Board of Directors (Part 1 – Public)

A meeting of the Board of Directors (Part 1 – Public) will be held at 09:30am on 5 June 2024, in Room 3, Education Centre, Queen Elizabeth Hospital / via Microsoft Teams

AGENDA

No	Start time	Item	Purpose	Lead	Paper / Verbal
1.	09:30	Welcome	Information	Chair	Verbal
2.	09:33	Declarations of interest	Information	Chair	Verbal
3.	09:34	Apologies for absence	Information	Chair	Verbal
4.	09:35	Minutes of the last meeting held on 31 January 2024	Decision	Chair	Paper
5.	09:40	Action log and matters arising	Assurance / decision	Chair	Paper
6.	09:45	Patient and Staff Story – A legacy of care: celebrating 80 years of the Trust's Maternity Unit	Assurance	Head of Midwifery	Presentation
ITEMS FOR DECISION					
7.	10:00	Board Assurance Framework 2024/25 – approval of opening position	Decision	Company Secretary	Paper
ITEMS FOR ASSURANCE					
8.	10:10	Chair's Report	Assurance	Chair	Paper
9.	10:20	Chief Executive's Report	Assurance	Chief Executive	Paper
10.	10:30	Governance Reports:			
		i) Organisational Risk Register	Assurance	Chief Nurse	Paper
11.	10:40	Assurance from Board Committees:			
		i) Finance and Performance Committee – April and May 2024	Assurance	Chair of the Committee	Paper
		ii) Quality Governance Committee – April 2024	Assurance	Chair of the Committee	Paper
		iii) Digital Committee – May 2024	Assurance	Chair of the Committee	Paper
		iv) People and Organisational Development Committee – May 2024	Assurance	Chair of the Committee	Paper
12.	11:05	Leading Indicators			
		i) Leading Indicators 2023/24 closure report	Assurance	Group Director of Finance and Digital	Paper
		ii) Leading Indicators 2024/25 report	Assurance	Group Director of Finance and Digital	Paper
13.	11:20	Maternity Update			
		i) Maternity Integrated Oversight Report	Assurance	Head of Midwifery	Paper
		ii) Maternity and Midwifery Staffing Report	Assurance	Head of Midwifery	Paper

No	Start time	Item	Purpose	Lead	Paper / Verbal
14.	11:35	Nurse Staffing:			
		i) Exception Report	Assurance	Chief Nurse	Paper
		ii) Bi-annual Inpatient Safer Nursing Care Staffing Report	Assurance	Chief Nurse	Paper
15.	11:50	Learning from Deaths Six Monthly Report	Assurance	Interim Medical Director	Paper
16.	12:00	QE Facilities Six Monthly Update Report	Assurance	QE Facilities Managing Director	Paper
ITEMS FOR INFORMATION / MEETING GOVERNANCE					
17.	12:10	Cycle of Business	Information	Company Secretary	Paper
18.	12:15	Questions from Governors in Attendance	Discussion	Chair	Verbal
19.	12:25	Any Other Business	Discussion	Chair	Verbal
20.	12:30	Date and Time of Next Meeting – 09:30am on Wednesday 31st July 2024	Information	Chair	Verbal
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					

Board of Directors (Part 1 – Public)

Minutes of a meeting of the Board of Directors (Part 1) held at 9.30am on Wednesday 27th March 2024 in Room 3, Education Centre, Queen Elizabeth Hospital and via MS Teams.

Name	Position
Members present	
Mrs Alison Marshall	Chair
Mr Adam Crampsie	Non-Executive Director
Mrs Trudie Davies	Group Chief Executive
Mr Gavin Evans	Managing Director for QE Facilities
Dr Gill Findley	Deputy Chief Executive / Chief Nurse
Mr Neil Halford	Medical Director of Operations
Mrs Joanne Halliwell	Group Chief Operating Officer
Mr Martin Hedley	Non-Executive Director
Mrs Kris Mackenzie	Group Director of Finance and Digital
Mr Andrew Moffat	Non-Executive Director
Mrs Hilary Parker	Non-Executive Director
Mrs Maggie Pavlou	Non-Executive Director
Mr Mike Robson	Vice Chair / Non-Executive Director
Mrs Anna Stabler	Non-Executive Director
Mrs Amanda Venner	Group Director of People & Organisational Development
Attendees present	
Ms Emma Atkinson	Macmillan Dietitian (24/03/06)
Mrs Jennifer Boyle	Company Secretary
Ms Nicola Bruce	Interim Director of Strategy, Planning and Partnerships (24/03/09)
Ms Abigail Garbutt	Macmillan Dietitian (24/03/06)
Ms Tracy Healy	Freedom to Speak Up Guardian (24/03/21)
Mrs Karen Parker	Head of Midwifery (24/03/22)
Ms Diane Waites	Corporate Services Assistant
Governors and Observers	
Dr Andy Lowes	Staff Governor
Apologies	

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24/03/01	**Chairs Business:** The meeting being quorate, Mrs A Marshall, Chair, declared the meeting open at 9.30 am and confirmed that the meeting had been convened in accordance with the Trust's Constitution and Standing Orders. She welcomed those present including the Trust's Governors and public observers.	

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24/03/02	**Declarations of Interest:** Mrs Marshall requested that Board members present report any revisions to their declared interests or any additional declaration of interest in any of the items on the agenda.	
24/03/03	**Apologies for Absence:** There were no apologies received.	
24/03/04	**Minutes of the Previous Meeting:** The minutes of the meeting of the Board of Directors held on Wednesday 31st January 2024 were approved as a correct record subject to the following minor amendments: 24/06 Staff Story Mentoring Programme (page 4) – "Trust's Global Ethnic Minority (GEM) Network" should read *Trust's Global Ethnic Majority (GEM) Network.* 24/08 Emergency Preparedness, Resilience and Response (EPRR) Core Standards Self-Assessment Report (page 5) – "Mrs Halliwell felt that this was positive position following the complexities" should read *Mrs Halliwell felt that this was a positive position reflecting the complexities of the new evidence requirements.*	
24/03/05	**Matters Arising from the Minutes:** The Board reviewed the action tracker as below: • Action 23/206 re. Freedom To Speak Up Guardian Report and providing details to Board members regarding training. Now compliant therefore action was agreed for closure. • Action 23/247 re. Integrated Oversight Report (IOR) and Leading Indicators and how future incident rates should be reported. Consideration still required however this will be discussed at the Quality Governance Committee. It was therefore agreed to close this action. • Action 24/08 re. EPRR core standards self assessment report and six monthly reports to be presented to Quality Governance Committee. This has been added to the cycle of business therefore it was agreed to close this action. • Action 24/11 re. Board Committee terms of reference. Amendments have been made to the Group Audit Committee and Group Remuneration Committee terms of reference to reflect feedback received therefore action agreed for closure.	

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	• Action 24/12 re. Assurance from Board Committees and suggestion to amend the Finance and Performance Committee terms of reference to include the Alliance discussions. This has been completed and factored into the cycle of business therefore action agreed for closure. • Action 24/14 re. Leading Indicators and development of new set of key performance standards. This was discussed at the Board Development Day in February 2024 and a paper is being presented to the Board on today's agenda. This action was therefore 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.	
24/03/06	**Staff Story – Dietetic Oncology Service:** The Board welcomed Emma Atkinson and Abigail Garbutt, Macmillan Dietitians, who provided a summary of the Trust's oncology dietetic services. They reported that the demand for oncology dietetic services has increased in Gateshead and explained the difficulties in not being able to meet the demands due to lack of sufficient resources and the impact this had on the staff and patients. Ms Atkinson reported that work has been undertaken to develop the service which includes funding from Macmillan to support a secondment post and there are further aims to expand the service. Ms Garbutt highlighted the progress made to the service following the secondment which has helped to reduce waiting times and increase capacity as well as improving the quality of the service and patient experience. She reported that the reputation of the service has also improved and one of the staff members won a Star Award. A five-year plan is in place and the team are committed to maintaining a sustainable service. Mr A Crampsie, Non-Executive Director, raised some concerns in relation to waiting times however Ms Atkinson reported that a business case was being developed to provide an additional post which would support the aim to reduce lengths of stay and improve waiting times. Mrs A Stabler, Non-Executive Director, highlighted that there are podcasts available for cancer patients and queried whether discussions around nutrition could also be included. Ms Atkinson reported that this has been done however the team are looking at providing more.	

