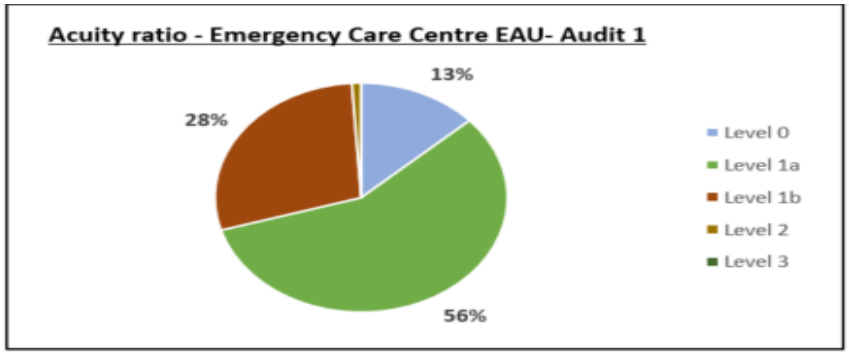

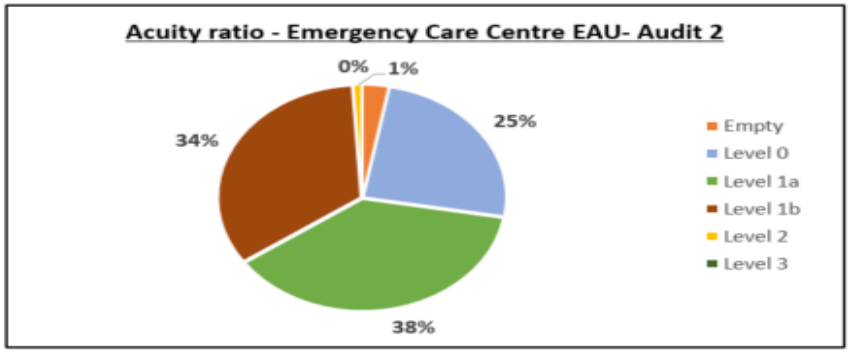

Nursing & Midwifery Care Quality Indicators

			input staffing	Input - process of care		Outcome - Incidence of harm			Outcome - Patient Experience	Outcome-Staff Experience					
Ward	Division	Audit	data compliance	Hand Hygiene	Observations on time	inpatient falls with harm	Hosp. acquired pressure ulcers	Reportable Medication errors	Friends and family test	Safer Staffing red flags	No. vacancies	% AL used	% sickness	CHPPD	Peer CHPPD
Emergency Care Centre EAU	Medicine	Audit 1	100.00%	96.90%	73.40%	22	6	75	83.80%	0		14.50%	5.79%	9.8	
		Audit 2	100.00%	98.60%	77.10%	18	3	89	83.80%	0	-2.63	14.00%	5.52%	10.7	

The recommended establishment for Emergency Care Centre EAU requires further review.

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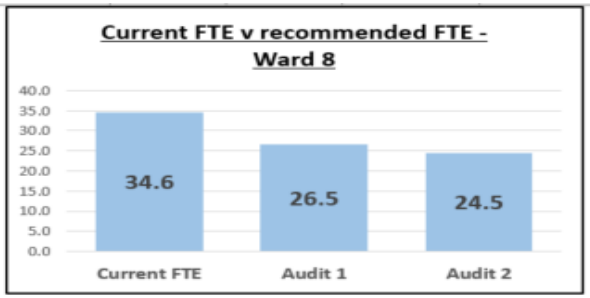
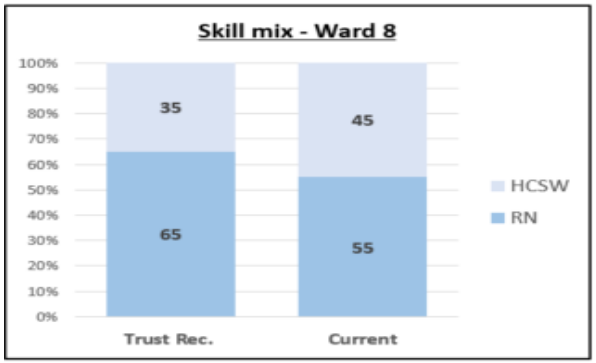
Medicine Service Line 2
Ward 8





Ward 8 SNCT results 2023

Top Graph on the left:
Demonstrates the comparison between the budgeted staffing, the recommended staffing according to the SNCT in Audit 1 and Audit 2.

Bottom graph on the left:
Compares the current and Trust recommended skill mix required.

Graphs on the Right:
Show the % of each level of care for the patients during the audit identified. Level 0 = Patients requiring hospital admission but can be cared for within normal duties, 1a = acutely ill patients who have the potential to deteriorate, 1b = stable patients with increased nursing support needs i.e. assistance with feeding, toileting, at risk of harm due to confusion/mobility, 2= High dependency patients requiring intensive clinical monitoring due to clinical instability, 3 = Patients needing advanced respiratory support and / or therapeutic support of multiple organs.

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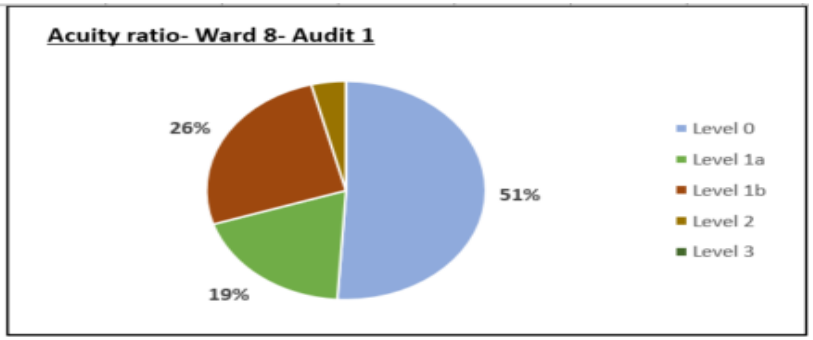

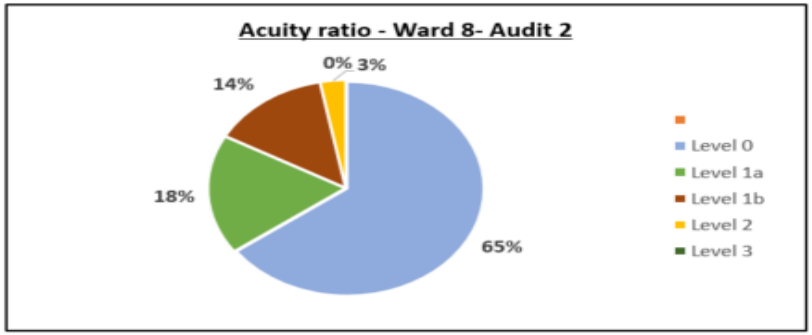

Nursing & Midwifery Care Quality Indicators

			input staffing	Input - process of care		Outcome - Incidence of harm			Outcome - Patient Experience	Outcome-Staff Experience					
Ward	Division	Audit	data compliance	Hand Hygiene	Observations on time	inpatient falls with harm	Hosp. acquired pressure ulcers	Reportable Medication errors	Friends and family test	Safer Staffing red flags	No. vacancies	% AL used	% sickness	CHPPD	Peer CHPPD
Ward 8	Medicine	Audit 1	100.00%	100.00%	74.00%	6	1	5	100.00%	0		10.50%	6.88%	7.4	
		Audit 2	100.00%	98.90%	75.20%	1	2	12	99.70%	0	5.25	13.90%	13.47%	7.6	

There is a service review required before recommended WTE can be identified.

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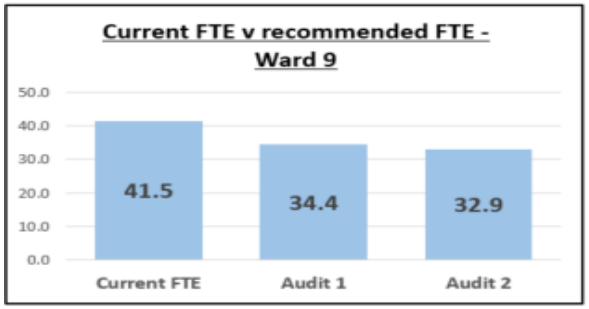
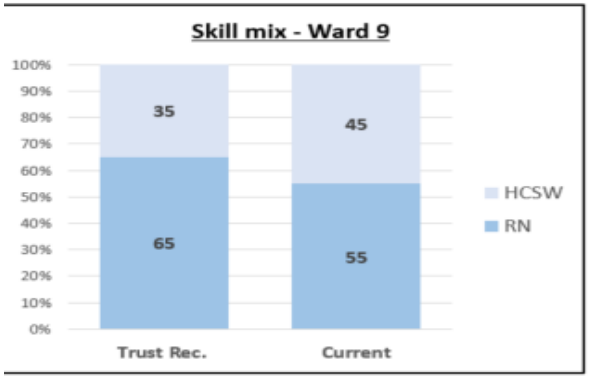
Ward 9





Ward 9 SNCT results 2023

Top Graph on the left:
Demonstrates the comparison between the budgeted staffing, the recommended staffing according to the SNCT in Audit 1 and Audit 2.

Bottom graph on the left:
Compares the current and Trust recommended skill mix required.

Graphs on the Right:
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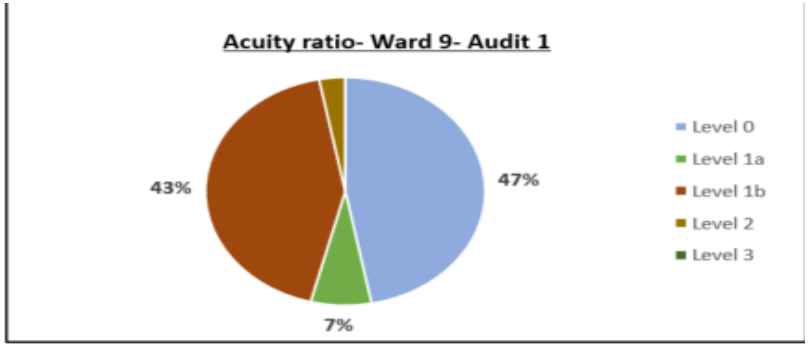

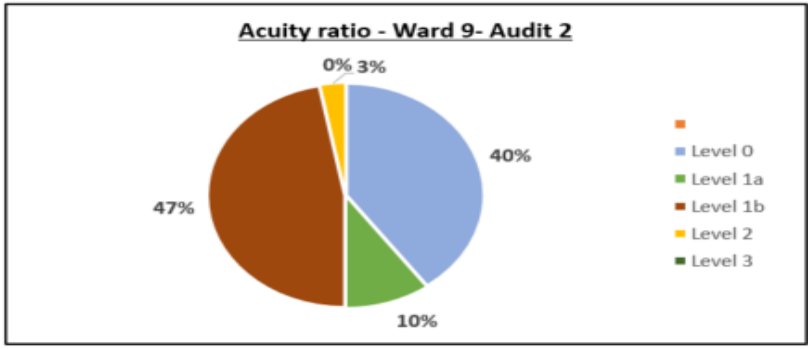

Nursing & Midwifery Care Quality Indicators

			input staffing	Input - process of care		Outcome - Incidence of harm			Outcome - Patient Experience	Outcome-Staff Experience					
Ward	Division	Audit	data compliance	Hand Hygiene	Observations on time	inpatient falls with harm	Hosp. acquired pressure ulcers	Reportable Medication errors	Friends and family test	Safer Staffing red flags	No. vacancies	% AL used	% sickness	CHPPD	Peer CHPPD
Ward 9	Medicine	Audit 1	100.00%	96.60%	89.40%	11	8	14	100.00%	0		8.50%	8.30%	5.7	
		Audit 2	100.00%	100.00%	91.00%	11	14	5	98.90%	0	0.97	9.80%	6.80%	6.1	

The recommended establishment for Ward 9 for next year is 34.04 FTE (NIV service not included).

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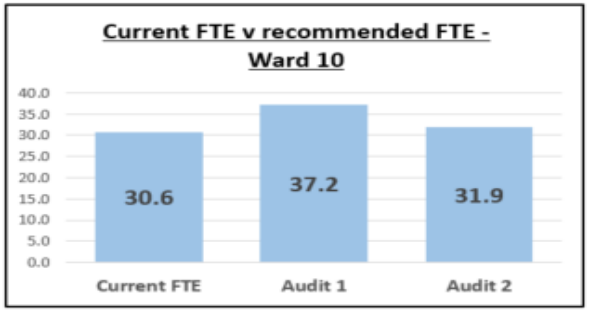
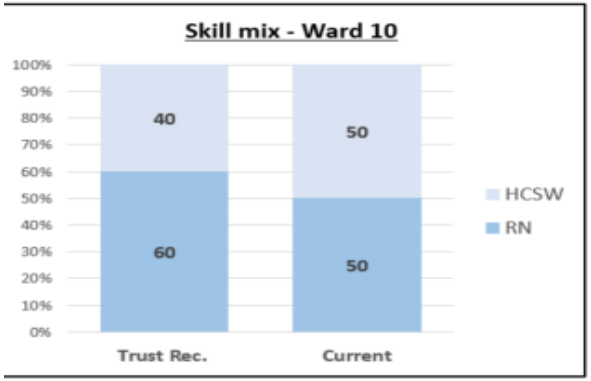
Ward 10





Ward 10 SNCT results 2023

Top Graph on the left:
Demonstrates the comparison between the budgeted staffing, the recommended staffing according to the SNCT in Audit 1 and Audit 2.

Bottom graph on the left:
Compares the current and Trust recommended skill mix required.

Graphs on the Right:
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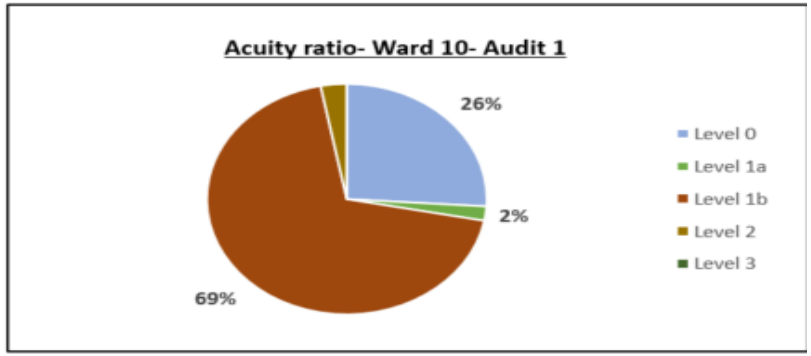

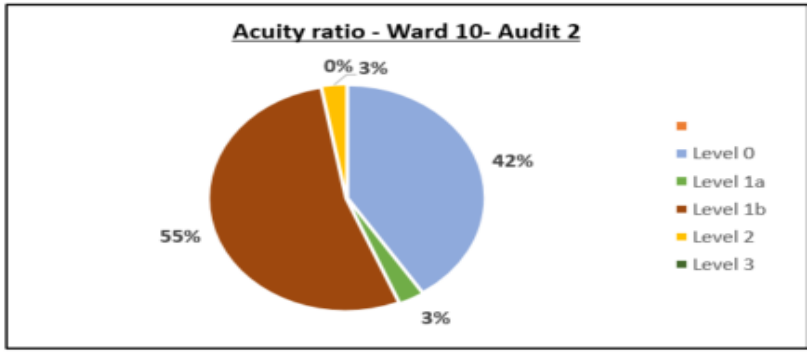

Nursing & Midwifery Care Quality Indicators

			input staffing	Input - process of care		Outcome - Incidence of harm			Outcome - Patient Experience	Outcome-Staff Experience					
Ward	Division	Audit	data compliance	Hand Hygiene	Observations on time	inpatient falls with harm	Hosp. acquired pressure ulcers	Reportable Medication errors	Friends and family test	Safer Staffing red flags	No. vacancies	% AL used	% sickness	CHPPD	Peer CHPPD
Ward 10	Medicine	Audit 1	100.00%	98.10%	86.70%	12	5	7	66.70%	22		11.10%	5.20%	6.2	
		Audit 2	100.00%	97.20%	86.40%	10	3	4	66.70%	4	3.58	13.00%	7.20%	6.9	

The recommended establishment for Ward 10 for next year is 34.07 FTE.

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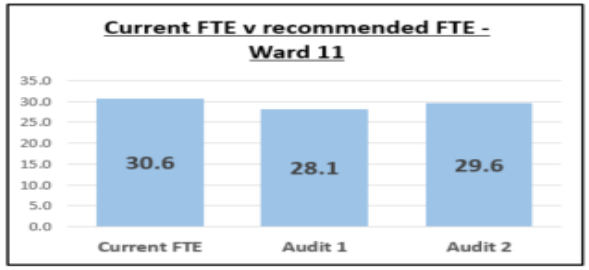
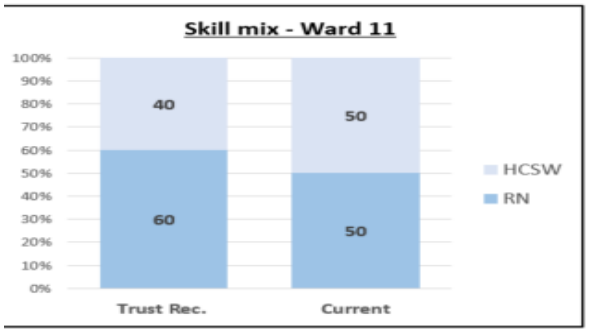
Ward 11





Ward 11 SNCT results 2023

Top Graph on the left:
Demonstrates the comparison between the budgeted staffing, the recommended staffing according to the SNCT in Audit 1 and Audit 2.