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	The Board thanked Ms Atkinson and Ms Garbutt for sharing their experiences and Dr G Findley, Deputy Chief Executive and Chief Nurse, complimented the team for their passion and commitment to patient care and thanked Ms Atkinson and Ms Garbutt for their hard work. Ms Atkinson and Ms Garbutt left the meeting.	
24/03/07	**Governance Reports:** **Corporate Governance Manual (Standing Orders, Standing Financial Instructions, and Scheme of Delegation)** Mrs J Boyle, Company Secretary, presented the draft revised Corporate Governance Manual which consists of the Board of Directors Standing Orders, Standing Financial Instructions and Scheme of Delegation. She reported that the manual has not been reviewed since 2019 therefore a comprehensive review has taken place incorporating recommendations and benchmarking against other trusts. The documents have been reviewed by the Group Audit Committee and are recommended for approval. Mrs K Mackenzie, Group Director of Finance and Digital, highlighted that significant changes have been made to the Standing Financial Instructions to ensure robust processes are in place for the Finance and Performance Committee, Group Audit Committee and Executive Management Team. Mr M Robson, Chair of the Finance and Performance Committee, thanked Mrs Boyle and Mrs Mackenzie for their work in updating the manual and felt that it was important to ensure relevant training is provided to staff to understand the requirements and ensure processes are embedded. Mrs Marshall queried whether a review would be included in the Internal Audit Plan to provide further assurances and Mrs Mackenzie reported that this should be included in the plan for 2025/26 however will confirm with Audit One. The Board felt that it was important that the Manual is considered as a “live” document and discussed the potential changes in relation to the work being completed around committee structure and Alliance work therefore this will be incorporated into the manual in due course. After further discussion, it was: **RESOLVED:** to approve and adopt the Corporate Governance Manual and its component parts on the recommendation of the Group Audit Committee.	Kmac

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	QE Facilities' Standing Financial Instructions and Scheme of Delegation Mr G Evans, QE Facilities Managing Director, presented the QE Facilities Standing Financial Instructions and Scheme of Delegation for formal ratification. He reported that the documents have been approved by the QE Facilities Board in December 2023 and have also been presented to the Group Audit Committee in March 2024 for information and comparability with the Trust versions. Following a query from Mr A Crampsie, Non-Executive Director, relating to the version control section, Mr Evans will ensure this is updated. Mrs Marshall also recommended that the Articles of Association would require review in conjunction with the approved Standing Financial Instructions. The Board thanked the teams for their work undertaken around the extensive review of the documents and after consideration, it was: **RESOLVED:** to ratify the QE Facilities Standing Financial Instructions and Scheme of Delegation.	GE
24/03/08	**Deputy Chair and Senior Independent Director Roles:** Mrs J Boyle, Company Secretary, presented the formal role descriptions and proposed appointment processes for the Deputy Chair and Senior Independent Director (SID). She reported that the roles have been reviewed and a new approach proposed to support succession planning, personal development and good governance. This will enable two separate Non-Executive Directors to undertake these additional responsibilities. There are no additional financial implications associated with the proposals. Both positions are appointments made by the Board with consultation with the Council of Governors required in relation to the SID. Mrs Boyle explained that expressions of interest will be sought from Non-Executive Directors however the Board noted that in accordance with the Provider Code of Governance, the Audit Committee Chair is ineligible to apply. If more than one candidate expresses an interest in each post, it is proposed that a formal process of appointment will be undertaken with delegated authority from the Board to enable the Chair and Chief Executive to oversee the process and make the appointment. The appointments will be effective from 1st July 2024 and formally ratified by the Board in June 2024. Following consideration, it was:	Cycle of business

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	RESOLVED: i) to approve the overall plan to formally separate the Deputy Chair and SID roles ii) to approve the role descriptions iii) to approve the proposed appointment processes for both contested and uncontested scenarios, providing the Chair and Chief Executive with delegated authority to make the appointments	
24/03/09	**Strategic Objectives 2024/25 and Leading Indicators:** Mrs J Halliwell, Group Chief Operating Officer and Ms N Bruce, Interim Director of Strategy, Planning and Partnerships presented the proposed Strategic Objectives and Leading Indicators for 2024/25. Mrs Halliwell highlighted that the national operating planning guidance has still not yet been received however the objectives and indicators have been progressed following discussion at the last Board Development Day. She reported that some additional objectives have been proposed to reflect opportunities in relation to the Alliance work and each objective has been linked with lead indicators and breakthrough objectives. These will have an allocated Executive Lead with the Chief Executive leading on the Alliance objectives. The Board felt that the objectives were much improved and provided a better understanding however discussion took place in relation to how outputs would be measured, and it was felt that some required further specification. It was suggested that it would be beneficial for the Strategic Aims, Objectives, Lead Indicators and Breakthrough Indicators to be presented together and this will be looked at. Mrs T Davies, Chief Executive, reminded the Board that the Tier One Committees will have allocated objectives to be monitored and an associated Board Assurance Framework extract to seek assurance over the management of the linked strategic risk. Mr A Crampsie, Non-Executive Director, commented on Strategic Aim 4 *We will be an effective partner and be ambitious in our commitment to improving health outcomes* and felt that it would be beneficial to include reference to the Voluntary, Community and Social Enterprise (VCSE) sector. He also highlighted that there was only one lead indicator identified for Strategic Aim 5 *We will develop and expand our services within and beyond Gateshead* and felt that this may need some further review. Mrs Halliwell explained that work with the VCSE sector was covered within Gateshead Place and there was no current indicator aligned however will review this. Mr M Robson, Vice Chair, queried whether Aim 5 should include the Alliance work and Mrs Davies explained that this could include opportunities for research and innovation therefore this will be considered.	

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	Mr Crampsie felt that there should also be some references to sustainability and social values and Mr G Evans, QE Facilities Managing Director, reported that these elements are included in the Estates Strategy and Green Plan. It was identified that the Green Plan required greater visibility at Board and this would be factored into the cycle of business. Discussion took place around whether a Group Strategic Aim should be introduced to demonstrate improving outcomes however Mrs Halliwell reminded the Board of previous discussions whereby it was agreed not to change the Trust's Strategic Aims therefore Mrs Davies felt that further discussion was required. Mrs J Boyle, Company Secretary, highlighted that due to the new financial year, the draft objectives would need to be used to ensure the Board Assurance Framework continues to be monitored via the Tier One Committees and Dr G Findley, Deputy Chief Executive and Chief Nurse, commented that the consultation for the Quality Account priorities is still ongoing and also needs to be approved via the Quality Governance Committee. Mrs Boyle reported that an Extraordinary Board meeting is planned to take place prior to the Board Development Day on Wednesday 24th April 2024 which would provide the opportunity for the Board to review the revised objectives. This approach was therefore agreed. It was agreed that Mrs Halliwell and Ms Bruce would collate the feedback from the Board and update the draft strategic objectives to be presented at the Extraordinary Board meeting in April 2024. This would include mapping the strategic objectives, leading indicators and breakthrough indictors together. Following further discussion, it was: **RESOLVED:** to note the work which had taken place to develop the strategic objectives and leading indicators and review a revised draft at the Extraordinary Board meeting in April.	Cycle of business JH/NB
24/03/10	**Board Assurance Framework Closure Report 2023/24:** Mrs J Boyle, Company Secretary, provided the Board with the closing position of the Board Assurance Framework (BAF) for 2023/24. The BAF has been reviewed and updated at each Board Committee meeting since the full BAF was presented to the Board in November 2023 and Mrs Boyle highlighted that two risks have been managed effectively to achieve the target risk score relating to improving our maternity services (SA1.1) and implementing a continuous quality improvement plan (SA1.2). Mrs Boyle drew attention to the next steps which includes the link to the new Strategic Objectives as discussed earlier in the meeting. The Board	

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	are also due to review risk appetite as part of the next Board Development Day in April 2024 and will inform the setting of the target risk levels within the BAF. The Board noted that any remaining gaps in control or assurance not aligned to a strategic objective and associated risk area will be transferred to the action logs of the respective Committee to ensure that gaps are covered. Mrs A Stabler, Non-Executive Director and Chair of the Quality Governance Committee, highlighted that concerns had been raised by the Quality Governance Committee in relation to SA4.1 (to identify key local health inequalities challenges and ensure improvement plans are in place by March 2024) therefore this will be looked at going forward. Mr M Robson, Vice Chair and Chair of the Finance and Performance Committee, reported that additional controls had been identified on the Organisational Risk Register however would not affect the risk scoring. After discussion, it was: **RESOLVED:** to approve the closing position of the BAF and take assurance that this has been actively utilised to seek assurance over the control and assurance environment during the year.	
24/03/11	**Constitutional Amendment:** Mrs J Boyle, Company Secretary, presented the proposed changes to the Constitution in relation to appointed Governor positions on the Council. She reported that there are number of vacant appointed Governor positions on the Council and reflects changes that have impacted on local partner organisations. The paper therefore proposes a change to the make-up of the appointed Governor positions on the Council to ensure that key partners are represented. It had been proposed to replace the Gateshead Diversity Forum with Healthwatch Gateshead however some concerns have been raised by Healthwatch around the potential impact on their independent role and they propose to observe some meetings prior to confirmation. Therefore the related recommendation has been withdrawn. It is also proposed to remove the Clinical Commissioning Group (CCG) seat from the composition of the Council noting that the organisation no longer exists and relationships with the Integrated Care Board are already in place. Mrs Boyle also reminded the Board that a number of core governance documents have been reviewed recently including the Governor Code of Conduct and the Council of Governors' Standing Orders. They are both currently appended to the Constitution however have their own	

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	processes for approval therefore the Council of Governors have formally approved the separation of the new Code of Conduct however the Standing Orders agenda item was deferred and will be reconsidered at the next Council meeting. Following consideration, it was: **RESOLVED:** i) to remove the CCG seat from the composition of the Council ii) to formally separate the Governor Code of Conduct and Council of Governors' Standing Orders from the Constitution so they are no longer appendices.	
24/03/12	**Annual Declarations of Interest:** Mrs J Boyle, Company Secretary, presented the Annual Declaration of Board Members Interests. Mrs Boyle highlighted that this also includes the declaration of interest for Mr Gavin Evans, QE Facilities Managing Director, as a new Board member. Following consideration, it was: **RESOLVED:** i) to approve and record in the Board minutes the declared interests ii) to note that the next annual review of the declaration of Board members' interests will take place in March 2025.	
24/03/13	**Care Quality Commission Statement of Purpose:** Dr G Findley, Deputy Chief Executive and Chief Nurse, provided an updated Care Quality Commission (CQC) Statement of Purpose to the Board. Dr Findley reported that the Statement of Purpose is a CQC registration requirement document that must be regularly reviewed and updated to reflect changes in the organisation and the description and location of services. She confirmed that all locations have previously appeared on the Trust's CQC registration certification and includes the "Good" outcome from the 2023 Maternity focussed inspection and updated bed numbers, whole time equivalent staff and annual review figures. Following a query from Mr M Robson, Vice Chair, in relation to the inclusion of the Bensham Hospital site, Dr Findley confirmed that this had been the main change following last year's statement of purpose and is included in the main document. Mrs H Parker, Non-Executive Director, queried whether the CQC registration for QE Facilities should be	

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	included however Dr Findley confirmed that this was included in a separate registration certification. After consideration, it was: **RESOLVED:** to approve the CQC Statement of Purpose and receive for assurance.	
24/03/14	**Chair's Report:** Mrs A Marshall, Chair, gave an update to the Board on some current issues, events and engagement work taking place across the organisation. This is the first iteration of the report therefore any feedback will be welcomed. She shared the sad news of the loss of two valued colleagues, Joanne Donnelly, a Sister in our Emergency Department for many years, passed away last month and Alison Sidebotham, a member of our finance team, sadly and unexpectedly passed away earlier this month. The Board's thoughts are with the family and friends of both Alison and Joanne at this time and colleagues have been paying their respects and sharing their memories through books of condolence, which will be shared with the families. Mrs Marshall provided some Governor and member updates which included the Medicine for Members' event on 11th March 2024. She highlighted that the event showcased the fantastic work of our community teams in caring for our patients and included a marketplace event with stalls hosted by different community services which was followed by an informative presentation from the teams in our lecture theatre. She also reported that the Trust will shortly be welcoming two new appointed Governors to the Council – Sasha Ban (Assistant Professor of Nursing, Midwifery and Head) representing Northumbria University and Councillor Dot Burnett representing Gateshead Council. Updates were also provided around stakeholder events and partnership working including the work taking place around the Great North Healthcare Alliance and a detailed report will be shared with the Board in Part 2 of the meeting. Mrs Marshall highlighted the work taking place around the Centre of Excellence for Women's Health including the Women's Health Hub at Gateshead Place which has seen excellent engagement across the Trust and wider system. Mrs Marshall drew attention to the Star of the Month nominations. The winners, Kelly Riley from Maternity and Sue Bunting from Accident and Emergency, were congratulated by the Board. Following discussion, it was:	

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	RESOLVED: to receive the report for assurance.	
24/03/15	**Chief Executive's 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 1: *we will continuously improve the quality and safety of our services for our patients* – which highlights that the Trust's maternity care was ranked 5th out of 61 providers across the country in the annual Care Quality Commission (CQC) maternity survey. In relation to Strategic Aim 2: *we will be a great organisation with a highly engaged workforce* – Mrs Davies highlighted that the results of the NHS Staff Survey have been shared and will be discussed in more detail later in the meeting. In relation to Strategic Aim 3: *we will enhance our productivity and efficiency to make the best use of resources* – Mrs Davies reported that the Trust continues to see improvements in performance against key metrics and this included being recognised in a BBC article as one of the top ten trusts nationally with the shortest waits for routine treatment in January 2024. In relation to Strategic Aim 4: *we will be an effective partner and be ambitious in our commitment to improving health outcomes* – Mrs Davies drew attention to the work Dr Andy Lowes, Consultant and Staff Governor, has been undertaking with schools in our community to produce artwork promoting organ donation and in February unveiled an incredible bespoke piece of artwork created by XP Gateshead school. 'Being Human' is displayed near the Windy Nook entrance. Work has also commenced on the Jubilee Courtyard Garden which will provide a safe and supportive outside space for our patients, including critical care patients, stroke rehabilitation patients and dementia patients. It will also provide families of organ donors with a memorial space and provide a quiet and tranquil environment for visitors and colleagues. This has been made possible through our Gateshead Health Charity. In relation to Strategic Aim 5: *we will develop and expand our services within and beyond Gateshead* – Mrs Davies drew attention to some of the work being undertaken around the Alliance and recognition of services including obstetrics, midwifery and urology and some good developments are being made. Building work is now underway for the new MetroCentre Community Diagnostic Centre (CDC) in partnership with Newcastle Hospitals and the aim is to offer 145,000 appointments per year and create 134 jobs when it opens in October 2024.	

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	Following a query from Mrs A Stabler, Non-Executive Director, in relation to discussions which have taken place around realigning posts, Mrs Davies explained that it is the Trust's ambition to retain posts and maintain its workforce however funding has been provided to create new roles within the CDC which will benefit the community and ensure service delivery. After further discussion, it was: **RESOLVED:** to receive the report for assurance.	
24/03/16	**Governance Reports:** **Strategic Objectives Quarter Four update:** Ms N Bruce, Interim Director of Strategy, Planning and Partnerships, presented the report which provides assurance over progress made towards the delivery of the strategic objectives for 2023/24. She informed the Board that the strategic objective delivery action plans have been developed by Executive Director owners of each of the objectives and have been reviewed by the relevant Board Committee. The risks identified within the report will be reviewed as part of the 2024/25 transitional work and addressed going forward. Following a query from Mr A Crampsie, Non-Executive Director, in relation to the format of the report, Mrs Bruce reported that this is being reviewed for future reports. After consideration, it was: **RESOLVED:** to note progress towards delivery of the strategic objectives in 2023/24. **Organisational Risk Register (ORR):** Dr G Findley, Deputy Chief Executive and Chief Nurse, 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 18th January 2024 to 18th March 2024. Dr Findley reported that there are currently 16 risks on the ORR. Following the Executive Risk Management Group meeting in March 2024, there have been no additions to the ORR, 3 reductions and 2 removals. Compliance with action reviews is currently at 100% which demonstrates active mitigation of organisational risks as part of the risk management framework. The top three organisational risks remain the same and relate to finance, performance and workforce.	