Bottom graph on the left:
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Graphs on the Right:
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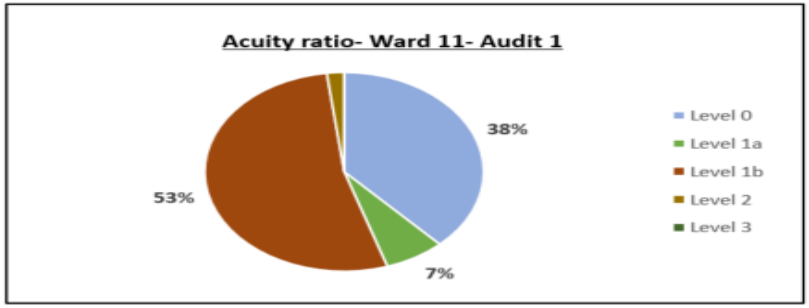

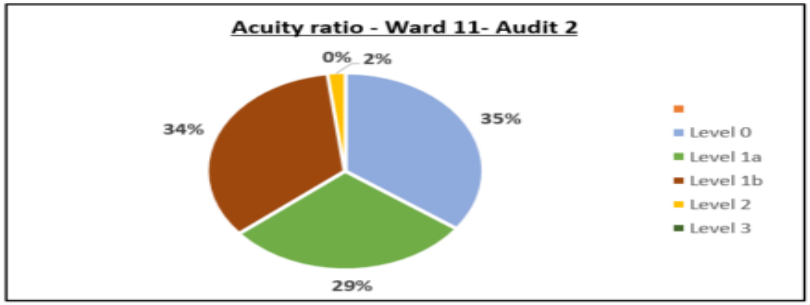

Nursing & Midwifery Care Quality Indicators														
			input staffing	Input - process of care		Outcome - Incidence of harm			Outcome - Patient Experience	Outcome-Staff Experience				
Ward	Division	Audit	data compliance	Hand Hygiene	Observations on time	inpatient falls with harm	Hosp. acquired pressure ulcers	Reportable Medication errors	Friends and family test	Safer Staffing red flags	No. vacancies	% AL used	% sickness	CHPPD	Peer median CHPPD
Ward 11	Medicine	Audit 1	100.00%	100.00%	78.70%	8	2	3	76.90%	0		10.50%	7.40%	8.4	
		Audit 2	100.00%	100.00%	88.90%	2	0	0	72.70%	1	2.02	11.30%	2.80%	11.4	6.68

The recommended establishment for Ward 11 for next year is 39.24 FTE.

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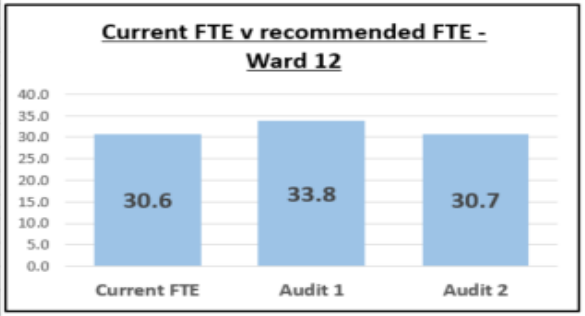
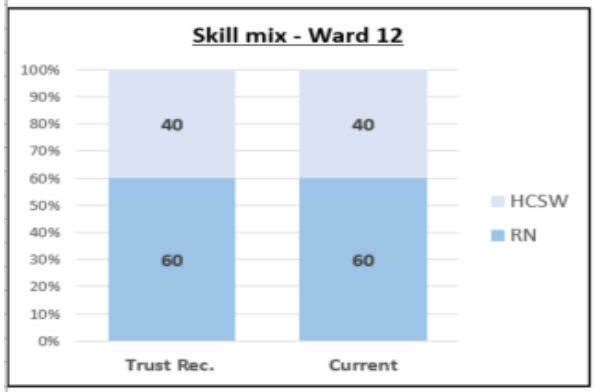
Ward 12





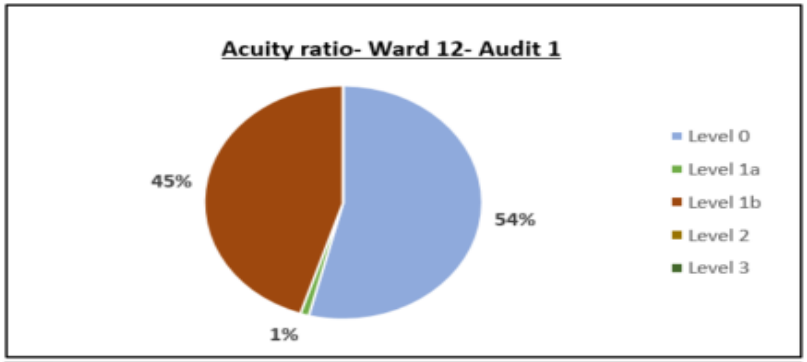
Ward 12 SNCT results 2023

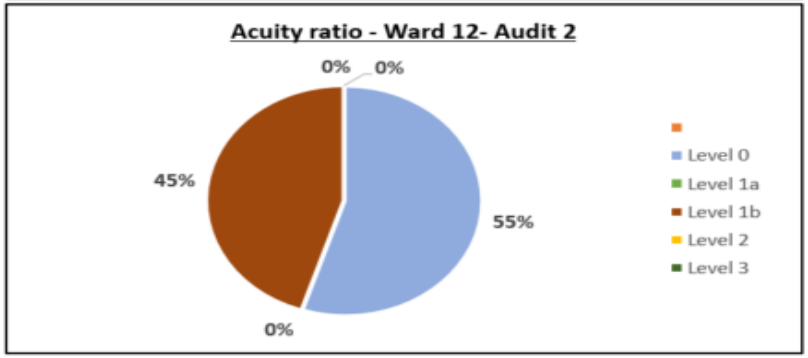
Top Graph on the left:
Demonstrates the comparison between the budgeted staffing, the recommended staffing according to the SNCT in Audit 1 and Audit 2.

Bottom graph on the left:
Compares the current and Trust recommended skill mix required.

Graphs on the Right:
Show the % of each level of care for the patients during the audit identified. Level 0 = Patients requiring hospital admission but can be cared for within normal duties, 1a = acutely ill patients who have the potential to deteriorate, 1b = stable patients with increased nursing support needs i.e. assistance with feeding, toileting, at risk of harm due to confusion/mobility, 2= High dependency patients requiring intensive clinical monitoring due to clinical instability, 3 = Patients needing advanced respiratory support and / or therapeutic support of multiple organs.

Table below:
Shows the data compliance, variance between the current funded establishment and the recommended establishment alongside the patient outcomes, patient experience and staff outcomes.





Nursing & Midwifery Care Quality Indicators

			input staffing	Input - process of care		Outcome - Incidence of harm			Outcome - Patient Experience	Outcome-Staff Experience					
Ward	Division	Audit	data compliance	Hand Hygiene	Observations on time	inpatient falls with harm	Hosp. acquired pressure ulcers	Reportable Medication errors	Friends and family test	Safer Staffing red flags	No. vacancies	% AL used	% sickness	CHPPD	Peer median CHPPD
Ward 12	Medicine	Audit 1	100.00%		72.30%	7	2	3	76.90%	17		12.40%	11.50%	5.5	
		Audit 2	100.00%	100.00%	88.90%	2	0	0	72.70%	5	5.46	15.40%	11.10%	5.7	

The recommended establishment for Ward 12 for next year is 30.23 FTE.

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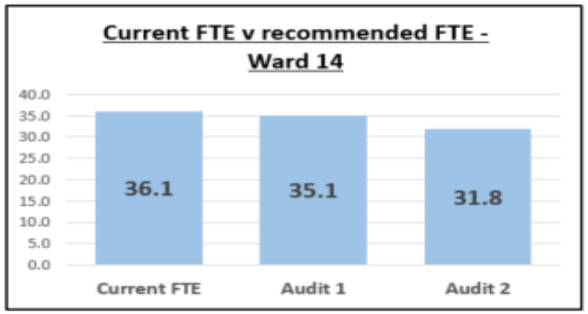
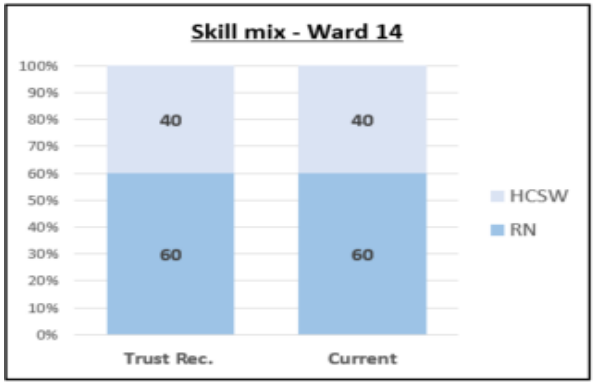
Ward 14





Ward 14 SNCT results 2023

Top Graph on the left:
Demonstrates the comparison between the budgeted staffing, the recommended staffing according to the SNCT in Audit 1 and Audit 2.

Bottom graph on the left:
Compares the current and Trust recommended skill mix required.

Graphs on the Right:
Show the % of each level of care for the patients during the audit identified. Level 0 = Patients requiring hospital admission but can be cared for within normal duties, 1a = acutely ill patients who have the potential to deteriorate, 1b = stable patients with increased nursing support needs i.e. assistance with feeding, toileting, at risk of harm due to confusion/mobility, 2= High dependency patients requiring intensive clinical monitoring due to clinical instability, 3 = Patients needing advanced respiratory support and / or therapeutic support of multiple organs.

Table below:
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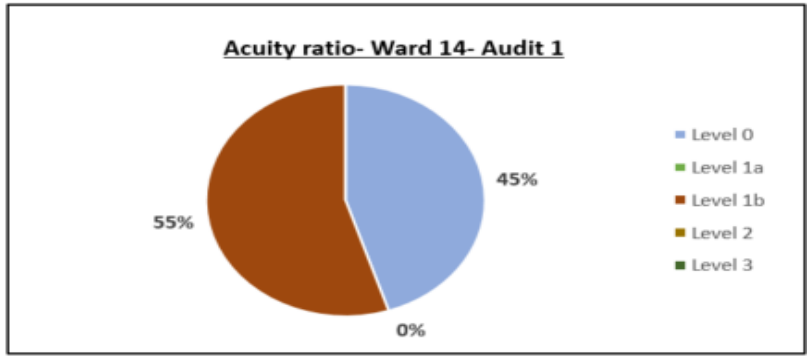

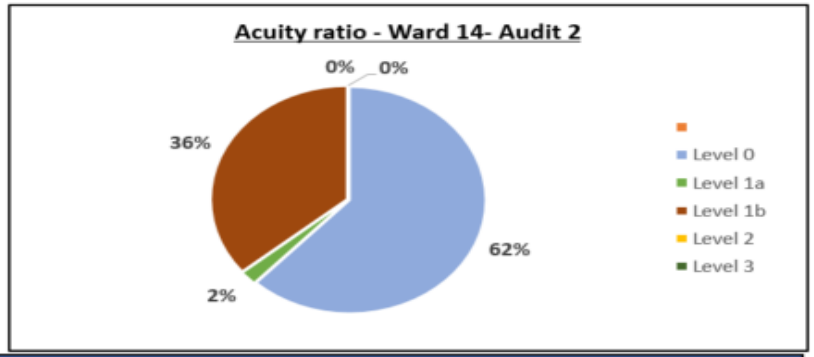

Nursing & Midwifery Care Quality Indicators

			input staffing	Input - process of care		Outcome - Incidence of harm			Outcome - Patient Experience	Outcome-Staff Experience					
Ward	Division	Audit	data compliance	Hand Hygiene	Observations on time	inpatient falls with harm	Hosp. acquired pressure ulcers	Reportable Medication errors	Friends and family test	Safer Staffing red flags	No. vacancies	% AL used	% sickness	CHPPD	Peer median CHPPD
Ward 14	Medicine	Audit 1	100.00%	100.00%	82.10%	8	3	10	72.70%	6		12.40%	11.50%	6.5	
		Audit 2	100.00%	100.00%	88.90%	2	0	0	72.70%	5	1.07	10.90%	9.30%	6.4	

The recommended establishment for Ward 14 for next year is 39.24 FTE.

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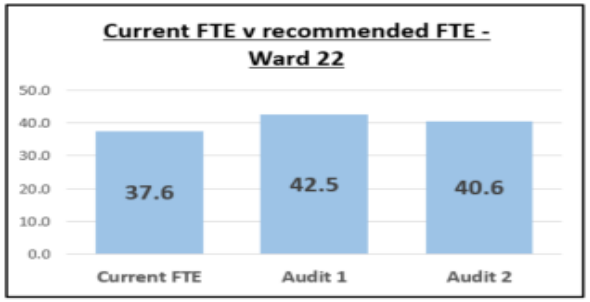
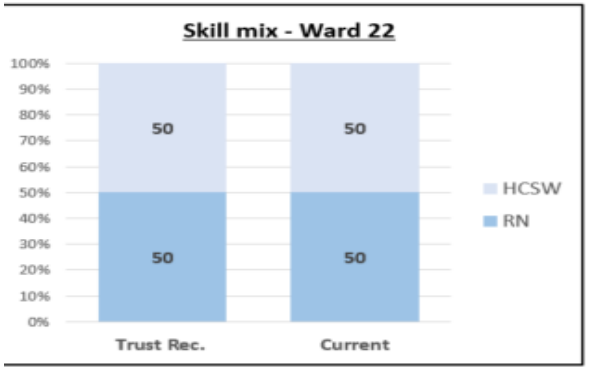
Medicine Service Line 3
Ward 22





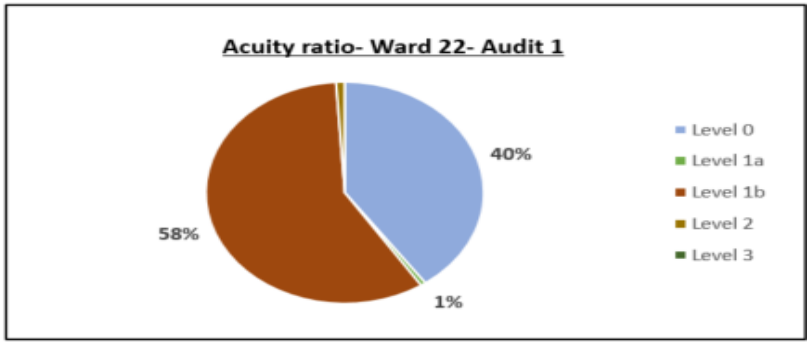
Ward 22 SNCT results 2023

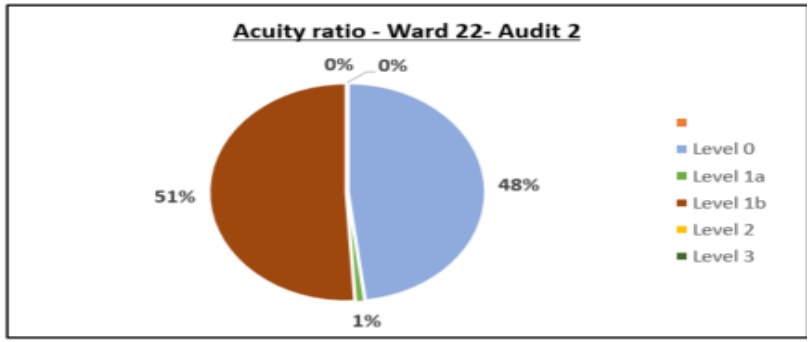
Top Graph on the left:
Demonstrates the comparison between the budgeted staffing, the recommended staffing according to the SNCT in Audit 1 and Audit 2.

Bottom graph on the left:
Compares the current and Trust recommended skill mix required.

Graphs on the Right:
Show the % of each level of care for the patients during the audit identified. Level 0 = Patients requiring hospital admission but can be cared for within normal duties, 1a = acutely ill patients who have the potential to deteriorate, 1b = stable patients with increased nursing support needs i.e. assistance with feeding, toileting, at risk of harm due to confusion/mobility, 2= High dependency patients requiring intensive clinical monitoring due to clinical instability, 3 = Patients needing advanced respiratory support and / or therapeutic support of multiple organs.

Table below:
Shows the data compliance, variance between the current funded establishment and the recommended establishment alongside the patient outcomes, patient experience and staff outcomes.





Nursing & Midwifery Care Quality Indicators

			input staffing	Input - process of care		Outcome - Incidence of harm			Outcome - Patient Experience	Outcome-Staff Experience					
Ward	Division	Audit	data compliance	Hand Hygiene	Observations on time	inpatient falls with harm	Hosp. acquired pressure ulcers	Reportable Medication errors	Friends and family test	Safer Staffing red flags	No. vacancies	% AL used	% sickness	CHPPD	Peer median CHPPD
Ward 22	Medicine	Audit 1	100.00%	100.00%	88.20%	15	5	8	66.70%	0		12.40%	11.50%	5.6	
		Audit 2	100.00%	100.00%	89.30%	13	7	8	91.70%	1	0.33	13.50%	7.50%	5.7	

The recommended establishment for Ward 22 for next year is 39.24 FTE.

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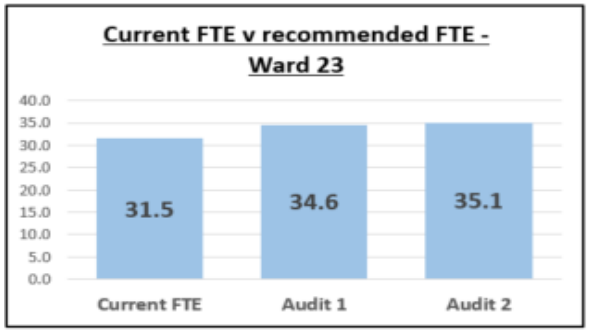
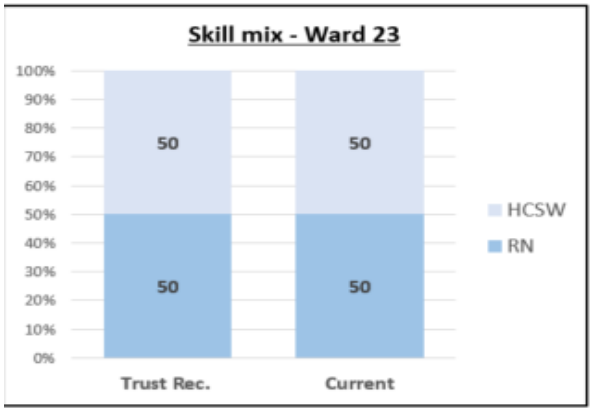
Ward 23





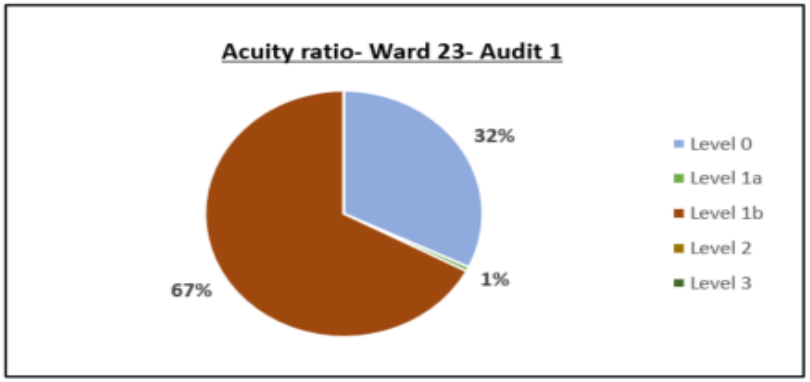
Ward 23 SNCT results 2023

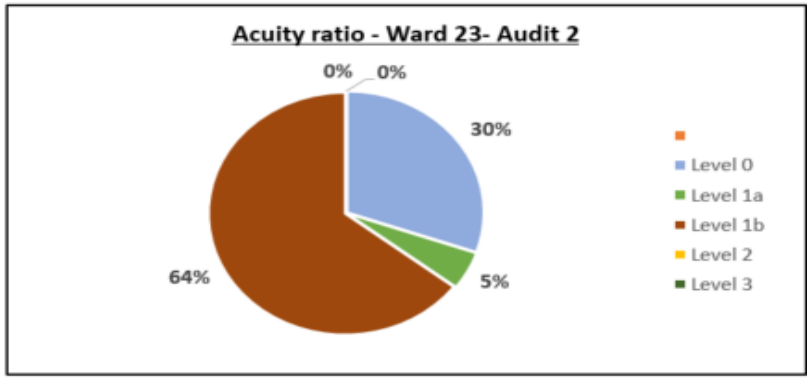
Top Graph on the left:
Demonstrates the comparison between the budgeted staffing, the recommended staffing according to the SNCT in Audit 1 and Audit 2.

Bottom graph on the left:
Compares the current and Trust recommended skill mix required.

Graphs on the Right:
Show the % of each level of care for the patients during the audit identified. Level 0 = Patients requiring hospital admission but can be cared for within normal duties, 1a = acutely ill patients who have the potential to deteriorate, 1b = stable patients with increased nursing support needs i.e. assistance with feeding, toileting, at risk of harm due to confusion/mobility, 2= High dependency patients requiring intensive clinical monitoring due to clinical instability, 3 = Patients needing advanced respiratory support and / or therapeutic support of multiple organs.

Table below:
Shows the data compliance, variance between the current funded establishment and the recommended establishment alongside the patient outcomes, patient experience and staff outcomes.





Nursing & Midwifery Care Quality Indicators

			input staffing	Input - process of care		Outcome - Incidence of harm			Outcome - Patient Experience	Outcome-Staff Experience					
Ward	Division	Audit	data compliance	Hand Hygiene	Observations on time	inpatient falls with harm	Hosp. acquired pressure ulcers	Reportable Medication errors	Friends and family test	Safer Staffing red flags	No. vacancies	% AL used	% sickness	CHPPD	Peer median CHPPD
Ward 23	Medicine	Audit 1	100.00%	99.30%	90.30%	12	1	1	66.70%	8		12.60%	8.70%	6.5	
		Audit 2	100.00%	100.00%	85.40%	10	3	5	66.70%	1	0.84	12.00%	5.60%	6.8	

The recommended establishment for Ward 23 for next year is 33.78 FTE.

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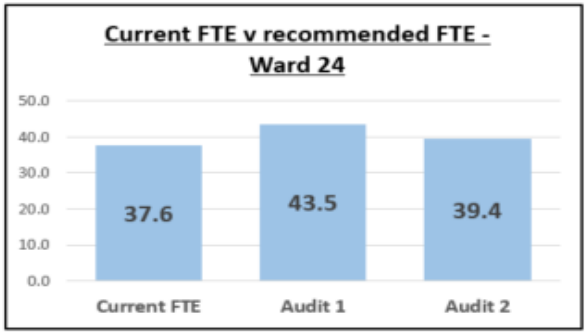
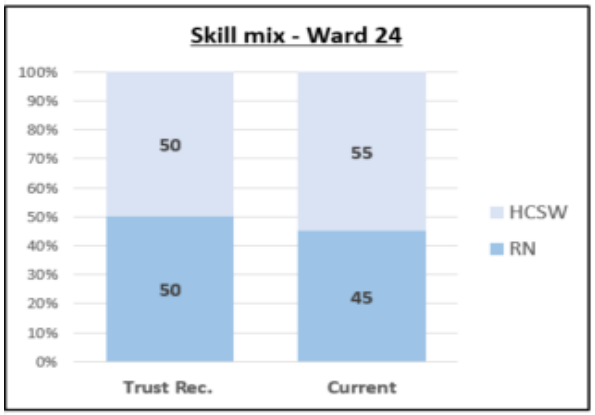
Ward 24





Ward 24 SNCT results 2023

Top Graph on the left:
Demonstrates the comparison between the budgeted staffing, the recommended staffing according to the SNCT in Audit 1 and Audit 2.

Bottom graph on the left:
Compares the current and Trust recommended skill mix required.

Graphs on the Right:
Show the % of each level of care for the patients during the audit identified. Level 0 = Patients requiring hospital admission but can be cared for within normal duties, 1a = acutely ill patients who have the potential to deteriorate, 1b = stable patients with increased nursing support needs i.e. assistance with feeding, toileting, at risk of harm due to confusion/mobility, 2= High dependency patients requiring intensive clinical monitoring due to clinical instability, 3 = Patients needing advanced respiratory support and / or therapeutic support of multiple organs.

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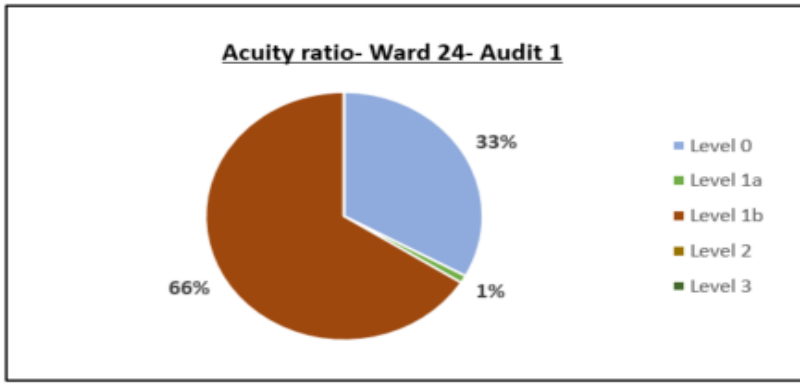

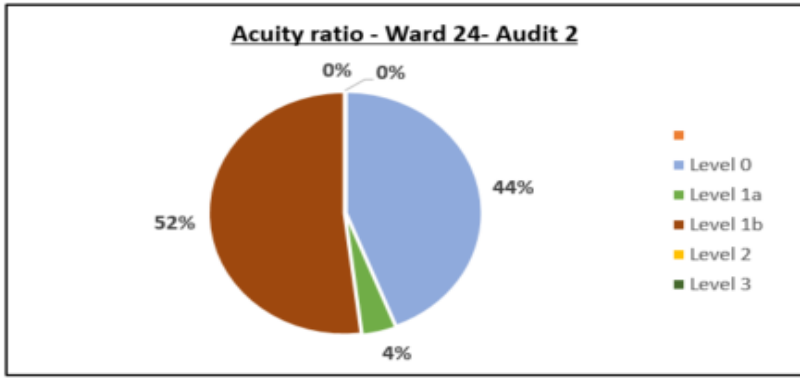

Nursing & Midwifery Care Quality Indicators

			input staffing	Input - process of care		Outcome - Incidence of harm			Outcome - Patient Experience	Outcome-Staff Experience					
Ward	Division	Audit	data compliance	Hand Hygiene	Observations on time	inpatient falls with harm	Hosp. acquired pressure ulcers	Reportable Medication errors	Friends and family test	Safer Staffing red flags	No. vacancies	% AL used	% sickness	CHPPD	Peer median CHPPD
Ward 24	Medicine	Audit 1	100.00%	100.00%	88.90%	14	1	1	66.70%	0		11.70%	8.00%	5.5	
		Audit 2	100.00%	97.20%	93.90%	11	3	5	96.70%	1	3.12	13.20%	9.10%	5.3	

The recommended establishment for Ward 24 for next year is 36.51 FTE.

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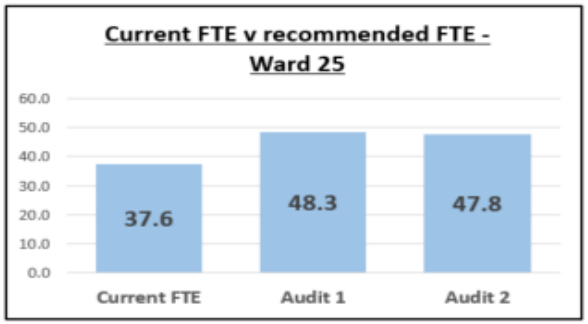
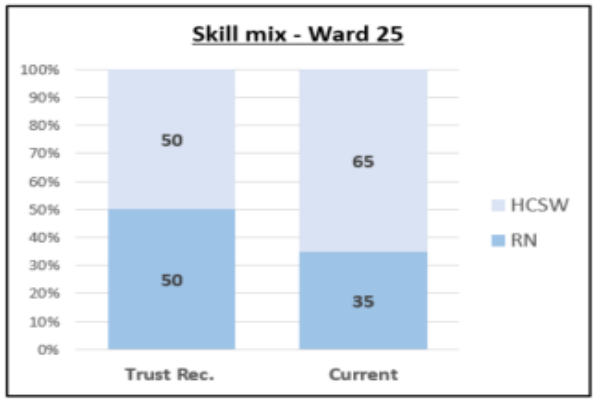
Ward 25





Ward 25 SNCT results 2023

Top Graph on the left:
Demonstrates the comparison between the budgeted staffing, the recommended staffing according to the SNCT in Audit 1 and Audit 2.

Bottom graph on the left:
Compares the current and Trust recommended skill mix required.

Graphs on the Right:
Show the % of each level of care for the patients during the audit identified. Level 0 = Patients requiring hospital admission but can be cared for within normal duties, 1a = acutely ill patients who have the potential to deteriorate, 1b = stable patients with increased nursing support needs i.e. assistance with feeding, toileting, at risk of harm due to confusion/mobility, 2= High dependency patients requiring intensive clinical monitoring due to clinical instability, 3 = Patients needing advanced respiratory support and / or therapeutic support of multiple organs.

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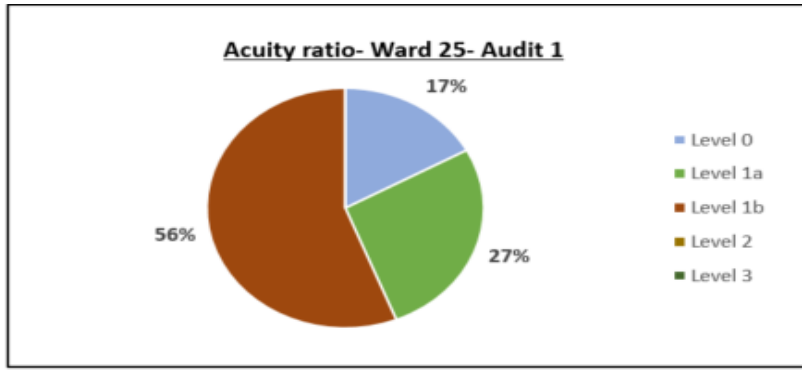

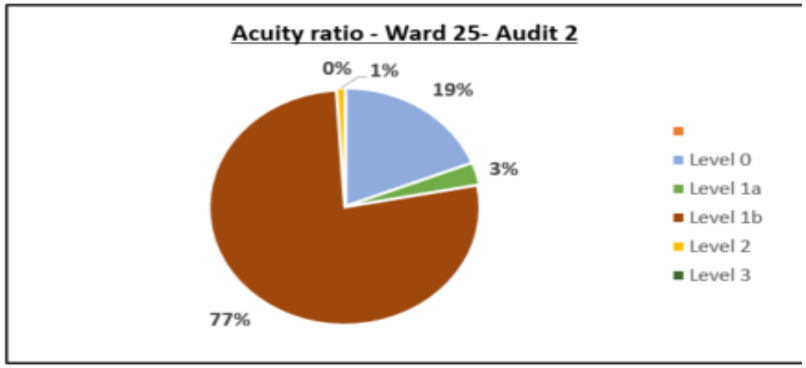

Nursing & Midwifery Care Quality Indicators														
			input staffing	Input - process of care		Outcome - Incidence of harm			Outcome - Patient Experience	Outcome-Staff Experience				
Ward	Division	Audit	data compliance	Hand Hygiene	Observations on time	inpatient falls with harm	Hosp. acquired pressure ulcers	Reportable Medication errors	Friends and family test	Safer Staffing red flags	No. vacancies	% AL used	% sickness	CHPPD	Peer median CHPPD
Ward 25	Medicine	Audit 1	100.00%	100.00%	83.60%	14	8	5	100.00%	7		11.40%	8.20%	4.7	
		Audit 2	100.00%	67.80%	83.40%	17	11	10	98.10%	10	1.97	13.20%	8.90%	5.7	

The recommended establishment for Ward 25 for next year is 39.24 FTE.

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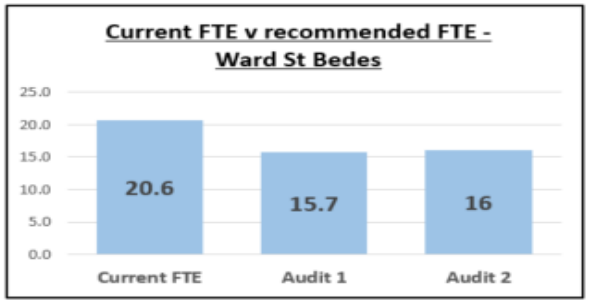
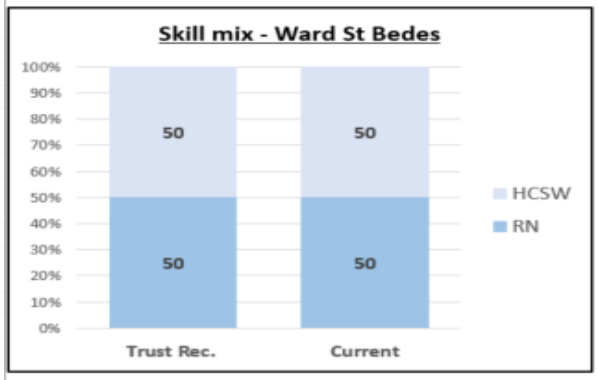
St bedes





Ward St Bedes SNCT results 2023

Top Graph on the left:
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Bottom graph on the left:
Compares the current and Trust recommended skill mix required.

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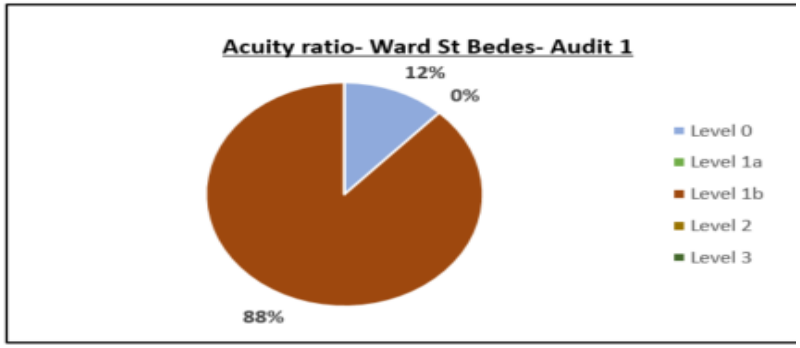

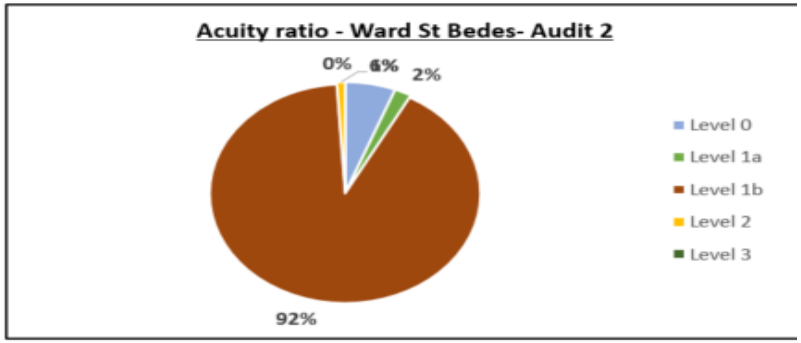

Nursing & Midwifery Care Quality Indicators

			input staffing	Input - process of care		Outcome - Incidence of harm			Outcome - Patient Experience	Outcome-Staff Experience					
Ward	Division	Audit	data compliance	Hand Hygiene	Observations on time	inpatient falls with harm	Hosp. acquired pressure ulcers	Reportable Medication errors	Friends and family test	Safer Staffing red flags	No. vacancies	% AL used	% sickness	CHPPD	Peer median CHPPD
Ward St Bedes	Medicine	Audit 1	100.00%	100.00%	79.90%	0	7	3	100.00%	0		13.40%	10.00%	10.3	
		Audit 2	100.00%	100.00%	82.10%	2	3	4		0	2.02	15.10%	9.00%	11.7	

The recommended establishment for Ward St Bedes for next year is 20.99 FTE.