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	Mr A Moffat, Non-Executive Director and Audit Committee Chair, highlighted that compliance with risk and action reviews was discussed by the Audit Committee and queried the process around monitoring risk reviews. Dr Findley explained that 15 plus risks are reviewed by the Executive Risk Management Group therefore assurance is being provided that these are being addressed. Further discussion took place around the presentation of the new In-Phase reports and Dr Findley explained that this is being reviewed for future Board reports. After consideration, it was: **RESOLVED:** to receive the report for assurance. Ms Bruce left the meeting.	
24/03/17	**Assurance from Board Committees:** The Board noted the new format for the Committee escalation and assurance reports which will provide improved processes to identify areas of concerns and ongoing monitoring of assurances. **Finance and Performance Committee:** Mr M Robson, Committee Chair, provided a brief verbal overview to accompany the narrative report following the February 2024 meeting and provided a verbal update of the meeting held yesterday (26th March 2024). Mr Robson reported that there were no issues identified as requiring escalation to the Board for further action however drew attention to some of the areas subject to ongoing monitoring where some assurance has been noted and/or further assurance is sought: • Detailed discussions took place in relation to the draft capital plan and further details have been requested in relation to underpinning plans. • Further detail has also been requested in relation to the monitoring of cost reduction plans and back to basics themes. • A report has been requested in relation to the paediatric autism pathway plan. • Further detail has been requested in relation to the internal audit actions relating to patient monies. Positive assurances were agreed in relation to: • Integrated Care System Digital Diagnostics – this will be discussed in more detail in Part 2 of the Board. • Financial Revenue Report. • Budget setting and year end target met however remaining risks were noted.	

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	• Performance metrics – positive movement seen on a number of metrics in the Leading Indicator report. Mr Robson highlighted that Risk 3127 has been closed as it relates to the current financial year and has been agreed that the current risk rating be reduced to 4 to match the target risk rate. Risk 3261 which relates to 52 week waits will be reviewed as it was felt that the zero target will not be achieved by year-end. **Quality Governance Committee:** Mrs A Stabler, Committee Chair, provided a brief verbal overview to accompany the narrative report following the February 2024 meeting. She reported that there were no items for escalation however highlighted the continued risk in relation to the Learning Disabilities service due to long term sickness and an update will be provided at the next meeting regarding any key risks and mitigations. She drew attention to other key areas of discussion relating to the Internal Audit Reports for the Word Health Organisation (WHO) surgical checklist and Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) and further reports will be presented to the Committee at the next meeting. **Digital Committee:** Mr A Moffat, Committee Chair, provided a brief verbal overview to accompany the narrative report following the February 2024 meeting. He reported that there no issues identified as requiring escalation to the Board for further action however drew attention to some of the areas subject to ongoing monitoring where some assurance has been noted and/or further assurance is sought: • The key performance indicator in relation to information asset owners has marginally improved and mitigations are in place around training and structural changes. • Some concerns have been raised in relation to the integrated Electronic Patient Record procurement (EPR) implementation date however action will be taken forward with digital leaders and the Executives to develop a decision making timeline around procurement. Positive assurances were agreed in relation to: • Work taking place in relation to addressing health inequalities through digital exclusion and the need for this to be tied into a visible work strand across the Trust. There have been no changes to any of the digital risk scores.	

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	People and Organisational Development Committee: Mrs M Pavlou, Committee Chair, provided a brief verbal overview to accompany the narrative report following the March 2024 meeting. She reported that there no issues identified as requiring escalation to the Board for further action however drew attention to some of the areas subject to ongoing monitoring where some assurance has been noted and/or further assurance is sought: • The Committee reviewed the Staff Survey Results and concerns were raised in relation to the number of GEM colleagues experiencing bullying and harassment including of a sexual nature. It was noted that a programme of work is underway on zero tolerance and that new national guidance in relation to a Sexual Safey Policy will form part of a wider piece of work being taken forward with staff networks on this issue. • The Committee were not fully assured following the Gender Pay Gap report however they will be reviewed and amended before the submission deadline at the end of March 2024. Discussions have taken place at the Executive Management Team meeting. • Some concerns were raised following the presentation of the Guardian of Safe Working report particularly around the level of support provided by the medical staffing team and this is being addressed. • Discussion took place around Equality, Diversity and Inclusion and it was felt that an overarching approach would be beneficial which will be monitored going forward including clearer metrics. **Group Audit Committee:** Mr A Moffat, Audit Committee Chair, provided a brief verbal overview to accompany the narrative report following the March 2024 meeting. He reported that there no issues identified as requiring escalation to the Board for further action however drew attention to some of the areas subject to ongoing monitoring where some assurance has been noted and/or further assurance is sought: • The Committee was pleased to see an improvement in the implementation of internal audit recommendations following the matter being raised with the Chief Executive by the Committee, but felt that this improved performance needed to be sustained. Positive assurances were agreed in relation to: • The Standing Orders and Standing Financial Instructions for the Trust and for QEF were reviewed by the Committee and were recommended for approval and adoption. Mrs Marshall thanked the Committee Chairs for their reports, and it was noted that the assurance report for the QE Facilities Board will be reviewed in Part 2 of the meeting due to some of the commercial areas included. After consideration, it was:	

Agenda Item No		Action Owner
	RESOLVED: to receive the reports for assurance	
24/03/18	**Annual Staff Survey Results:** Mrs A Venner, Group Director of People and Organisational Development, provided an insight into the 2023 staff survey results and shared plans for the year ahead in response to the feedback received. She reminded the Board of the progress undertaken around the actions in place following the last survey which included the appointment of a full time Freedom to Speak Up Guardian, the appointment of a permanent Health and Well-Being manager and increased communications around speaking up and discriminatory behaviour. There has been an overall Group completion rate of 50% and Mrs Venner drew attention to top 5 and bottom 5 responses for the Trust and QE Facilities. This demonstrates that there is further work to do on feeling valued and burnout however progress is being made. There is evidence that some Global Ethnic Majority (GEM) colleagues have experienced discrimination - focussed work is taking place around this and progress will be monitored. Mrs Venner reported on the key finding and next steps which includes analysing the data to inform the culture programme actions and themes will be shared with the Senior Management Team, Clinical Strategy Group and other key stakeholders. Data around the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) will inform the Equality, Diversity and Inclusion Manager's portfolio of work and high impact actions to produce an overarching action plan. Following a query from Mr A Moffat, Non-Executive Director, on response rates Mrs Venner reported that some comparison work will be undertaken and Mrs T Davies, Group Chief Executive, reported that this will form part of the Alliance work and Northumbria Healthcare are working with the Trust to support this. Following further discussion, it was: **RESOLVED**: to receive the reports for assurance	
24/03/19	**Finance Report:** Mrs K Mackenzie, Group Director of Finance and Digital, provided the Board with a summary of financial performance as of 29th February 2024 (Month 11) for the Group (inclusive of the Trust and QE Facilities, excluding Charitable Funds).	

Agenda Item No		Action Owner
	Mrs Mackenzie highlighted some of the key points and reported that the Trust had approved a planned deficit of £12.588m for 2023/24 however following an additional Integrated Care System allocation of £4.636m, the deficit plan has been revised to £7.952m. The Trust is therefore forecasting to achieve the revised planned deficit for 2023/24. Mrs Mackenzie also reminded the Board that it was agreed that an overspend of £1m against the original Capital Departmental Expenditure Limit (CDEL) was approved however only £600k has been spent and this has also been covered by additional allocations. After consideration, it was: **RESOLVED:** to receive Month 11 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.	
24/03/20	**Leading Indicators:** Mrs K Mackenzie, Group Director of Finance and Digital, presented the report which highlights progress, risk and assurance in relation to the Trust's Leading Indicators and Elective Recovery Programme for the reporting period of February 2024. She drew attention to the summary provided in relation to elective recovery and the Board acknowledged the significant achievements in relation to waiting lists and ambulance handovers. Significant improvements have also been made around long waiters and the Trust will not have patients wating longer than 65 weeks by year end. Following a query from Mrs A Stabler, Non-Executive Director, in relation to the low allowance rate for C.Difficile cases, Dr G Findley, Deputy Chief Executive and Chief Nurse, reported that it is not planned to include this as a leading indicator going forward however the rates for the Trust compare well with the previous year. Following consideration, it was: **RESOLVED:** to receive the report for assurance, noting the improvements and ongoing challenges in key areas.	
24/03/21	**Freedom to Speak Up Guardian Report:** Ms T Healy, Freedom to Speak Up (FTSU) Guardian, provide an update of FTSU activity for Quarters 1, 2, and 3 (April 2023 to December 2023).	