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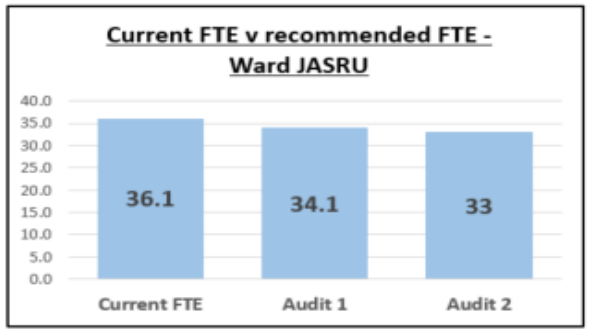
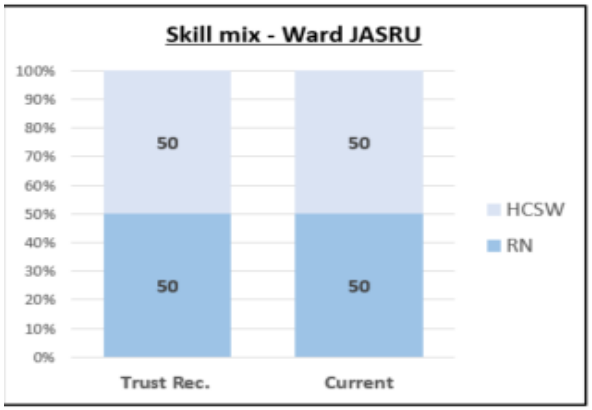
JASRU





Ward JASRU SNCT results 2023

Top Graph on the left:
Demonstrates the comparison between the budgeted staffing, the recommended staffing according to the SNCT in Audit 1 and Audit 2.

Bottom graph on the left:
Compares the current and Trust recommended skill mix required.

Graphs on the Right:
Show the % of each level of care for the patients during the audit identified. Level 0 = Patients requiring hospital admission but can be cared for within normal duties, 1a = acutely ill patients who have the potential to deteriorate, 1b = stable patients with increased nursing support needs i.e. assistance with feeding, toileting, at risk of harm due to confusion/mobility, 2= High dependency patients requiring intensive clinical monitoring due to clinical instability, 3 = Patients needing advanced respiratory support and / or therapeutic support of multiple organs.

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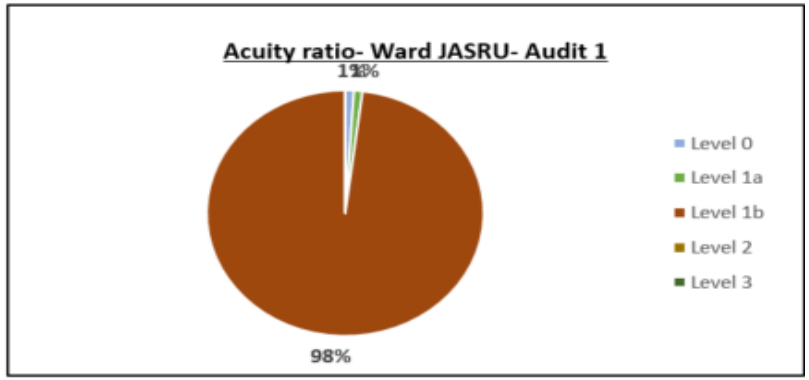

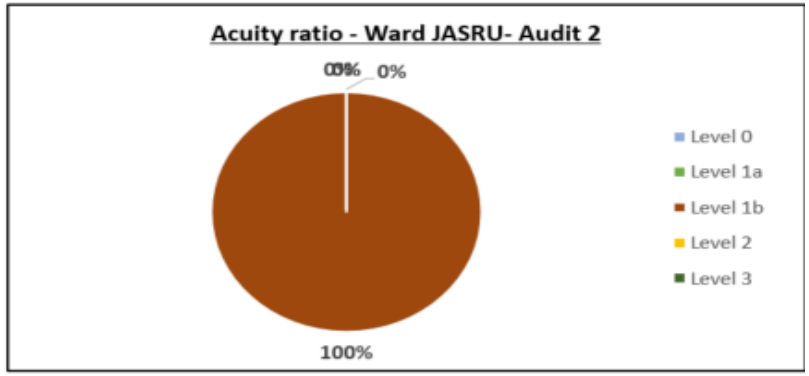

Nursing & Midwifery Care Quality Indicators

			input staffing	Input - process of care		Outcome - Incidence of harm			Outcome - Patient Experience	Outcome-Staff Experience					
Ward	Division	Audit	data compliance	Hand Hygiene	Observations on time	inpatient falls with harm	Hosp. acquired pressure ulcers	Reportable Medication errors	Friends and family test	Safer Staffing red flags	No. vacancies	% AL used	% sickness	CHPPD	Peer median CHPPD
Ward JASRU	Medicine	Audit 1	100.00%	100.00%	80.10%	4	4	4	93.30%	0		14.90%	14.00%	7.5	
		Audit 2	100.00%	97.50%	84.90%	6	4	3	93.30%	2	2	13.00%	18.10%	7.6	

The recommended establishment for Ward JASRU for next year is 36.51 FTE.

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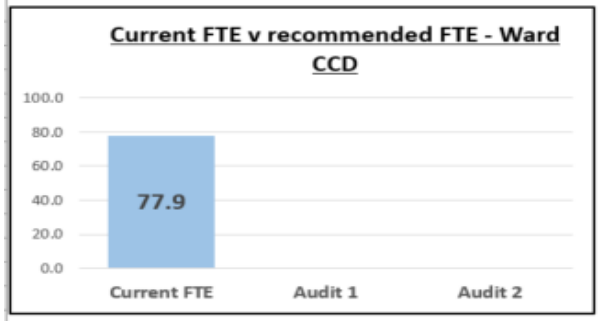
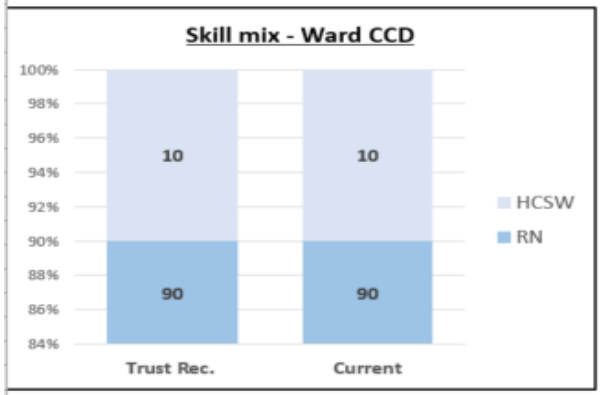
Surgery Service Line 1
Critical Care Department





Ward CCD SNCT results 2023

Top Graph on the left:
Demonstrates the comparison between the budgeted staffing, the recommended staffing according to the SNCT in Audit 1 and Audit 2.

Bottom graph on the left:
Compares the current and Trust recommended skill mix required.

Graphs on the Right:
Show the % of each level of care for the patients during the audit identified. Level 0 = Patients requiring hospital admission but can be cared for within normal duties, 1a = acutely ill patients who have the potential to deteriorate, 1b = stable patients with increased nursing support needs i.e. assistance with feeding, toileting, at risk of harm due to confusion/mobility, 2= High dependency patients requiring intensive clinical monitoring due to clinical instability, 3 = Patients needing advanced respiratory support and / or therapeutic support of multiple organs. Level 3+ = Inotrope therapy

Table below:
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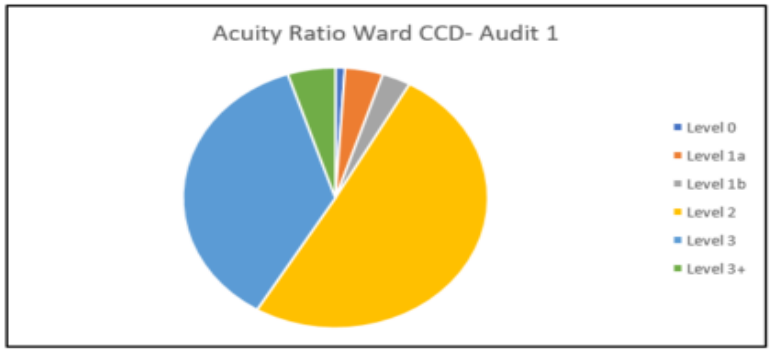

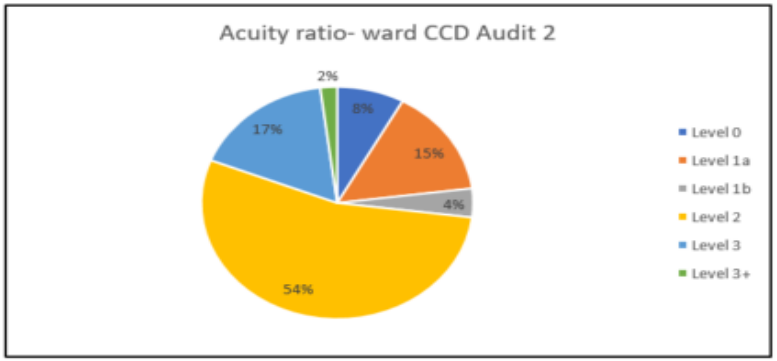

Nursing & Midwifery Care Quality Indicators

			input staffing	Input - process of care		Outcome - Incidence of harm			Outcome - Patient Experience	Outcome-Staff Experience					
Ward	Division	Audit	data compliance	Hand Hygiene	Observations on time	inpatient falls with harm	Hosp. acquired pressure ulcers	Reportable Medication errors	Friends and family test	Safer Staffing red flags	No. vacancies	% AL used	% sickness	CHPPD	Peer median CHPPD
Ward CCD	Surgery	Audit 1	100.00%	97.80%	29.00%	0	14	13	83.30%	0		14.10%	10.20%	31.8	
		Audit 2	100.00%	100.00%	24.90%	0	9	12	100.00%	0	6.84	15.60%	8.00%	48.7	

National guidance needs to be reviewed prior to a recommende WTE .

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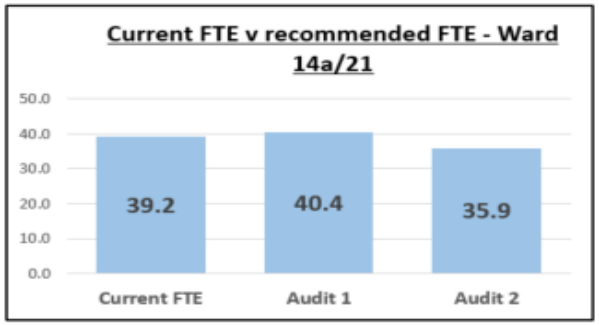
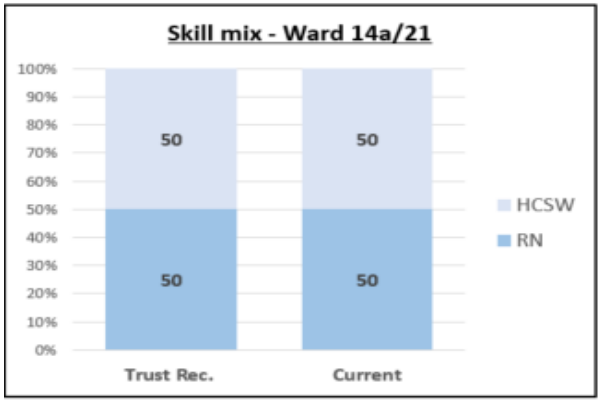
Ward 14a/21





Ward 14a/21 SNCT results 2023

Top Graph on the left:
Demonstrates the comparison between the budgeted staffing, the recommended staffing according to the SNCT in Audit 1 and Audit 2.

Bottom graph on the left:
Compares the current and Trust recommended skill mix required.

Graphs on the Right:
Show the % of each level of care for the patients during the audit identified. Level 0 = Patients requiring hospital admission but can be cared for within normal duties, 1a = acutely ill patients who have the potential to deteriorate, 1b = stable patients with increased nursing support needs i.e. assistance with feeding, toileting, at risk of harm due to confusion/mobility, 2= High dependency patients requiring intensive clinical monitoring due to clinical instability, 3 = Patients needing advanced respiratory support and / or therapeutic support of multiple organs.

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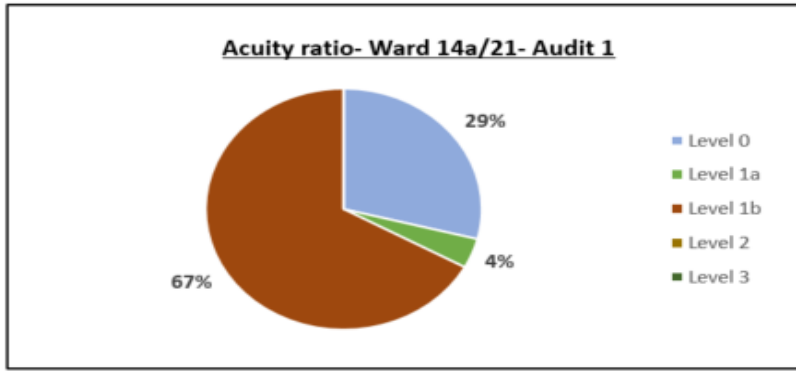

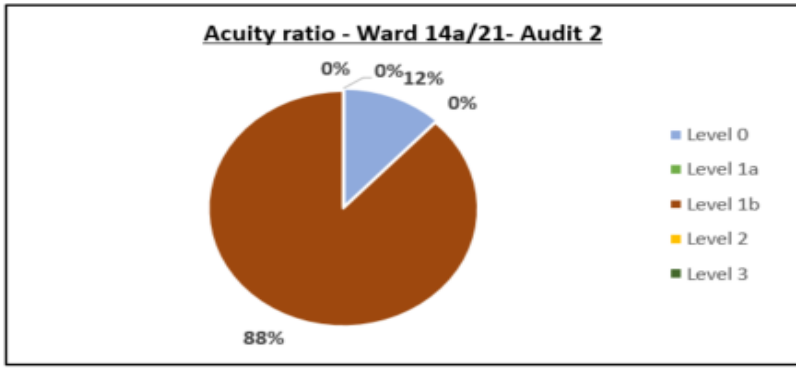

Nursing & Midwifery Care Quality Indicators

			input staffing	Input - process of care		Outcome - Incidence of harm			Outcome - Patient Experience	Outcome-Staff Experience					
Ward	Division	Audit	data compliance	Hand Hygiene	Observations on time	inpatient falls with harm	Hosp. acquired pressure ulcers	Reportable Medication errors	Friends and family test	Safer Staffing red flags	No. vacancies	% AL used	% sickness	CHPPD	Peer median CHPPD
Ward 14a/21	Surgery	Audit 1	100.00%	99.40%	70.80%	4	14	4	83.30%	0		12.20%	8.50%	6.5	
		Audit 2	100.00%	94.10%	71.80%	2	10	7	97.00%	0	2.08	13.60%	6.50%	7.9	

The recommended establishment for Ward 14a/21 for next year is 38.92 FTE.

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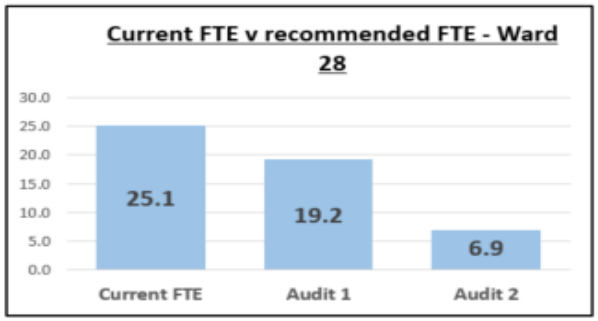
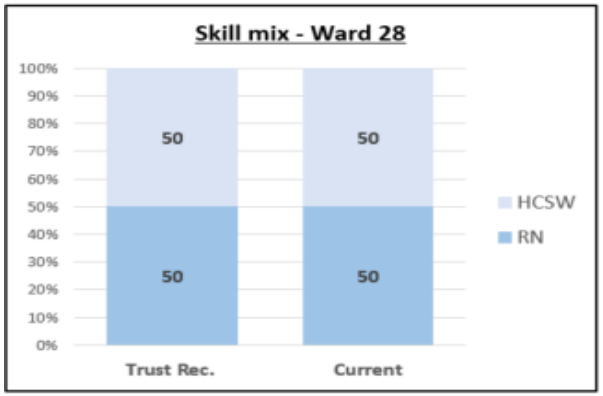
Ward 28





Ward 28 SNCT results 2023

Top Graph on the left:
Demonstrates the comparison between the budgeted staffing, the recommended staffing according to the SNCT in Audit 1 and Audit 2.

Bottom graph on the left:
Compares the current and Trust recommended skill mix required.

Graphs on the Right:
Show the % of each level of care for the patients during the audit identified. Level 0 = Patients requiring hospital admission but can be cared for within normal duties, 1a = acutely ill patients who have the potential to deteriorate, 1b = stable patients with increased nursing support needs i.e. assistance with feeding, toileting, at risk of harm due to confusion/mobility, 2= High dependency patients requiring intensive clinical monitoring due to clinical instability, 3 = Patients needing advanced respiratory support and / or therapeutic support of multiple organs.

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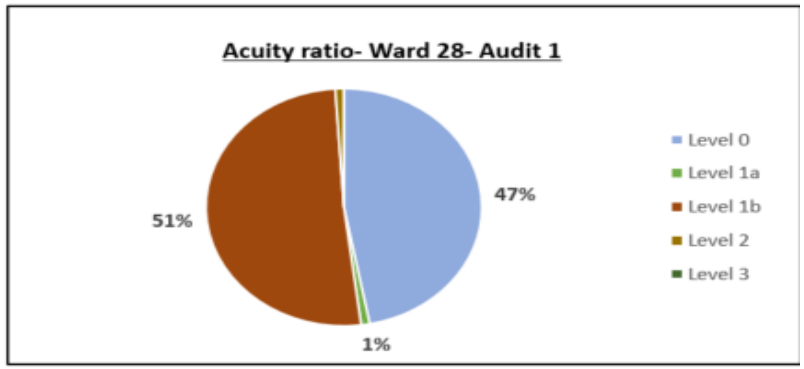

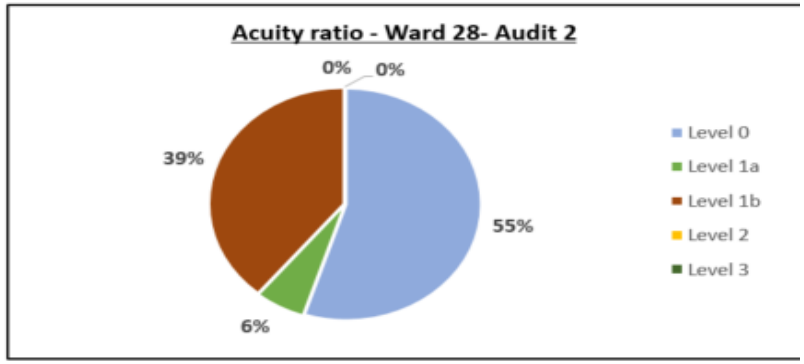

Nursing & Midwifery Care Quality Indicators

			input staffing	Input - process of care		Outcome - Incidence of harm			Outcome – Patient Experience	Outcome-Staff Experience					
Ward	Division	Audit	data compliance	Hand Hygiene	Observations on time	inpatient falls with harm	Hosp. acquired pressure ulcers	Reportable Medication errors	Friends and family test	Safer Staffing red flags	No. vacancies	% AL used	% sickness	CHPPD	Peer median CHPPD
Ward 28	Surgery	Audit 1	100.00%	100.00%	84.70%	1	1	2	100.00%	0		14.40%	9.90%	10.9	
		Audit 2	100.00%	100.00%	88.40%	0	1	0	100.00%	0	5.81	15.40%	5.50%	9.6	

The recommended establishment for Ward 28 for next year is 23.43 FTE.

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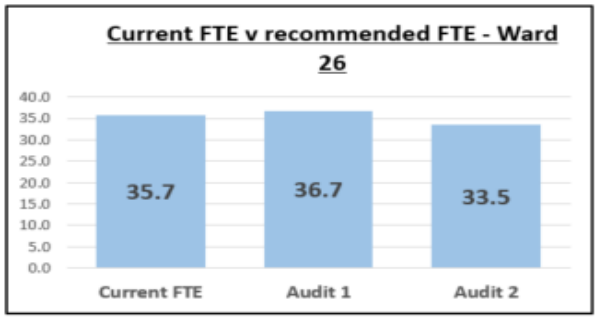
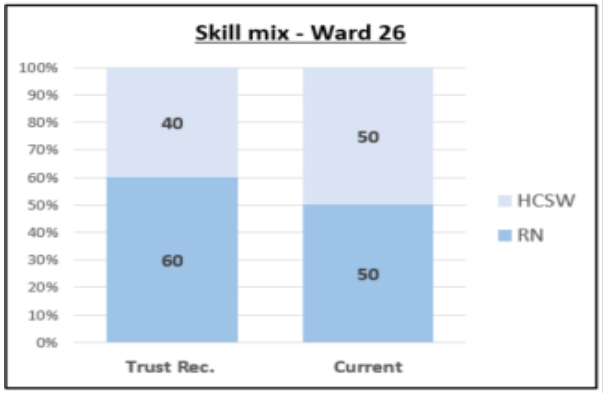
Surgery Service Line 3
Ward 26





Ward 26 SNCT results 2023

Top Graph on the left:
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Bottom graph on the left:
Compares the current and Trust recommended skill mix required.

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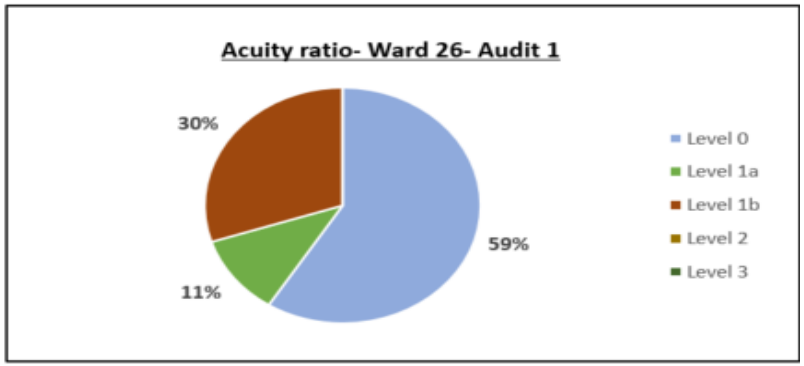

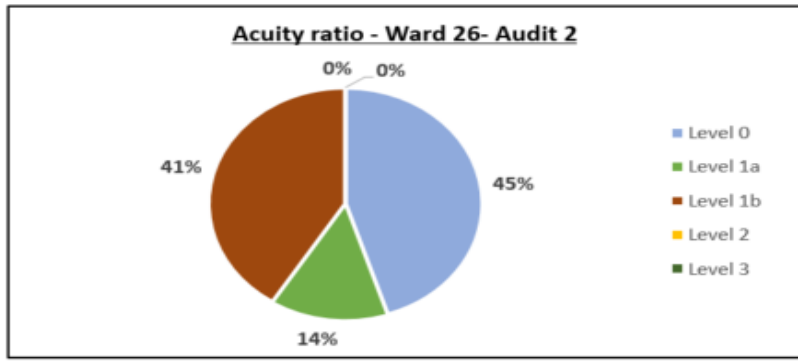

Nursing & Midwifery Care Quality Indicators

			input staffing	Input - process of care		Outcome - Incidence of harm			Outcome - Patient Experience	Outcome-Staff Experience					
Ward	Division	Audit	data compliance	Hand Hygiene	Observations on time	inpatient falls with harm	Hosp. acquired pressure ulcers	Reportable Medication errors	Friends and family test	Safer Staffing red flags	No. vacancies	% AL used	% sickness	CHPPD	Peer median CHPPD
Ward 26	Surgery	Audit 1	100.00%	100.00%	65.90%	10	4	12	85.50%	0		11.30%	10.70%	5.9	
		Audit 2	100.00%	96.40%	68.70%	3	8	10	93.90%	0	6.18	14.40%	7.00%	7.7	

The recommended establishment for Ward 26 for next year is 39.24 FTE.

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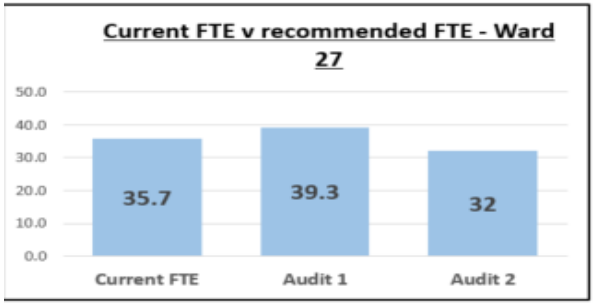
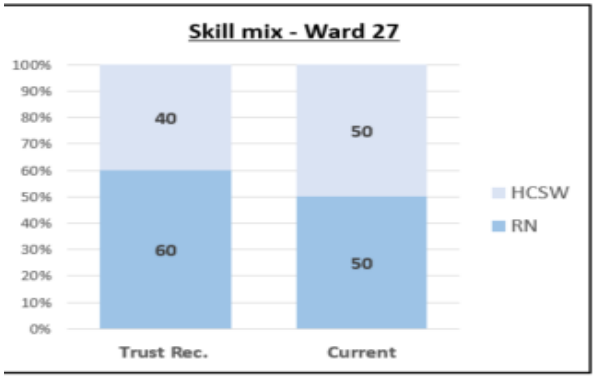
Ward 27





Ward 27 SNCT results 2023

Top Graph on the left:
Demonstrates the comparison between the budgeted staffing, the recommended staffing according to the SNCT in Audit 1 and Audit 2.

Bottom graph on the left:
Compares the current and Trust recommended skill mix required.

Graphs on the Right:
Show the % of each level of care for the patients during the audit identified. Level 0 = Patients requiring hospital admission but can be cared for within normal duties, 1a = acutely ill patients who have the potential to deteriorate, 1b = stable patients with increased nursing support needs i.e. assistance with feeding, toileting, at risk of harm due to confusion/mobility, 2= High dependency patients requiring intensive clinical monitoring due to clinical instability, 3 = Patients needing advanced respiratory support and / or therapeutic support of multiple organs.

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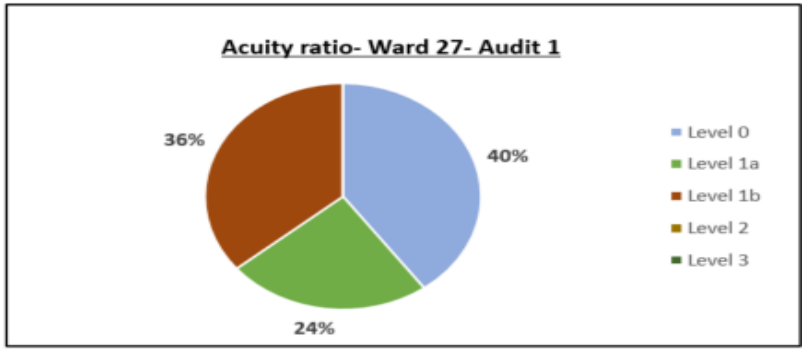

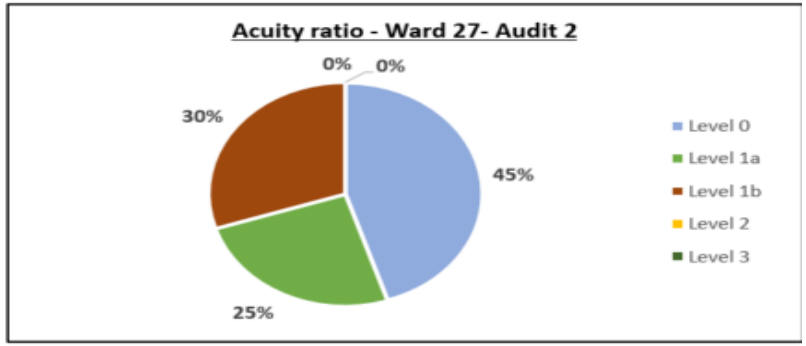

Nursing & Midwifery Care Quality Indicators

			input staffing	Input - process of care		Outcome - Incidence of harm			Outcome – Patient Experience	Outcome-Staff Experience					
Ward	Division	Audit	data compliance	Hand Hygiene	Observations on time	inpatient falls with harm	Hosp. acquired pressure ulcers	Reportable Medication errors	Friends and family test	Safer Staffing red flags	No. vacancies	% AL used	% sickness	CHPPD	Peer median CHPPD
Ward 27	Surgery	Audit 1	100.00%	73.00%	74.10%	4	5	17	79.30%	0		10.60%	9.50%	6	
		Audit 2	100.00%	83.40%	78.60%	6	0	9	89.10%	0	1.89	13.50%	8.40%	7.4	

The recommended establishment for Ward 27 for next year is 39.24 FTE.

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Report Cover Sheet Agenda Item:15

Report Title:	**Inpatient Safer Nursing Care Staffing Bi-Annual Report**			
Name of Meeting:	Quality Governance Committee			
Date of Meeting:	Tuesday 31st October 2023			
Author:	Drew Rayner, Deputy Chief Nurse Laura Edgar, Workforce Lead			
Executive Sponsor:	Dr Gillian Findley, Chief Nurse			
Report presented by:	Drew Rayner, Deputy Chief Nurse			
Purpose of Report	**Decision:** ☐	**Discussion:** ☒	**Assurance:** ☒	**Information:** ☐
	This paper provides an overview of the Safe Staffing Nursing review undertaken at Gateshead Health in July 2023. The purpose of this paper is to provide the board with continual assurance that the nursing workforce at the Gateshead Health is safe, competent, and compliant with National Institute for Clinical Excellence (NICE), National Quality Board (NQB) and NHSI Safer Staffing guidelines and standards at a time when nationally nursing is facing the greatest recruitment and retention challenges			
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:	Actions to be reviewed at EMT			
Key issues:	Bi-annual review of staff staffing using Safer Nursing Care Tool (SNCT) has been undertaken in line with national recommendations. The SNCT is a recognised, evidence-based tool approved by the national institute of health and care Excellence for calculating staffing establishments. The paper highlights current challenges across the nursing workforce and mitigations on how we are monitoring and working to provide safe, effective patient care. Individual ward areas have been reviewed and some small adjustments are required that can be completed within budget.			

<table>
<tr><td></td><td colspan="5">There are a number of areas where the Trust is not aligned with other providers or national guidance.

A pilot of supervisory ward management staff is underway. Headroom calculations remain at 21%, this is at the lower end of the acceptable range. Work to address sickness/absence will assist this. Some adjustment to the rosters are required to increase night shift cover. The staffer nursing care calculations for the Emergency Department and Emergency admissions Unit need further detailed work due to the acuity of the patients and the way in which the units are currently running.

A business case will be developed for consideration by the Senior Management Team to address any remaining gaps once the more detailed work is completed.</td></tr>
<tr><td>Recommended actions for this meeting:</td><td colspan="5">Recommendations:

Quality Governance Committee is asked to:
Note the content of the report
Note that the SNCT report indicates some areas where the Trust is at odds with national or local recommendations including supervisory ward managers, headroom calculations and night shift cover.
Note that a business case will be developed to explore how these issues can be covered</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:</td><td>Aim 1
☒</td><td colspan="4">We will continuously improve the quality and safety of our services for our patients</td></tr>
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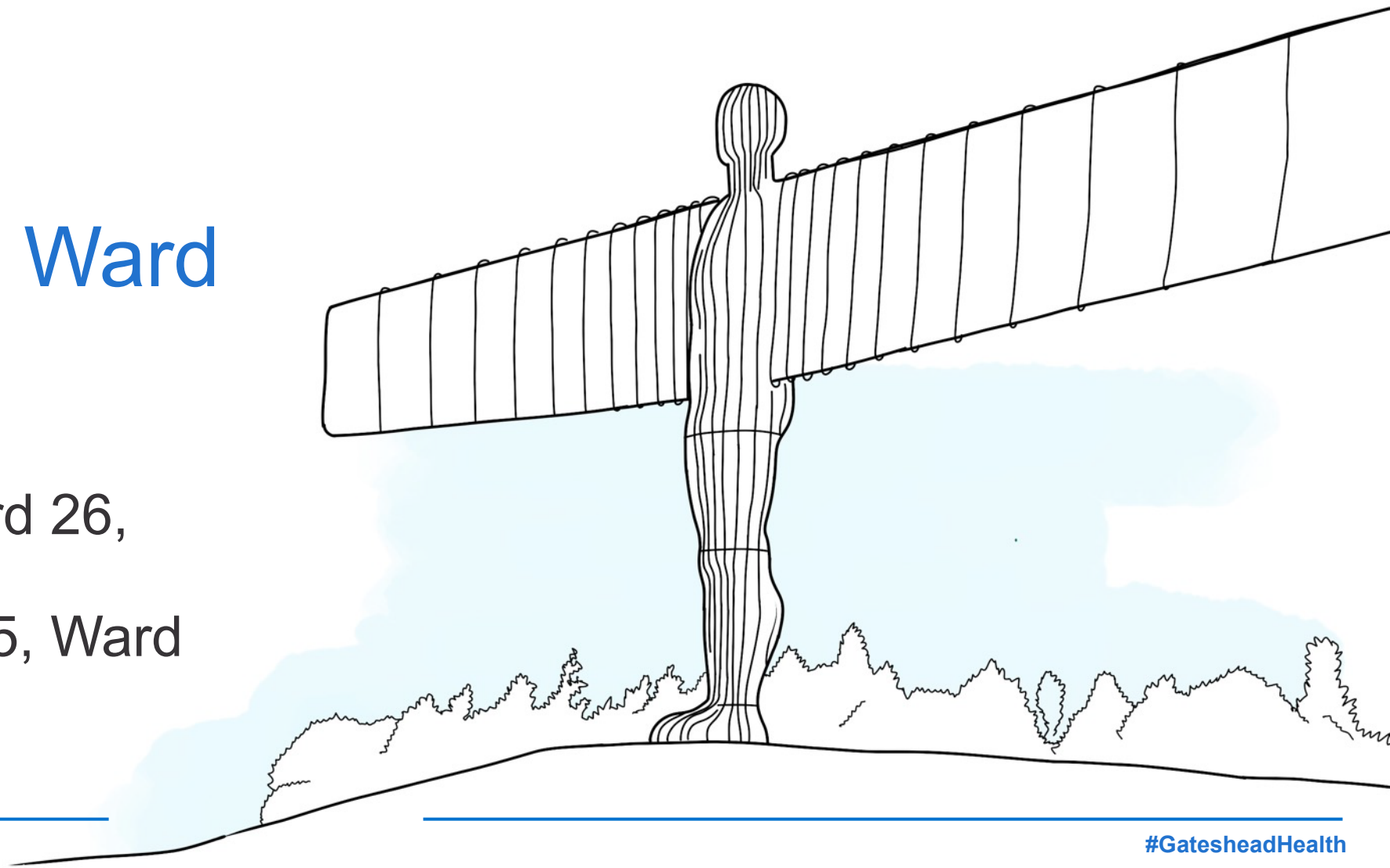
Role of the supervisory B7 Ward Manager



Dionne Johnston, Ward 26, Acting Ward Manager
Carly Sinclair, Ward 25, Ward Manager

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Background

- The role of the supervisory ward sister/charge nurse is ideally situated in the hospital system to supervise clinical care, oversee quality and safety standards, co-ordinate patient care activities at ward level, and promote nursing leadership and mentoring
- Francis Report (2013) Recommendation 195 ‘Ward nurse managers should operate in a supervisory capacity, and not be office-bound or expected to double up…. They should know about the care plans relating to every patient…. visible to patients and staff alike, and be available to discuss concerns with all, including relatives.’
- Shape of Caring review (2015), which was undertaken by Health Education England and the Nursing & Midwifery Council has recommended that nurses “adapt, support and lead research and innovation to deliver high-quality care.”
- Royal College of Nursing published a report 2009, ‘Breaking down barriers, driving up standards’
- “Nurse Leadership: Being Nice is Not Enough” Hay Group 2006

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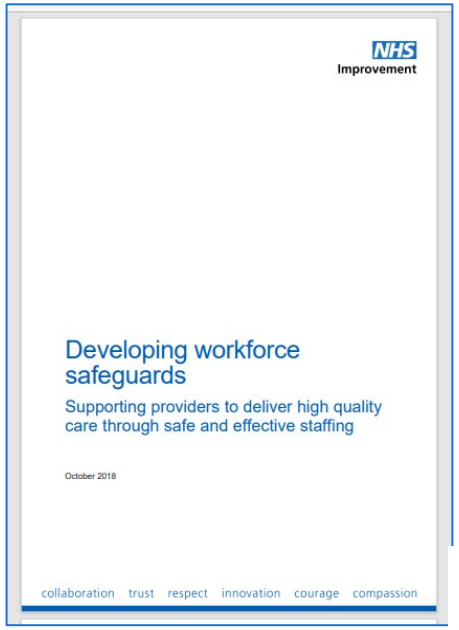
Ward 25 - Effective Roster

- Visibility Monday to Friday
- Produce a roster six weeks in advance
- Reduce bank and agency spend
- Actively recruit to band 5 and band 2 vacancies.