Agenda Item No		Action Owner
	The Board noted the increase in managed cases and Ms Healy highlighted that where concerns have been raised, these are being managed in a variety of ways depending upon the risk level and issues raised. Those of significant high risk in relation to patient safety are being escalated immediately to the Deputy Chief Executive/ Chief Nurse. The Board are now fully compliant in relation to FTSU training and increased communications have been undertaken around speaking out. There are currently 8 FTSU champions in post and a relaunch is being carried out with the aim to recruit further champions. Ms Healy drew attention to some of the key findings which highlights that the majority of cases relate to culture, bullying and harassment and treatment at work. The highest trend in Quarter 3 was around unfair treatment of staff from managers or individuals/teams they are working with. Mrs Healy reported that there is a distribution across areas of the Trust of concerns raised however moving forward the data will be broken down further to specific areas when concerns are raised to help identify hot spot areas within Business Units to support managers to be able to identify these areas and follow up with improvements. Future recommendations include a review of the Champions Programme, the aim of which is to have FTSU Champions in each department. Mrs Healy also highlighted that the next report will ensure that the vision and goals are aligned to the Quality Report, Patient Safety Incident Response Framework (PSIRF) and the national plan. Mrs A Marshall queried whether any of the referrals had been made via the FTSU champions and Ms Healy confirmed that six cases had been raised via the champions. Further development will be undertaken to support training and education for the champions. This will also be highlighted in future reports. Mr A Crampsie, Non-Executive Director, noted 81.25% of cases were concerns raised about staff compared to 18.75% relating to concerns about patient safety and queried whether staff concerns should be directed via current People processes. Ms Healy reported that the National Guardians Office advise that FTSU should cover all issues. It was noted that many staff do report incidents directly to managers and use FTSU where escalation is required. It was also noted that some cases are referred back to People and Organisational Development where appropriate. Mr A Moffat, Non-Executive Director, felt that it was important for the Board Committees to receive inter-related assurances and Dr G Findley, Deputy Chief Executive and Chief Nurse, explained that this is still being developed via the In-Phase module. Mrs T Davies, Chief Executive, reported that there was evidence of assurance from other areas including the Reportable Issues Log which	

Agenda Item No		Action Owner
	will be presented in Part 2 of the Board however was important to understand the findings and address these together. Mr M Hedley, Non-Executive Director, also felt that it would be useful to correlate with other key indicators including sickness absence and this will be reviewed for further development of the reports, alongside including further information about the utilisation of the champions. After further discussion, it was: **RESOLVED:** to receive the report for assurance Ms Healy left the meeting.	GF/TH
24/03/22	**Maternity Update:** **Maternity Integrated Oversight Report:** Mrs K Parker, Head of Midwifery, presented a summary of the maternity indicators for the Trust for January and February 2024. She drew attention to the key performance indicators within the Maternity Dashboard and highlighted that the Trust was a positive outlier for SATOD (smoking at time of delivery) and Induction of Labour rates. These are requirements of the Saving Babies Lives Care Bundle and the Trust has now reached 100% compliance. There is a new emerging risk in relation to the ventilation system in the delivery rooms on labour ward as they do not provide enough air changes to remove Entonox from the atmosphere and staff are therefore exposed to higher than acceptable levels when caring for a patient using Entonox for long periods of time. Mrs Parker explained that this was previously on the Organisational Risk Register but remains a risk in maternity. Exposure testing has been undertaken and the Estates team are looking at mitigations. Following exposure testing, maternity is the only area identified as posing higher exposure risk for staff. Mrs A Stabler, Non-Executive Director, highlighted that this had been discussed at the Maternity Safety Champion meeting and has been acknowledged. Mrs Parker also drew attention to the MBRRACE 2022 report which confirms that there is a robust system in place for all perinatal deaths and no further action is required. Work is also taking place with the People and Organisational Development Team around themes highlighted from learning from complaints and Freedom To Speak Up and these will be explored further. Following discussion, it was: **RESOLVED:** to receive the report for assurance.	

Agenda Item No		Action Owner
	Maternity Staffing Report – Quarters Two and Three: Mrs Parker presented the report to inform the Board that the required staffing review has been completed within maternity and the results are now being aligned with the funded establishments. She reported that significant work has taken place to understand and align midwifery budgeted establishments and current workforce. The Birthrate Plus workforce assessment is currently in progress and the report is anticipated by end of March 2024 therefore a more detailed report will be presented to the Board at the next meeting. Dr G Findley, Deputy Chief Executive and Chief Nurse, explained that a separate staffing report has been completed for maternity and midwifery staffing to provide assurance that there is an effective system of midwifery workforce planning and monitoring of safe staffing levels. After consideration, it was: **RESOLVED:** to receive the report for assurance.	Cycle of Business
24/03/23	**Nurse Staffing Exception Report:** Dr G Findley, Deputy Chief Executive and Chief Nurse, presented the report for February 2024 which provides information relating to ward staffing levels (funded against actual) and details of the actions taken to address any shortfalls. Dr Findley reported that the national checklist for the Quality Report is required to be reported to the Board. She highlighted that a self-assessment staffing checklist will be sent out to departments and will be presented to the Quality Governance Committee. This will also feed into the six monthly staffing review which is presented to the Board in line with the cycle of business. Following discussion, it was: **RESOLVED:** to receive the report for information and assurance.	
24/03/24	**Cycle of Business 2024/25:** Mrs J Boyle presented the cycle of business for 2024/25 which outlines forthcoming items for consideration by the Board. This provides advanced notice and greater visibility in relation to forward planning. Mrs Boyle highlighted that the cycle of business has been prepared for the Board of Directors for the forthcoming financial year and is aligned with internal and external reporting requirements. The six monthly	

Agenda Item No		Action Owner
	maternity staffing report and Green Plan will be factored in following discussions at today's meeting. After consideration, it was: **RESOLVED:** to review and approve the cycle of business for the forthcoming financial year 2024/25.	
24/03/25	**Questions from Governors in Attendance:** There were no Governors present however questions received in advance of the meeting have been addressed via meeting discussions.	
24/03/26	**Any Other Business:** There was no other business to discuss.	
24/03/27	**Date and Time of Next Meeting:** The next meeting of the Board of Directors will be held at 9.30am on Wednesday 5th June 2023.	
Exclusion of the Press and Public: Resolved to exclude the press and public from the remainder of the meeting, due to the confidential nature of the business to be discussed.		

PUBLIC BOARD ACTION TRACKER

Gateshead Health NHS Foundation Trust

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

Agenda Item Number	Date of Meeting	Agenda Item Name	Action	Deadline	Lead	Progress	RAG-rating
24/03/07	27/03/2024	Corporate Governance Manual	To ensure a review of the Corporate Governance Manual is included on the Internal Audit Plan 2024/25	05/06/2024	Kmac	Internal Audit have an audit in the plan to review compliance with SFIs. **Action recommended for closure**	
24/03/07	27/03/2024	QEF SFIs and Scheme of Delegation	To undertaken a review of the Articles of Association in line with the approved SFIs	05/06/2024	GE		
24/03/09	27/03/2024	Strategic objectives and leading indicators 2024/25	To discuss and incorporate Board comments and present back at the Extraordinary Board meeting on 24 April 2024	24/04/2024	NB/JH	June 24 – strategic objectives considered and approved at the Board in April. The new leading indicator report is on today's agenda. **Action recommended for closure.**	
24/03/21	27/03/2024	FTSU Guardian Report	To consider including information around referrals received from FTSU champions as well as linking with other key indicators ie. sickness absence.	05/06/2024	GF/TH	To be included in report going forward. **Action recommended for closure.**	
24/03/24	27/03/2024	Cycle of Business	To update the cycle of business to reflect the items discussed as part of the meeting: Green Plan, maternity staffing report, Deputy Chair and SID appointments	05/06/2024	JB	June 24 – cycle of business updated and included on the agenda. **Action recommended for closure.**	

Closed Actions from last meeting

Agenda Item Number	Date of Meeting	Agenda Item Name	Action	Deadline	Lead	Progress	RAG-rating
23/206	27/09/2023	FTSU Guardian Report	To provide details to Board members re. FTSU training	29/11/2023	GR / AV	**Nov 23 –** details shared at POD Committee however a reminder will be sent to Board members. To remain open until completed **Mar 24** – now compliant therefore action agreed for closure	
23/247	29/11/2023	IOR and Leading Indicators	To consider how future rates should be reported following introduction of PSIRF. To be discussed with planning and performance team	31/01/2024	GF	**Jan 24** - in progress. Awaiting information from the regional team as to how incidents will be reported to Boards across the region. In the meantime, all significant incidents are reviewed by the Chief Nurse and Medical Director and reported via reportable issues log. To remain open until process agreed to ensure the Trust is aligned with other trusts. **Mar 24 –** to be picked up by the Quality Governance Committee therefore action agreed for closure.	
24/08	31/01/2024	EPRR Core Standards Self Assessment Report	Six monthly reports to be presented to the Quality Governance Committee to ensure ongoing assurances around compliance	27/03/2024	GF/JH	**Mar 24** – added to the cycle of business for Quality Governance Committee therefore action agreed for closure	
24/11	31/01/2024	Board Committee Terms of Reference	To amend the Group Audit Committee and Group Remuneration Committee terms of reference to reflect the feedback received	27/03/2024	JB	**March 24** – terms of reference amended to reflect the feedback received. Action therefore agreed as closed.	
24/12	31/01/2024	Assurance from Board Committees	To amend the Finance and Performance Committee Terms of Reference to include the Alliance discussions.	27/03/2024	JB	**March 24** – terms of reference amended to reflect the feedback received and this has been factored into the cycle of business. Action therefore agreed as closed.	

Agenda Item Number	Date of Meeting	Agenda Item Name	Action	Deadline	Lead	Progress	RAG-rating
24/14	31/01/2024	Leading Indicators	To discuss development of new set of key performance standards in more detail at a future Board Development Day.	27/03/2024	JB	**March 24** – this was incorporated into the annual planning discussions at the Board development day in February 2024. Action therefore agreed as closed.	

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 7

Report Title:	**Board Assurance Framework 2024/25 – Opening Position**			
Name of Meeting:	Board of Directors			
Date of Meeting:	5 June 2024			
Author:	Jennifer Boyle, Company Secretary Executive Directors			
Executive Sponsor:	Executive Directors			
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 approve the opening position of the Board Assurance Framework (BAF)			
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*	Executive Management Team			
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 new strategic objectives were approved by the Board at the last meeting in March 2024. • The BAF has been developed based on the strategic objectives and the summary risks identified in relation to their achievement. • Initial controls and assurances and any identified gaps have been documented and will be dynamically updated as we progress through the year. Note that some of the owners and timescales for the actions to address gaps are still in the process of being populated. • The summary risks have been reviewed by the Executive Team and are recommended to the full Board. • A Board development session will be held following the Board meeting to provide an opportunity to debate and discuss the scoring for the summary risks (current and target scores). • The scores will therefore be populated ready for the BAF being reviewed at committees during June 2024.			

Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	The Board is recommended to review and approve the opening position of the BAF, particularly in relation to agreeing the summary risks behind each objective. The Board is asked to note that the scoring of the risks will be subject to full Board discussion and agreement and recognise that this is a dynamic document which will be further updated.				
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:	All – the BAF links to every objective.				
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):	Identified on the BAF itself.				
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒		

	Strategic Aim 1: we will continuously improve the quality and safety of our services for our patients						
Strategic objective:	Evidence full compliance with the Maternity Incentive Scheme (MIS) and the Ockenden actions						
Executive Owner:	Chief Nurse						
Board Committee Oversight:	Quality Governance Committee						
Date of Last Review:	-						
Summary risk							
There is a risk that the Trust is not able to comply with the MIS and Ockenden actions, caused by pressures on resources (finance, workforce, estates and demand), resulting in a negative impact upon the quality of maternity services and a decline in performance against the maternity metrics and patient outcomes.	*Risk graph to insert here*	**CURRENT RISK SCORE**			**TARGET RISK SCORE**		
		Likelihood	Impact	Score	Likelihood	Impact	Score
		TBC	*TBC*	*TBC*	*TBC*	*TBC*	*TBC*
Links to risks on the ORR:	3107 - Risk that MDT are delayed to a maternity emergency/delayed CCU transfers for maternity patients due to separate buildings – 15 2438 - Quality - Risk of quality failures in patient care due to external causes such as delayed discharges and external pressures – 8 2341 - There is a risk to ongoing business continuity of service provision due to ageing Trust estate – 12 2425 - 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**
Core maternity roles substantively filled		Increased birth rates and increasing acuity / interventions observed over 2023/24. Working being undertaken to formulate recommendations on midwifery workforce requirements	Head of Midwifery	TBC		
Six monthly reviews of maternity staffing conducted		Estates strategy currently being refreshed – next report to Board due in July 24	QEF Managing Director	Jul-24		
Maternity Safety Champion role in place and active						
Neonatal Badger system in place						
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						
Divisional Safecare meetings in place						

Twice daily safety huddles in place in maternity						
Assurance (Level 2: Reports / metrics seen by Board / committee etc)						
Maternity staffing report presented to Board and Quality Governance Committee biannually						
Maternity IOR presented to every QG Committee and Board meeting						
Assurance (Level 3 – external)						
MIS audit from AuditOne provided reasonable assurance – actions taken to enhance compliance and achieve MIS						
Full compliance with MIS Year 5 confirmed by NHS Resolution						
Maternity services rated ‘good’ by CQC in 2023						
CQC patient survey ranked GH maternity as 5th best in the country						

Strategic Aim 1: we will continuously improve the quality and safety of our services for our patients							
Strategic objective:	Full delivery of the actions within the Quality Improvement Plan leading to improved outcomes and patient experience with particular focus on improvements relating to mental health, learning disabilities and cancer.						
Executive Owner:	Chief Nurse						
Board Committee Oversight:	Quality Governance Committee						
Date of Last Review:	-						
Summary risk							
There is a risk that the quality improvement plan is not delivered, caused by resourcing pressures (finance, people, demand and external influences) resulting in no improvement in patient outcomes and experience and a potential lack of compliance with regulatory standards and requirements.	*Risk graph to insert here*	**CURRENT RISK SCORE**			**TARGET RISK SCORE**		
		Likelihood	Impact	Score	Likelihood	Impact	Score
		TBC	*TBC*	*TBC*	*TBC*	*TBC*	*TBC*
Links to risks on the ORR:	3107 - Risk that MDT are delayed to a maternity emergency/delayed CCU transfers for maternity patients due to separate buildings – 15 2438 - Quality - Risk of quality failures in patient care due to external causes such as delayed discharges and external pressures – 8 2341 - There is a risk to ongoing business continuity of service provision due to ageing Trust estate – 12 2425 - Activity is not delivered in line with planned trajectories, leading to reduction in income – 16 2432 - Risk of Significant, unprecedented service disruption due to industrial action – 16 2545 - Risk of delayed transfers of care and increased hospital lengths of stay - 8						

Controls		**Gap in controls and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
CQC compliance manager in place		New governance structure currently being implemented and requires time to fully launch and embed	Chief Nurse / Company Secretary	Sep-24		
Clinical audit programme in place						
Transformation team in place to support quality improvements						
Quality Strategy approved in 2023						
PSIRF policy in place and training has been delivered						
New governance structure simplifies and streamlines quality oversight and reporting						
Assurance (Level 1: Operational Oversight)		**Gaps in assurance and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Safecare meetings in place at corporate and divisional level						
Quality improvement plan is reviewed at the Group Leadership Meeting						

Assurance (Level 2: Reports / metrics seen by Board / committee etc)						
Leading indicator report reviewed at Quality Governance Committee and Board						
Patient / staff story presented to every Board and Council of Governors' meeting						
Safe staffing reports presented to Board and Quality Governance Committee						
Clinical audit outcomes reported to Quality Governance Committee						
Quality and safety reporting on QEF non-core contract now in place						
Assurance (Level 3 – external)						
Awarded National Joint Registry (NJR) Quality Data Provider – reflects high standards of patient safety						
Awarded Gold Standard for Autism Acceptance by the North East Autism Society.						