Health Roster

OP96 Nursing and Midwifery Safer Staffing Policy

PP51 E-Rostering Policy

PP43 Flexible Resourcing Policy

People Promise

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- Staff Survey – increased participation
- Core Skills Pre pilot: 70.5%, Now: 83.57%
- Appraisals Pre pilot: 42.5% Now: 86%
- Promote attendance at work

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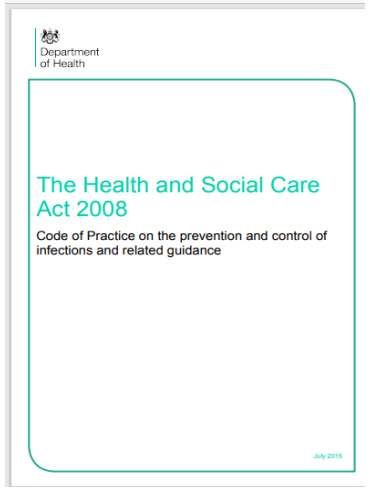
Patient Quality and Safety

- Reduce patient harms and improve patient safety
- Learning and responding to patient complaints in a timely manner
- CQC preparedness
- Matron's walkabouts
- Positive patient experience



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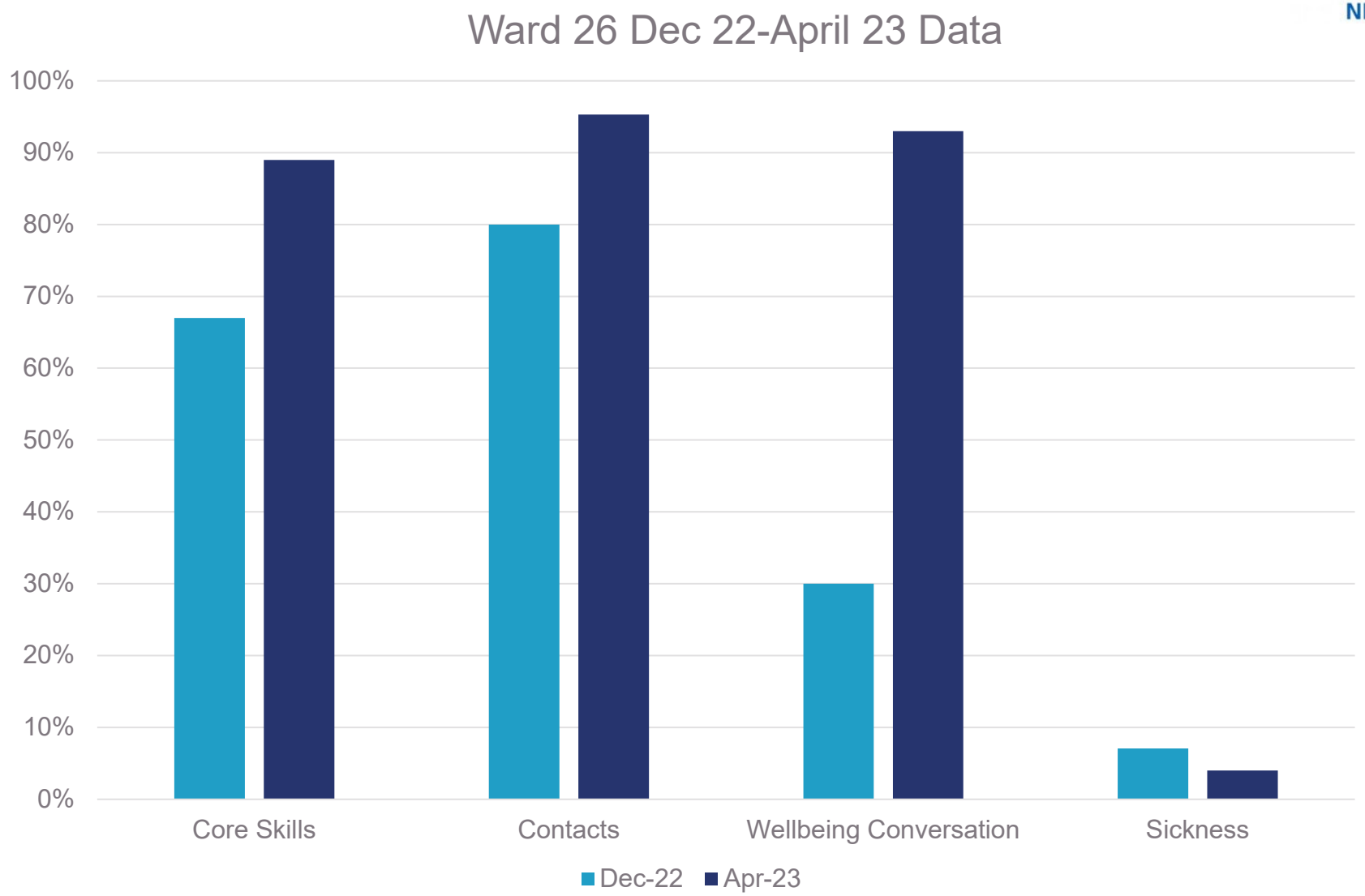

Managerial Improvements

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- Increased compliance with sickness management
- Timely investigations/responses to Datix
- Increased time to support staff/wellbeing
- Managing core skills and mandatory training
- Identification of training needs and seeking training opportunities
- Increased attendance to business unit meetings/agenda
- Attendance at Band 7 meetings
- Off duty completed in advance
- Recruitment drive

Staff Feedback

Gateshead Health NHS Foundation Trust

- Listening space/counselling
- Better off duty- able to have a greater work-life balance
- Able to attend training as manager has factored this into working time
- Encouraged to take on further training
- Improved morale
- Increase in staffing
- Better cover of shifts at short notice
- De-escalation of conflicts before they become a problem

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Report Cover Sheet Agenda Item: 14

Report Title:	**Maternity Integrated Oversight Report**			
Name of Meeting:	Board of Directors in Public			
Date of Meeting:	Wednesday 29th November 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			
Report presented by:	Mrs Jane Conroy, Head of Midwifery			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
	This report presents a summary of the maternity indicators for the Trust from the month of September 2023.			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☒ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	This paper has been considered by the departmental Safecare in October, SBU Business meeting in November and Trustwide Safecare/Risk and Safety Council in November 2023.			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	**Maternity dashboard:** • In September 2023, we had 159 births, 0 serious incidents (SI's), 0 HSIB cases and 0 perinatal losses. • Our PPH rate (>1.5 L blood loss after birth) were 13 and 10 which continues to flag high based on SPC. This is in line with regional and national trends. **Moderate harm event 114868:** • There were no concerns around management of clinical care. • Learning from this event is outlined within in relation to its impact on the wider Trust workforce and the Maternity estate. **NENC Ockenden assurance visit:** • The Maternity service welcomed an assurance team from the ICB/LMNS with a peer review team from North Tees on 13th September 2023.			

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- Positive feedback was received both on the day and via a formal report.
- Several areas of outstanding practice were noted by the team including digital, diabetes, new theatre/pool/bereavement facilities.
- Actions include strengthening work with our MVP and support for SCBU both with staffing planning and work towards UNICEF Stage 1 accreditation.

National policy drivers/incentive schemes:

- The service is 71% compliant with the Saving Babies Lives v3 based on the implementation tool calculations. The standards required by March 2024 is overall 70% with the minimum ambitions achieved in each element.
- CO readings at booking and 36 are below the new ambitions of 90% (booking) and 80% (36 weeks).

</td></tr>
<tr><td>Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper</td><td colspan="5">The Trust Board of Directors are asked to review the detail provided within this report for assurance.</td></tr>
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Maternity Integrated Oversight Report

Maternity data from September 2023

Maternity IOR contents

- Maternity Dashboard 2023/24:
    - September 2023 data

- Exception reports:
    - Maternity dashboard exceptions
        - Massive PPH

- Items for information:
    - Perinatal Clinical Quality Surveillance Model
    - Training data and trajectory
    - Learning from incidents
    - Feedback from Regional Ockenden Assurance Visit – 13th September 2023
    - Saving Babies Lives Care Bundle (v3) Quarterly Update

    - Incidents
        - No SIs reported in September 2023
        - No HSIB cases reported in September 2023
        - 1 moderate harm learning event (114868)
    - Perinatal Mortality and Morbidity
        - No perinatal losses in September 2023

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Total Births	Sep 23	159	-			147	106	187
Spontaneous vaginal deliveries	Sep 23	81	-			75	51	100
Assited births	Sep 23	78	-			72	42	101
Induction of Labour	Sep 23	59.00	-			65	43	86
Maternity Readmissions	Sep 23	3	-			3	0	6
Neonatal Readmissions	Sep 23	3	-			5	-3	12
Smoking at time of booking	Sep 23	8.09%	15.00%		?	11.10%	6.11%	16.09%
Smoking at time of delivery	Sep 23	6.29%	6.00%		?	10.26%	3.38%	17.15%
In area CO at booking	Sep 23	75.48%	90.00%		?	82.07%	71.12%	93.02%
In area CO at 36 weeks	Sep 23	73.38%	80.00%		?	79.47%	68.78%	90.17%
Admitted directly to NNU (SCBU) (>37 weeks)	Sep 23	6	4		?	5	-3	13
Percentage Admitted directly to NNU (SCBU) (>37 weeks)	Sep 23	4.03%	6.00%		?	3.65%	-2.24%	9.53%
Preterm birth rate <=36+6 weeks at birth	Sep 23	6.29%	6.00%		?	5.70%	1.56%	9.85%
Continuity of Carer: Percentage placed on pathway (29 w	Sep 23	19.88%	-			18.25%	10.74%	25.77%
Continuity of Carer: Percentage from BAME backgrounds	Sep 23	15.79%	-			28.47%	4.06%	52.87%
Spontaneous Vaginal Births (%)	Sep 23	50.94%	-			51.51%	36.27%	66.75%
Induction Rate	Sep 23	37.34%	-			44.64%	32.21%	57.08%
Instrumental Delivery Rate	Sep 23	11.39%	-			11.57%	2.05%	21.09%
Elective C Section Rate	Sep 23	16.35%	-			18.56%	9.08%	28.03%
Emergency C Section Rate	Sep 23	21.38%	-			18.05%	7.79%	28.30%
C Section Rate	Sep 23	37.74%	-			36.60%	24.16%	49.05%
3rd or 4th degree tear (Total) Precentage	Sep 23	1.90%	5.00%		?	1.64%	-1.81%	5.08%
Massive PPH >=1.5L (All births)	Sep 23	10	2	H	?	7	-1	15
Breastfeeding: Percentage of Initiated Breasfeeding	Sep 23	65.19%	66.20%		?	68.47%	48.37%	88.57%
Breastfeeding: Breasfeeding at Discharge (Transfer to Co	Sep 23	43.40%	56.20%		?	51.08%	36.51%	65.65%

Maternity

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Safe

Responsive

Maternity Dashboard 2023/24

Maternity Dashboard 2023/24

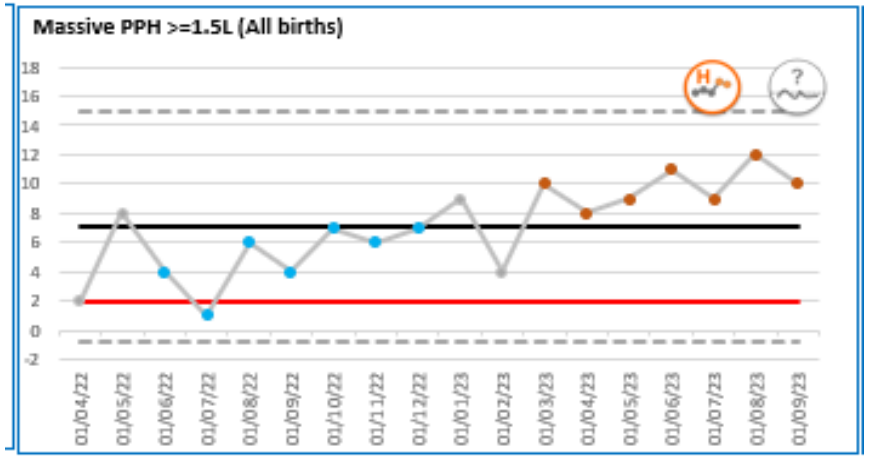
Maternity

NHS

Gateshead Health
NHS Foundation Trust

Safe

Responsive



- **Background**
  - **Increasing PPHs rates sustained over 6 months - not anticipated to decline given increasing acuity of birthing population and increased interventions/operative delivery rates**
- **Assessment**
  - Sustained increase in PPH observed even after change in measuring process
  - PPH rate around 6% at Gateshead, NENC around 9%
- **Actions**
  - Moderate harm case review (114868) to understand organisational impact of massive PPH – movement of staff, separate building, transfer of patients to ITU (see learning from incidents slides)
  - Thematic review of PPHs underway to understand risk factors, acuity, antenatal optimisation and management (to be reported November 2023)
  - NENC review of PPH underway led by intrapartum specialist group
- **Recommendations**
  - Await outcomes of above reviews
  - Share learning internally and at NENC Maternity Patient Safety Learning Network and Intrapartum Group
  - Engage with LMNS-wide action/learning on PPH

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Items for information

Perinatal Clinical Quality Surveillance Model

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CQC Maternity Rating February 2023	Overall	Safe	Effective	Caring	Well-led	Responsive
	Good	Good			Good	
Maternity Safety Support Programme – Not applicable						
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)					**97.5%**	

2. Saving Babies Lives v3 compliance Q1 2022/23	Maternity Incentive Scheme Q2 2023/24	
Element 1:	Safety Action 1 (PMRT):	Safety Action 6 (SBL Care Bundle):
Element 2:	Safety Action 2 (MSDS):	Safety Action 7 (MVP):
Element 3:	Safety Action 3 (ATAIN):	Safety Action 8 (Core Competency Framework):
Element 4:	Safety Action 4 (Clinical Workforce Planning):	Safety Action 9 (Trust Board Oversight):
Element 5:	Safety Action 5 (Midwifery Workforce):	Safety Action 10 (HSIB & ENS):
Element 6:		

Key Themes from HSIB referrals, perinatal data reviews & moderate harm/above cases	Key Safety Interventions Implemented
Listening to pregnant people and families	Patient stories included at start of every departmental Safecare meeting “You said, we did” posters and actions Individual patient feedback meetings and/or birth reflections
PPH rates	Thematic review and SEIPS learning event Share learning across LMNS for shared improvement actions

Perinatal Clinical Quality Surveillance Model (continued)

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2023		Jan	Feb	March	April	May	June	July	August	Sept	Oct	Nov	Dec
Number of perinatal losses		1	1	0	0	1	2	0	0	0			
Number of HSIB cases		0	0	0	0	0	0	0	0	0			
Number of incidents logged as moderate harm or above		0	0	0	0	1	3	1	2	1			
Minimum obstetric safe staffing on labour ward		100%	100%	100%	100%	100%	100%	100%	100%	100%			
Minimum midwifery safe staffing including labour ward (average fill rates)	Day shift fill rate	146%	151.3%	150.10%	135.30%	161%	156.10%	155.20%	148.1%	145.5%			
	Night shift fill rate	104.60%	101.40%	102.30%	107.90%	108.10%	104.10%	101.70%	106.4%	107.7%			
	Overall CHPPD*	20.7	21.4	20.8	21.6	20.6	21.2	20.6	19.3	20.8			
Service user feedback	FFT "Overall how was your experience of our service" – total score for *very good* and *good* responses	100%	100%	100%	100%	100%	100%	100%	100%				
	Complaints	1	1	1	0	0	1	0	1	3			
HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust		0	0	0	0	0	0	0	0	0			
Coroner Reg 28 made directly to Trust		0	0	0	0	0	0	0	0	0			

Training data and trajectory

Effective

Safe

The following two slides show current & predicted essential maternity safety training compliance as reported in Q2 provider reporting to LMNS (updated 17/11/2023)

Final compliance >90% required by 31/12/2023

Areas for focus:

- HCA/MSW bookings for emergency training days
- NLS training sessions for all eligible staff groups (except midwifery/paediatric Consultants)

- Essential training compliance to be moved to financial year reporting (April-April) in line with other NENC Trusts to accommodate standardised TNA syllabus in line with Core Competency Framework v2
- Confirmation from ICB that training data for training completed in line with CCFv1 plus CCFv2 from start of amended TNA will be looked at collectively for 12 month period in total

Training data and trajectory

Updated 17/11/2023

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Emergency training day					
Staff group	**CCFv1 compliant**	**CCFv2 compliant**	**Booked by December**	**Total projected compliance by December**	**Non-compliant**
Obstetric Consultants	58%	33%		92%	
Obstetric Doctors		39%	57%	96%	
Midwives	49%	20%	30%	99%	
Anaesthetic Consultants	60%	13%	33%	100%	
Anaesthetic Doctors	44%	33%	17%	94%	
HCA/MSW	46%	21%	15%	83%	17% (7 to book)