Strategic Aim 1: we will continuously improve the quality and safety of our services for our patients								
Strategic objective:	Evidence an agreed strategic approach to the development of an EPR supported by a documented and timed implementation plan.							
Executive Owner:	Group Director of Finance and Digital							
Board Committee Oversight:	Digital Committee							
Date of Last Review:	-							
Summary risk								
There is a risk that the Trust does not develop an effective EPR system delivery plan, caused by a lack of resource (financial, digital team capacity, lack of strategic clarity) or lack of a robust process for identifying the most appropriate EPR system. This may result in clinical disengagement, continued clinical risk presented by the current system (ie. lack of joined-up system containing all patient records) and a reduced ability to deliver future efficiencies and productivity gains.	*Risk graph to insert here*	**CURRENT RISK SCORE**			**TARGET RISK SCORE**			
		Likelihood	Impact	Score	Likelihood	Impact	Score	
		TBC	*TBC*	*TBC*	*TBC*	*TBC*	*TBC*	
Links to risks on the ORR:	4405 - Risk that data is not accessed appropriately, leading to misuse or inappropriate disclosure - 16 4402 - Inability to support legislation and best practice associated with records management - 16 2424 - Risk that efficiency requirements are not met - 16							

Controls		**Gap in controls and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
EPR engagement event held in December 2023		The EPR business case has not yet been completed	Group Director of Finance & Digital	TBC		
Gap analysis completed which supports the implementation of an EPR		Chief Digital Information Officer position is vacant with cover arrangements in place from existing team. Role to be recruited to provide strategic leadership and increase capacity	Group Director of Finance & Digital	TBC		
Digital strategy in place		New governance structure currently being implemented and requires time to fully launch and embed	Chief Nurse / Company Secretary	Sep-24		
Assurance (Level 1: Operational Oversight)		**Gaps in assurance and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Assurance (Level 2: Reports / metrics seen by Board / committee etc)						
Digital delivery plan reviewed at every Digital Committee						
Assurance (Level 3 – external)						

Strategic Aim 1: we will continuously improve the quality and safety of our services for our patients							
Strategic objective:	Development and implementation of an Estates strategy that provides a 3 year capital plan to address the key critical infrastructure and estates functional risks across the organisation by March 2025						
Executive Owner:	Managing Director, QE Facilities						
Board Committee Oversight:	Finance and Performance Committee						
Date of Last Review:	-						
Summary risk							
There is a risk that the Trust is unable to deliver services in line with its operational plan and strategic ambition due to estates-related issues. This is caused by a lack of available capital and / or inappropriate prioritisation of capital investment in the estates strategy. This may result in a negative impact on operational delivery, patient outcomes and staff experience (including recruitment and retention)	*Risk graph to insert here*	**CURRENT RISK SCORE**			**TARGET RISK SCORE**		
		Likelihood	Impact	Score	Likelihood	Impact	Score
		TBC	*TBC*	*TBC*	*TBC*	*TBC*	*TBC*
Links to risks on the ORR:	2341 - 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**
Asset condition survey carried out by external specialists resulting in risk based condition scoring of all fixed assets.		The current Estates Strategy 2023-2028 has not been agreed by Board and no longer reflects the Organisations priorities - A revised strategy is to be submitted to the Group Board.	QEF Managing Director	Mar-25		
Board Approved Estates Strategy including a 3 year Capital Programme.		Capital plan for 24/25 not yet approved by Board. - Capital plan to be presented for approval in June 24.	QEF Managing Director	Jun-24		
Clinically led Capital planning process.		There is no agreed Capital Planning process. - A process for the prioritisation, review and agreement of the Capital Programme is to be developed.	QEF Managing Director	Aug-24		
Regular review of Capital delivery by the Finance & Performance Committee.		New governance structure currently being implemented and requires time to fully launch and embed	Chief Nurse / Company Secretary	Sep-24		
Assurance (Level 1: Operational Oversight)		**Gaps in assurance and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Monthly review of the Capital Delivery by the Capital Steering Group.		The Capital Programme for 2024/25 is still to be agreed. - Capital Programme for 2024 / 25 to be	QEF Managing Director	Jun-24		
		The format for Capital reporting is still to be developed. - A monthly Capital report summary to be agreed.	QEF Managing Director	Jul-24		
		The reporting route for Capital delivery is still to be agreed as part of the review of the Organisations Governance Structure.	QEF Managing Director	Aug-24		

		The reporting route to Board is to be agreed. - The reporting requirements for Capital Delivery are to be agreed and detailed in the Finance and Performance Committee Terms of Reference.	QEF Managing Director	Aug-24		
Assurance (Level 2: Reports / metrics seen by Board / committee etc)						
Regular reports to Trust Board on estates prioritisation and strategy development						
Assurance (Level 3 – external)						
External Assessment of the Estate against the 6 facets identified in Estatecode including, Estate condition.						

Strategic Aim 2: we will be a great organisation with a highly engaged workforce							
Strategic objective:	Caring for our people in order to achieve the sickness absence and turnover standards by March 2025						
Executive Owner:	Group Executive Director of People and OD						
Board Committee Oversight:	People and OD Committee						
Date of Last Review:	-						
Summary risk							
There is a risk that our people may be absent from work or leave the Trust. This may be caused by a range of internal factors and / or external factors (i.e. those factors not directly within the control of the Trust). This may result in increased vacancies, reductions in morale, poor reputation as an employer and ultimately impact negatively on our ability to deliver high quality care to our patients	*Risk graph to insert here*	**CURRENT RISK SCORE**			**TARGET RISK SCORE**		
		Likelihood	Impact	Score	Likelihood	Impact	Score
		TBC	*TBC*	*TBC*	*TBC*	*TBC*	*TBC*
Links to risks on the ORR:	2425 - Activity is not delivered in line with planned trajectories, leading to reduction in income - 16 4417 - Increase in incivility and disrespectful behaviours being reported - 12 3132 - Exposure to incidents of violence and aggression in ECC - 15						

Controls	**Gap in controls and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Health and wellbeing lead in place	New governance structure currently being implemented and requires time to fully launch and embed	Chief Nurse / Company Secretary	Sep-24		
Dedicated health and wellbeing resource and links accessible to staff - Balance	Vaccination programme - challenge of no bank staff support for 24/25 this year and low levels of uptake in 23/24				
Zero tolerance campaign in place	Low uptake of exit interviews				
Show Racism the Red Card training provided with further sessions planned	Lack of adherence to Managing Attendance policy				
Nursing is fully established					
New governance structure provides a greater focus on workforce and culture through the POD Tier 2 and Tier 3 groups					
FTSU Guardian in place full-time and supported by FTSU Champions					
Refreshed Managing Attendance policy in place with associated training plan					
People strategy in place					
Assurance (Level 1: Operational Oversight)	**Gaps in assurance and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
POD team meetings in place to review people metrics	POD Steering Group not yet in place	Executive Director of POD	Jul-24		

POD Steering Group		Absence levels remain higher than plan - POD Committee to receive a deep dive report in July 24	Executive Director of POD	Jul-24		
SMT - specific topic discussions on absence		WRES and WDES data identify challenges in relation to bullying and harassment, which indicate further work is required to ensure colleagues with protected characteristics do not suffer detriment	Executive Director of POD	TBC		
Assurance (Level 2: Reports / metrics seen by Board / committee etc)						
Leading Indicator report and people metrics presented to POD Committee for assurance						
Assurance reports to POD demonstrate the vacancy rate remains well below the 5% threshold						
POD Steering Group Metrics report - once finalised						
Assurance (Level 3 – external)						
Engagement score on NHS staff survey is above average						