Fetal wellbeing/surveillance training day

Staff group	CCFv1 compliant	CCFv2 compliant	Booked by December	Total projected compliance by December	Non-compliant
Obstetric Consultants	50%	25%	25%	100%	
Obstetric Doctors		13%	74%	87%	13% (3 to book)
Midwives	37%	44%	10%	91%	

Newborn Life Support training

Staff group	CCFv1 compliant	CCFv2 compliant	Booked by December	Total projected compliance by December	Non-compliant
Paediatric Consultants		78%	22%	100%	
Paediatric Doctors		18%	6%	24%	76% (13 to book)
Midwives	54%	20%	30%	104% - some have done CCFv1 (on MMAT) & CCFv2 (on emergencies) therefore total is >100%	
Neonatal Nurses		67%	7%	73%	17% (4 to book)
Anaesthetic Doctors (*NLS not mandated in CCFv1 for this staffing group)	*N/A	24%	24%	48%	52% (17 to book)
Obstetric Doctors	*N/A	37%	37%	74%	26% (9 to book)
HCA/MSW	*N/A	21%	15%	36%	64% (25 to book)

Learning from incidents

Moderate harm – case 114868

- Clinical detail removed from public Board circulation

- Clinical management of PPH – no concerns
- Graded as moderate harm to reflect systems learning from this event related to a number of Maternity known risks captured on Risk Register:
  - 2398 – risk of delayed treatment due to maternity estate being a separate building
  - 2928 – theatre scrub function
  - 3158 – safe staffing for obstetric theatre

Learning from incidents (continued)

- Key learning identified:
  - Issues with communication (switchboard) when requesting 2222 calls
  - Timing and location of higher risk emergency deliveries
  - Theatre location/equipment/skills in return to theatre/escalating clinical complexity
  - Maternity estate has potential to affect timely provision of emergency care – this case required multiple resources from main hospital, including a theatre team, additional anaesthetic Consultant, Gynae-Oncology team, Critical Care team
  - Impact of significant cases within maternity on wider Trust – Critical Care, theatres, Gynae-Onc staffing present in Maternity – impact on planned elective theatre cases, staffing levels left on Critical Care
  - Mother and baby separated to transfer Mum to HDU – failure to meet critical care quality standards and transitional care aims
  - Consideration of daily on-coming elective operative workload in planning of delivery timing
  - Maternity theatre occupied for management of this case for long period of time – impact on labour ward cases, 2 concurrent patients awaiting delivery delayed, plus delay to planned elective workload
  - Increasing maternal co-morbidities, interventions and acuity make this scenario more likely to occur more frequently
  - High risk mother into birthing room for recovery – small room, difficult to accommodate additional staff/equipment in emergency

Learning from incidents (continued)

- Actions:
  - Meeting arranged with switchboard to discuss standardised emergency call scripts
  - Half day MDT skills drill to be arranged to include main theatre, switchboard, blood bank/porters etc to review processes in situ of major obstetric haemorrhage, including review of stock, additional spare equipment required for escalation of surgical procedures, “grab bag”, theatre familiarisation
  - Review process for “phoning a friend” if additional senior/Consultant support required – high risk period of 7-8am due to traffic delays, or handovers in other areas
  - Out of hours access for additional support not normally required access to maternity
  - Safety messages to include need to look around at end of procedure to ensure any other bleeding is added to measured blood loss for accuracy, consideration of room used for recovery
  - Review patient information to ensure patients are fully aware of separate building when making delivery location choices (in line with Ockenden IEA7)
  - Update maternity risks to reflect this case and separation of mother and baby/failure to meet critical care standards

Feedback from Ockenden Assurance Visit

Microsoft Word Document

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- Assurance visit 13th September 2023
- Full report available
- Pre-visit evidence submitted on request

- Overall a really positive visit was experienced by the review team with support from North Tees 'Peer Review team'. Staff demonstrated commitment and were clearly passionate about their roles, and the service. There were multiple areas of good practice which should be shared to benefit other maternity units in the NENC.

- **Areas of good practice:**
  - Antenatal appointments lengthened to give more time for women with complex needs.
  - Diabetes Team – CQC identified as an area of outstanding practice, focus on gestational diabetes. Utilising MODY assessment (Maturity Onset Diabetes of the Young), we are the only Trust in the region to use this.
  - Good open Multi Disciplinary Team working including the Specialist Midwives collaboration.
  - Work and input from Non Executive Board safety champion, who was well sighted and embedded into the maternity team
  - Floor to Board process evident.
  - Work with Jewish community
  - Open culture, reporting concerns readily.

- **Areas for support and improvement:**
  - Maternity Voice Partnership development
  - UNICEF achievement SCBU – BFI stage 1, in particular training
  - Estates and Ambulance transfer internally (on risk register)
  - SCBU staffing model - escalated to the Trust risk register

Q2 Saving Babies Lives v3 Implementation

Gateshead Health NHS Foundation Trust

Background

Version three of the Saving Babies' Lives Care Bundle (SBLCBv3) published on 31 May 2023, aims to provide detailed information for providers and commissioners of maternity care on how to reduce perinatal mortality across England. The third version of the care bundle brings together six elements of care that are widely recognised as evidence-based and/or best practice:

1. Reducing smoking in pregnancy
2. Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction (FGR)
3. Raising awareness of reduced fetal movement (RFM)
4. Effective fetal monitoring during labour
5. Reducing preterm birth
6. Management of diabetes in pregnancy

The Care Bundle is now a universal innovation in the delivery of maternity care in England and continues to drive quality improvement to reduce perinatal mortality. It has been included for a number of years in the NHS Long Term Plan, NHS Planning Guidance, the Standard Contract and the CNST Maternity Incentive Scheme, with every maternity provider expected to have fully implemented SBLCBv2 by March 2020.

ONS and MBRRACE-UK data demonstrate the urgent need to continue reducing preventable mortality. Developed 4 years after SBLCBv2, Version 3 of the Care Bundle (SBLCBv3) has been developed through a collaboration of frontline clinical experts, service users and key stakeholder organisations. All existing elements have been updated, incorporating learning from the Clinical Negligence Scheme for Trusts: Maternity Incentive Scheme (CNST MIS) and insights from NHS England's regional maternity teams. SBLCBv3 aligns with national guidance from NICE and the RCOG Green Top Guidelines where available but it aims to reduce unwarranted variation where the evidence is insufficient for NICE and RCOG to provide guidance. SBLCBv3 also includes a new element on optimising care for women with pregnancies complicated by diabetes.

As part of the Three Year Delivery Plan for Maternity and Neonatal Services, all NHS maternity providers are responsible for fully implementing SBLCBv3 by March 2024.

Implementation Progress

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Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)
Element 1	Smoking in pregnancy	Partially implemented	40%		0%
Element 2	Fetal growth restriction	Partially implemented	80%		0%
Element 3	Reduced fetal movements	Partially implemented	50%		0%
Element 4	Fetal monitoring in labour	Partially implemented	80%		0%
Element 5	Preterm birth	Partially implemented	89%		0%
Element 6	Diabetes	Partially implemented	50%		0%
All Elements	TOTAL	Partially implemented	74%		0%

- Requirement by March 2024 is 70% across all six interventions (with a minimum of 50% in each intervention)
- Must also be compliant with minimum ambition for each element – risk described in slide 8 of non-compliance with element 1 (MIS Safety action 6) around CO monitoring as booking (90% ambition) and 36 weeks (80% ambition)
- Q2 LMNS validation meeting 20/11/2023

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 15

Report Title:	Mortality Report – six monthly update			
Name of Meeting:	Trust Board			
Date of Meeting:	Wednesday 29th November 2023			
Author:	Andy Ward – Senior Information Analyst – Quality & Patient Safety Wendy McFadden – Strategic Lead Clinical Effectiveness			
Executive Sponsor:	Andy Beeby – Medical Director			
Report presented by:	Andy Beeby – Medical Director			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
	To provide an update on Mortality and Learning from deaths over the last six months.			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☒ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	NA			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	• The Trust's latest publications of national mortality indicators places the Trust with bandings of 'As expected' and 'Lower than expected' for the HSMR and SHMI respectively. • All but 1 death scrutinised by the Medical Examiner's office (referred to the coroner directly by the police) • 99.3% of cases reviewed are identified as being definitely not preventable; 96.4% of cases reviewed were identified as good practice; No potentially preventable deaths were identified during the period. • 97 cases still require a Mortality Council review. • 73 cases still require a ward level review.			
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	To receive the paper for assurance			

Trust Strategic Aims that the report relates to:	**Aim 1** ☒	We will continuously improve the quality and safety of our services for our patients			
	Aim 2 ☐	We will be a great organisation with a highly engaged workforce			
	Aim 3 ☐	We will enhance our productivity and efficiency to make the best use of resources			
	Aim 4 ☐	We will be an effective partner and be ambitious in our commitment to improving health outcomes			
	Aim 5 ☐	We will develop and expand our services within and beyond Gateshead			
Trust corporate objectives that the report relates to:	*List corporate objective reference and headline – e.g., 1.4 Maximise the use of Nervecentre to improve patient care*				
Links to CQC KLOE	Caring ☐	Responsive ☐	Well-led ☐	Effective ☒	Safe ☒
Risks / implications from this report (positive or negative):					
Links to risks (identify significant risks and DATIX reference)	NA				
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒		

Mortality Report

Executive Summary

The latest SHMI was published on 12th October 2023 covering the period from June 2022 to May 2024. The Trust has a SHMI Banding of 'Lower Deaths than Expected' with a score of 0.88.

The HSMR for the period August 2022 to July 2023 is 103.7 showing 'Deaths as Expected'.

All deaths continue to be initially scrutinised by the Trusts Medical Examiner office and are scored or referred for further review where appropriate.

99.3 % of cases are identified as being definitely not preventable.
96.4% of cases reviewed were identified as good practice.
No potentially preventable deaths were identified during the period. (Hogan score >=4)

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

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

1. Introduction:

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

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

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

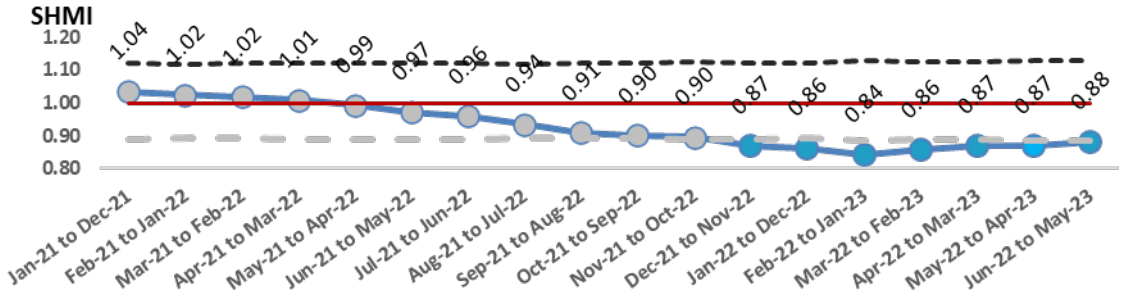
The SHMI compares the actual number of patients who die following hospitalisation (both in- hospital deaths and deaths within 30 days of discharge) at a trust with the number that would be expected to die based on average England figures, given the characteristics of the patients treated there.

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

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

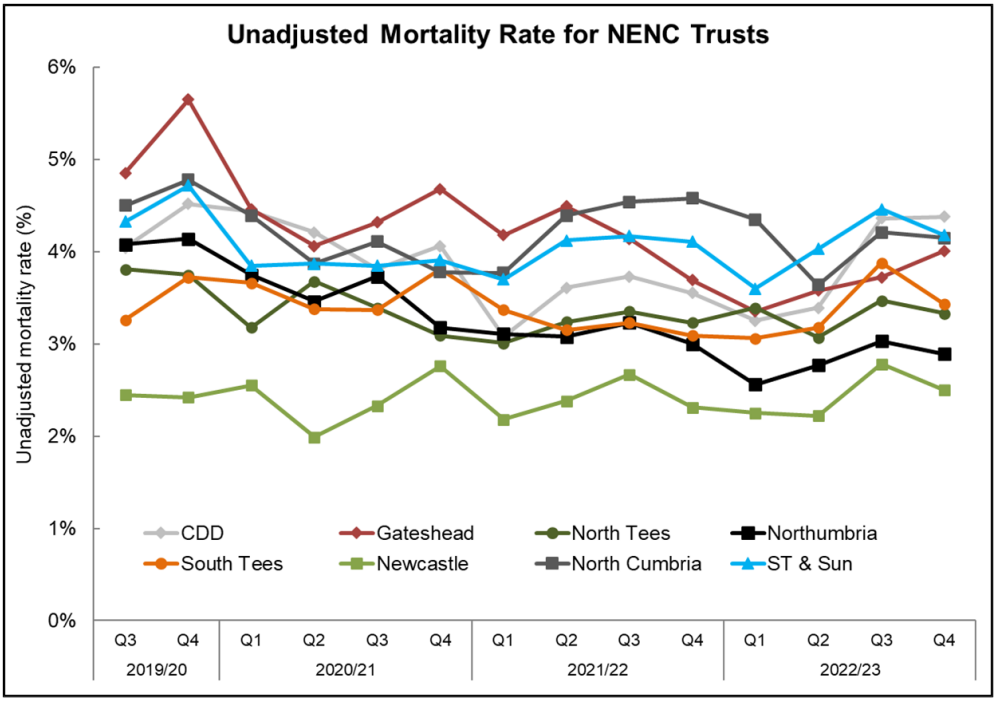
SHMI Trust Position June 2022 to May 2023

The latest SHMI was published on 12th October 2023 covering the period from June 2022 to May 2023. The Trust has a SHMI Banding of 'Lower Deaths than Expected' with a score of 0.88, below the national baseline of 1.00. The Trust has received the banding of 'Lower Deaths than Expected. For the last seven consecutive periods.



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 A&E activity (Planned early 2024-25) then the SHMI score is likely to adjust and increase at that point.

The SHMI for trusts in the region mirrors unadjusted mortality.
Unadjusted mortality varies between trusts from approximately 2% to 6%.
SHMI mortality is 'as expected' in six of the NENC acute trusts for April 2022 to March 2023, County Durham and Darlington is 'higher than expected' and Gateshead is 'lower than expected'.



3. Trust based data analysis:

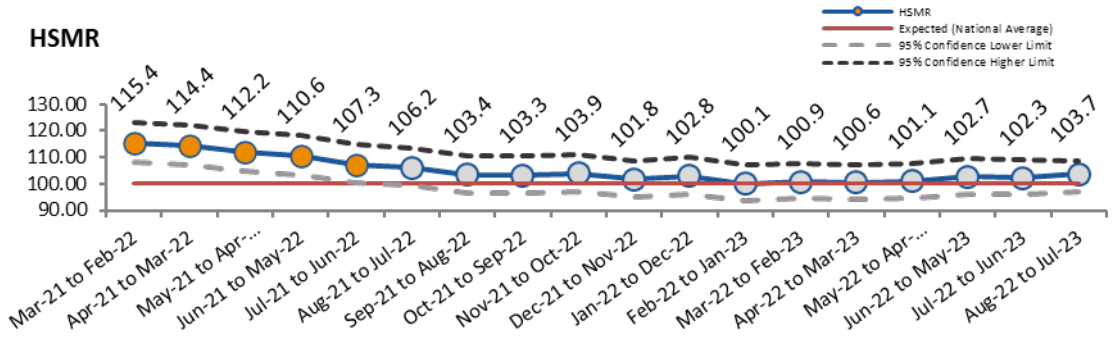
The Hospital Standardised Mortality Ratio (HSMR) is a risk-based assessment using a basket of 56 primary diagnosis groups which account for approximately 80% of hospital mortality.

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

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

HSMR Trust Position August 2022 to July 23

The HSMR for the period August 2022 to July 2023 is 103.7 showing 'Deaths as Expected'. Following a reducing trend, the Trust has a banding od 'Deaths as Expected' for thirteen consecutive periods.



Mortality Alerts from HED (Healthcare Evaluation Data)

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

	Alert	CCS Diagnostic Group	Period	Observed Deaths	Expected Deaths	Obs -Exp	HSMR SHMI / CUSUM Score	% Reviewed (where death within Trust)	% Definitely not preventable	% NCEPOD Good Practice
	No HSMR or SHMI alerts for any individual diagnosis groups in the 12-month period Aug-22 to Jul-23									
	HSMR CUSUM*	Gastrointestinal haemorrhage	Jun-23	6	2.3	3.7	5.94	100%	80.0%	80.0%
	HSMR CUSUM	Cancer of rectum and anus	Jul-23	3	1.2	1.8	5.36	100%	100%	100%
	HSMR CUSUM*	Congestive heart failure	Jul-23	18	11.8	7.2	3.90	100%	100%	94.4%
	HSMR CUSUM	Aspiration pneumonitis; food/vomitus	Jul-23	19	16.1	2.9	3.55	100%	100%	89.5%
	HSMR CUSUM	Respiratory failure; insufficiency; arrest	Jul-23	7	3.6	3.5	3.24	100%	!00%	100%

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

No standard mortality alerts for individual diagnosis groups for the period only CUSUM alerts.

HSMR: CUSUM Alerts

CUSUM alerts flag any diagnosis groups where the observed deaths are higher than the expected deaths for consecutive months. All cases have had some level of scrutiny and were mainly deemed to be 'Definitely not preventable.

Gastrointestinal Haemorrhage

One case recorded by the ME office as 'Some evidence of preventability'. The patient had been put on an end of life pathway early, this was rescinded several days later for further optimisation. The case is yet to be reviewed by the ward team and mortality council and therefore the scoring may change post review.

Congestive Heart Failure

Review of the two cases scoring room for improvement in clinical care indicated the following learning. Both cases were deemed to be definitely not preventable.

Case 1: Multiple ward moves for one patient with a Datix submitted by the ward due to cardiac arrest after moving to ward 4. Case referred by the ME Office to review by ward-based team. Not yet undertaken.

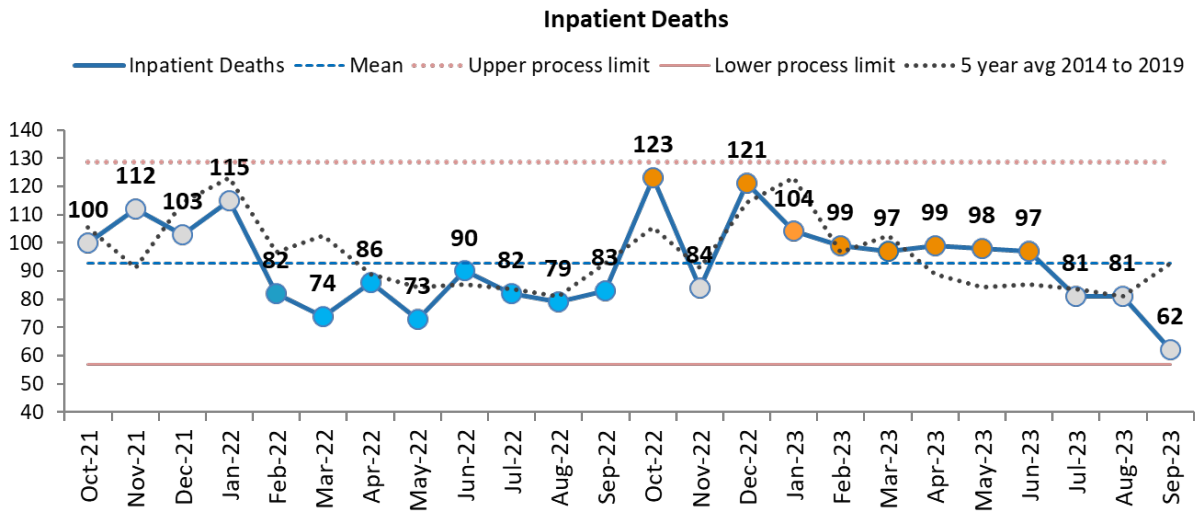
Case 2: An echo was requested urgently on admission but not done. No heart failure team input. This may have helped give realistic end of life expectations. Not referred for further review.

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

Inpatient mortality

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

Inpatient mortality remained below the 18 month mean for 8 months between Feb-22 and Sep-22; then above the 18 months mean between Dec-22 and Jun- 23. Monthly volumes observed are broadly tracking the pre pandemic 5-year average, however higher volumes were observed between Apr-23 to Jun-23; and the September 2023 figure of 62 marks the lowest number of monthly deaths.



4. Learning from Deaths and Mortality Review

Mortality Review Reporting September 2022 to August 2023

Mortality Review Deaths 01/09/2022 to 31/08/2023 — **Data Extracted** 06/10/2023

Deaths in period	Deaths reviewed by Medical Examiner	Learning Disability Deaths reviewed at Mortality Council	Severe Mental Illness deaths reviewed at Mortality Council	Total cases fully reviewed and scored	Number awaiting scoring further scoring at Ward Team and/or Mortality Council	Number awaiting Ward Level review following referral by ME	Cases referred to Ward Team by ME reviewed	of which reviewed in 8 weeks	Cases referred to Mortality Council by ME reviewed	of which reviewed in 12 weeks
1241	1240	4	5	1079	97	73	9	6	42	4
Denominators	1241	8	14				82	79	94	84
	* 99.9%	50.0%	35.7%				11.0%	7.6%	44.7%	4.8%

* 1 case referred to the coroner directly from the police and will not be reiviewed by ME office.

The scores below relate to reviews undertaken by either the Medical Examiner Scrutiny, Mortality Council, or the Ward based team.
Mortality Council review score supercedes the Ward Based Team review score, which in turn supercedes the ME scrutiny.
The figures below represent the outcomes of 1079 cases fully reviewed and scored.

Ward Team Reviews	
274	22.1%

Hogan 1 - Definitely Not Preventable	Hogan 2 - Slight Evidence of Preventabiliy	Hogan 3 - Possibly Preventable (Less than 50:50)	Hogan 4 - Probably preventable (more than 50:50)	Hogan 5 - Strong Evidence Preventable	Hogan 6 - Definitely Preventable	Potentially avoidable deaths (Hogan 4 and above)
99.3%	0.7%	0.0%	0.0%	0.0%	0.0%	0.0%

NCEPOD Score 1 Good Practice	NCEPOD Score 2 Room for improvement - Clinical Care	NCEPOD Score 3 Room for Improvement - Organisational Care	NCEPOD Score 4 Room for Improvement Clinical and Organisational Care	NCEPOD Score 5 Less Than Satisfactory	NCEPOD score 6 Insuficient data
96.4%	0.7%	2.0%	0.7%	0.0%	0.1%

Figures bassed on the following priority order of scoring: Mortality Council > Ward Based Team Review > ME Scrutiny.

99.9% of deaths (all but one) have been reviewed by the medical examiner in the latest reporting period. One death was referred directly to the coroner by the police and therefore won't be reviewed by the medical examiners office.

50% (4/8) of Learning disasblity deaths and 35.7% (5/14) of deaths from patients with severe mental ilnness (SMI) have been reviewed.

Since the introduction of initial scoring by the Medical Examiners office in October 2022 a total of 1079 cases have been fully reviewed (including ward level reviews and or Mortality Council reviews where required). The outcomes from those reviews are:

- 99.3 % of cases are identified as being definitely not preventable.
- 96.4% of cases reviewed were identified as good practice.
- 3.4 % of cases identified room for improvement.
- 0 deaths identified as potentially avoidable (Hogan score >=4)

There are 97 cases that require a further review by either the ward based team or the Mortality Council from deaths witin the period.

In an attempt to decrease the backlog of cases requiring review by the Mortality Council, additional Councils have been held and two existing have been increased in length. Unfortunately, the Council scheduled for September was stood down due to industrial action, this has impacted on the backlog. 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, with an aim to decrease the occasions when the meeting cannot go ahead due to lack of representation.

Outstanding ward level reviews have been escalated to the SafeCare Lead to be discussed with the Clinical Leads to agree a way forward.

Learning from Mortality Council

For the period April – September 2023, 69 cases were reviewed by the Mortality Council. The scores of the review are detailed in the table below:

Hogan 1 – Definitely not preventable	59
Hogan 2 – Slight evidence of prevention	7

NCEPOD 1 – Good practice	39
NCEPOD 2 – Room for improvement clinical care	5
NCEPOD 3 – Room to improve organisation of care	16
NCEPOD 4 – Room to improve clinical and organisational	6

3 cases that were reviewed are to return with further information before a final score can be determined.

Good practice

- Communication with family
- Referrals made to relevant service for further support
- Dementia team liaising with care homes to share good practice
- Number of reasonable adjustments made to support patient with Autism; had a hugely positive impact on the care able to be provided
- Handwritten documentation very clear and concise
- Documentation of DNACPR discussion with patient and family very thorough
- Provision of hospital passports for patients with a learning disability

Learning

Organisation of care

- **Nervecentre** – Nervecentre is used in different ways in different specialties. This makes it difficult to access information. A consistent method is required across the organisation.

- **Support for patients with additional needs –**
  - Reasonable adjustments were made for a patient with autism, this had a positive impact on the care provided, however were facilitated by the Learning Disability Nurse, the patient did not have a learning disability. This emphasised the need for an Autism Lead. This has been raised in a number of forums and is on the corporate risk register.
  - There is currently no information on any trust publications informing patient's that they can request any relevant reasonable adjustments.

- **Alcohol & Smoking Cessation –** in a small proportion of patients at end of life, it was identified that there was a number of potentially inappropriate visits by the smoking and alcohol cessation teams. This was subsequently highlighted to the leads for each team, who confirmed this was an error and have since changed their flagging process to ensure that this does not reoccur.

- **Level 1 care provision –** lack of level 1 care provision has been identified in a number of mortality council reviews as well as a number of patient safety investigations. This has been highlighted to the executive team by the Head of Risk & Patient Safety.

- **Ward moves & transfers -** there were a number of excessive ward moves and transfers of unwell patients without the appropriate handover.

Clinical care

- **NG tube insertion -** During an emergency laparotomy inserting an NG tube should be considered. A patient was eating and drinking with no issues until three days after surgery, there was no clinical indication for an NG tube.

- **Management of Pulmonary Embolism (PE) -** A gap was identified in terms the lack of written guidelines for the treatment of intermediate / sub-massive PEs. Particularly for cases where the risk of intracranial bleed or secondary bleed can be as great as giving a high dose of tinzaparin. These have now been drafted and approved by the VTE Steering Group and is available on the intranet.

- **Post fall protocol –**
  - It is essential that all elements of the post fall protocol are completed – post fall CT scan not undertaken.
  - Relevant neuro observations should be taken and recorded after a patient has fallen.

- **Inpatient Echo provision –** gap identified in terms of echo provision within 48 hours for inpatients – this has been raised within the organisation and a plan to address this is already in place.

- **Medication –** following a drug error involving midazolam, it was identified that there isn't an automatic alert set on the JAC system to alert to the different dosages of midazolam.

- **Documentation –** reminder for teams to document all of the patient's options relating to the surgery they are having.

Quarterly learning bulletins are shared at the Business Unit SafeCare meetings, in the staff newsletter and available on the learning library.

5. Triangulation of mortality data

There are a number of ways in which mortality data in triangulated with other areas within the organisation:

- Any potential patient safety incidents identified during the medical examiner scrutiny are highlighted to the Patient Safety Team for review at the Safety Triangulation Group for a wider discussion and decision as to whether a learning response is required.
- Deaths referred to the coroner which have the potential to progress to an inquest are shared with the Legal Team.
- For deaths reviewed by the Mortality Council, information is obtained in advance of the meeting in relation complaints/PALs, patient safety, legal and safeguarding, to ensure that the full picture is available for the discussion.
- Complaints from relatives/carers of the deceased are shared by the complaints team for discussion at the Mortality Council.
- Outcomes and learning from Inquests for individual patients is presented to the Mortality Council.

6. Recommendation

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

BUSINESS REVIEW

H1 2023/24

CONTENTS

QEF HIGHLIGHTS

- £2.5m profit delivered into GHNFT so far
- Significantly improved colleague engagement
- Stronger QEF/Trust relationship
- Business efficiency programme success
- CDC project progression
- Stronger new business pipeline
- Improved business controls in place
- Changed leadership
- Governance Review Complete
- New Chair

QEF FINANCE

QE Facilities Limited Profit

	2022-23 Outturn	2023-24 YTD	2023-24 Budget
Total	£2.989m	£2.534m	£4.538m
- Internal	£2.783m	£1.664m	£2.664m
- External	(£0.092m)	£0.878m	£1.660m
- Financing and Tax	£0.298m	(£0.008m)	£0.214m

QE Facilities Limited Turnover

	2022-23 Outturn	2023-24 YTD	2023-24 Budget
Total	£72.318m	£37.462m	£75.003m
- Internal	£61.751m	£31.957m	£64.685m
- External	£10.567m	£5.505m	£10.318m

QEF FINANCE - BUSINESS EFFICIENCIES

Target	Achieved to Date	Forecast
£2.31m	£1.30 m	£2.63 m

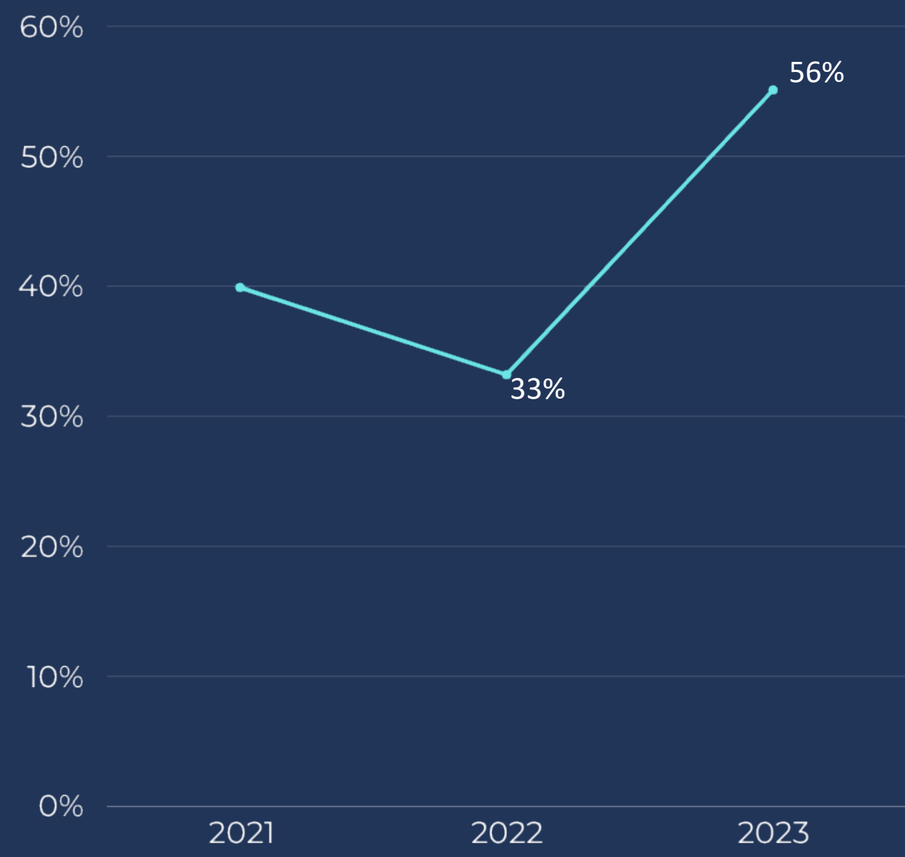
QEF PEOPLE - Engagement

QEF RESPONSE RATE - Staff Survey

55.6%

How?

- Leadership
- Comms plan
- SLT Visibility
- SLT Commitment
- Roadshows



QEF PEOPLE - Development

- Actioned 22/23 staff survey results
  - Leadership Training
  - Appraisal Documentation/process review
  - Effective Management Conversations
  - Developing Effective Teams
  - Core skills focus
  - Created People Action Plan
  - Alignment with Group Policies
    - HR policies/training
    - Recruitment policies
  - Zero tolerance to poor behaviours
  - Focus on absence management
  - Focus on ER casework
  - Health & Wellbeing signposting

QEF ESTATES AND FACILITIES

- Reactive repairs : 12,562 activities complete
- Planned Maintenance: 7,364 activities complete
- Ward refurbishment - Wards 11 & 14
- Ward 28 development
- Ventilation upgrade/backlog maintenance - critical care
- Bowel hub project underway
- CDC (Metro Centre) works commenced
- First stages of Mycad help desk rolled out at Newcastle

CSSD successfully passed their annual surveillance audit

QEF ESTATES AND FACILITIES

- 5* Hygiene rating for Catering Services
- 144,959 patient meals served
- 87% patient satisfaction - catering

Medical Engineering: Runner up at the International RFID journal awards.

QEF TRANSPORT, PORTERING & SECURITY

PMVA department attained Bild certification First Acute Hospital

- 945 Security patrols
- 41,662 patient moves by the Portering team
- 218,293 assets transported
- 2,723 patients transported
- Continued logistics support to Lothian and Coventry Trusts

QEF PHARMACY

- 52,000 items dispensed to date - 89,000 planned this year
- Joined the Trust Pharmacy Clinical Supervision Group alongside the Inpatient Pharmacy team
- ISO 9001 accreditation maintained (internal and external services)
- SACT (Systemic Anti-Cancer Therapy) Homecare.
- QEF Wholesale accepted Cumbria Medical Services as a new customer for the wholesale supply of medicines

QEF BUSINESS DEVELOPMENT

- Improved contract governance and management
- Process for assessing Business Development opportunities
- Improving pipeline
- Extension on Coventry logistics contract
- Fire Risk Assessments; East Durham College
- Growing internal services - new Operated Healthcare Contract for the CDC after construction
- Dispensing additional or ‘co-meds’ prescribed with anti-cancer medicines for the Chemo Day Unit
- Increased profits in VAT Advisory
- Improved external exposure at conference/events

QEF COMMUNICATIONS

2,557 - Followers across Twitter, Facebook & LinkedIn

Held first healthcare Estates and Facilities day

Supported the NHS 75th birthday

Attended local school career fairs

- Strategy developed
- Improved Group interaction
- Established an internal QEF newsletter
- Created a dedicated QEF comms inbox and distribution list of our employees with PC access

CORPORATE SOCIAL RESPONSIBILITY

Sca Fell pike climb to raise funds for Cash for Kids

Gateshead Food bank donations

GATESHEAD FOODBANK
EMERGENCY FOOD FOR GATESHEAD PEOPLE IN CRISIS

Medical Equipment and toys donated to Ukraine aid

QEF CHALLENGES

- Changing Regulatory Frameworks
- ICB/NHSE influences
- NHS funding
- HMRC policy changes
- Leadership Team/Board in Transition
- Ageing estate
- Finance constraints
  - GHNT sustainability
  - SOF 3 status
- Intensified competition
- Stakeholder relations e.g. Trust, NEAS
- Rising cost base
- Staff expectations
- Resource/skills constraints
- Lower margin legacy contracts
- New SFI’s /SLA’s to be agreed

QEF OPPORTUNITIES

- Partnerships
  - Regional & National Collaborations
  - Joint Ventures
  - Shared services
- Growing healthcare market
- Higher margin commercial opportunities
- Revenue leakage
- Greater environmental sustainability
- Enhanced profile/visibility
  - Internally
  - Externally
- Maximise staff engagement
- Further enhance Trust/QEF relationship
- Improvements in internal services
  - Improved productivity
  - Further efficiencies
  - Use of technology/innovation
  - Reviewed scope of services
  - Reduced costs

Meeting:	Trust Board
Chair:	Alison Marshall
Financial year:	2023/24

	Lead	Type of item	Public/Private	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 Assurance	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	√	√	√
Inpatient Safer Nursing Care Staffing Bi-Annual 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		√	
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			√
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	√		