Strategic Aim 2: we will be a great organisation with a highly engaged workforce							
Strategic objective:	Growing and developing our people in order to improve patient outcomes, reduce reliance on temporary staff and deliver the 24-25 workforce plan						
Executive Owner:	Group Executive Director of People and OD						
Board Committee Oversight:	People and OD Committee						
Date of Last Review:	-						
Summary risk							
There is a risk that the composition of our workforce does not align with our strategic intent and plans, caused by incremental historic growth without reference to the ambition of the Trust. This results in a risk that operational plans and the strategic ambition of the Trust is not achieved, impacting on patient outcomes, our reputation and financial challenges should this result in the use of agency staff.	*Risk graph to insert here*	**CURRENT RISK SCORE**			**TARGET RISK SCORE**		
		Likelihood	Impact	Score	Likelihood	Impact	Score
		TBC	*TBC*	*TBC*	*TBC*	*TBC*	*TBC*
Links to risks on the ORR:	2425 - Activity is not delivered in line with planned trajectories, leading to reduction in income - 16 2272 - People may lose trust and confidence in our services - 12						

Controls		**Gap in controls and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Operational plan for 24-25 developed in consultation with the Board and Governors.		Integrated approach to workforce planning not currently in place - plans to adopt an approved methodology	Executive Director of POD	TBC		
Agency spend authorisation process in place		Medical staffing function and processes under review	Executive Director of POD	May-24		
Planning group in place to respond to industrial action		Workforce alignment to strategic intent not yet completed.	Executive Director of POD	TBC		
Managing and Leading Well programmes in place to support learning and development		New governance structure currently being implemented and requires time to fully launch and embed	Chief Nurse / Company Secretary	Sep-24		
GAiN apprenticeship programme in place		Long term workforce plan implications and associated funding not confirmed				
Engagement and involvement in the Healthcare Academy to support workforce progression		Challenge between the WTE reduction and increases training places/capacity needed in the LTWFP				
Professional Nurse Advocacy programme in place to support reflection and learning		Training space limited and not always fit for purpose				
Assurance (Level 1: Operational Oversight)		**Gaps in assurance and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**

Agency spend monitored in financial reports		POD Steering Group not yet in place	Executive Director of POD	Jul-24		
Dashboards showing workforce information shared via numerous professional forums and wider						
POD team meetings						
POD Steering Group						
Education and training group - sub group of POD steering group						
Assurance (Level 2: Reports / metrics seen by Board / committee etc)						
Development of workforce plans reported to Board and POD Committee						
POD metrics on workforce establishment, recruitment reported to POD Committee						
Nursing fully established and reported to POD Committee						
Assurance (Level 3 – external)						
Positive feedback from the ICB on the consistency and robustness of the operational plan						

Strategic Aim 2: we will be a great organisation with a highly engaged workforce							
Strategic objective:	Evidence an improvement in the staff survey outcomes and increase staff engagement score to 7.3 in the 2025 survey						
Executive Owner:	Group Executive Director of People and OD						
Board Committee Oversight:	People and OD Committee						
Date of Last Review:	-						
Summary risk							
There is a risk that the Trust's culture does not reflect the organisational values. This may be caused by pockets of poor behaviour which is not appropriately addressed and / or resourcing pressures which impact on the ability of our people to work to the best of their ability. The result is that our people may feel disengaged, disempowered or discriminated against, leading to reduced retention rates, loss of reputation and poor staff survey results - ultimately impacting on our ability to be a good employer delivering excellent care to our patients.	*Risk graph to insert here*	**CURRENT RISK SCORE**			**TARGET RISK SCORE**		
		Likelihood	Impact	Score	Likelihood	Impact	Score
		TBC	*TBC*	*TBC*	*TBC*	*TBC*	*TBC*
Links to risks on the ORR:	4417 - Increase in incivility and disrespectful behaviours being reported - 12 3132 - Exposure to incidents of violence and aggression in ECC - 15 2272 - People may lose trust and confidence in our services - 12						

Controls		**Gap in controls and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Zero tolerance programme in place		New governance structure currently being implemented and requires time to fully launch and embed	Chief Nurse / Company Secretary	Sep-24		
FTSU resource and focus increased with a full time FTSU Guardian and a network of champions		Staff networks not providing strategic input to the Board or EMT				
Processes in place to respond to staff survey results and take action on a local level		Staff survey feedback shows unacceptable behaviours in terms of racism, discrimination and sexual safety				
Anti-racism charter in place with Unison						
Pulse surveys held during the year						
Tea and chat engagement events						
EDI dashboard in progress						
EDI strategy in place						
Active staff networks in place						
People Strategy in place						
Northumbria patient and staff experience work being shared						

Assurance (Level 1: Operational Oversight)		**Gaps in assurance and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
POD team meetings		POD Steering Group not yet in place	Executive Director of POD	Jul-24		
POD Steering Group		Culture programme group not yet reformed				
Culture Programme Group						
Assurance (Level 2: Reports / metrics seen by Board / committee etc)						
Staff survey outcomes and actions presented to the POD Committee and Board						
EDI Dashboard						
Assurance (Level 3 – external)						
NHS Staff Survey results provide valuable intelligence						
GMC Survey						
WRES and WDES national reports						

Strategic Aim 3: we will be a great organisation with a highly engaged workforce							
Strategic objective:	Improve the quality of care delivery and accessibility for patients by meeting the locally agreed stretch standards by March 2025.						
Executive Owner:	Group Chief Operating Officer						
Board Committee Oversight:	Finance and Performance Committee						
Date of Last Review:	-						
Summary risk							
There is a risk that the Trust is unable to meet the locally agreed stretch standards as described in the Leading & Breakthrough Indicators, due to resource pressures (such as demand and capacity imbalances) or external factors (for example reliance on other providers, impact of Industrial Action or regulatory requirements). This may result in reduced responsiveness for patients, reputational damage and loss of confidence in the organisation	*Risk graph to insert here*	**CURRENT RISK SCORE**			**TARGET RISK SCORE**		
		Likelihood	Impact	Score	Likelihood	Impact	Score
		TBC	*TBC*	*TBC*	*TBC*	*TBC*	*TBC*
Links to risks on the ORR:	2438 - Quality - Risk of quality failures in patient care due to external causes such as delayed discharges and external pressures – 8 2425 - Activity is not delivered in line with planned trajectories, leading to reduction in income – 16 2545 - Risk of delayed transfers of care and increased hospital lengths of stay - 8 2432 - Risk of Significant, unprecedented service disruption due to industrial action – 16 2582 - 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**
Annual plan developed and in place	New governance structure currently being implemented and requires time to fully launch and embed	Chief Nurse / Company Secretary	Sep-24		
Leading & Breakthrough Indicators developed to support monitoring of performance	No clear documented process in place for the approval of mutual aid arrangements	Chief Operating Officer	Jul-24		
New business intelligence post in place	Revision of information and reporting required	Chief Operating	Jul-24		
Membership and participation in the UEC strategic board	Patient Access Policy to be reviewed and updated	Chief Operating Officer	Sep-24		
Membership and participation in the Strategic Elective Care Board					
Leadership of the Theatres and Perioperative Medicine regional workstream					
Patient Access Policy in place					
Assurance (Level 1: Operational Oversight)	**Gaps in assurance and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Monthly corporate oversight meetings	Operations Oversight Group under development	Chief Operating Officer	Jul-24		

Weekly Access and Performance Meetings	[redacted]	Tier 3 groups specifically focussed on activity monitoring / operational capital programme delivery being implemented	Chief Operating Officer	Aug-24		
Assurance (Level 2: Reports / metrics seen by Board / committee etc)						
Finance and Performance Committee receive the Leading Indicators and Elective Recovery report						
Board receives the Leading Indicators report at every meeting						
Mutual aid report presented to the Finance and Performance Committee						
Performance reported and discussed at the regional ICB Performance Improvement and Oversight meeting monthly						
Assurance (Level 3 – external)						
Regional benchmarking report provides assurance over the Trust's relative performance						

Strategic Aim 3: we will be a great organisation with a highly engaged workforce							
Strategic objective:	Evidence of reduction in cost base and an increase in patient care related income by the end of March 2025 leading to a balanced financial plan for 2025-26.						
Executive Owner:	Group Director of Finance and Digital						
Board Committee Oversight:	Finance and Performance Committee						
Date of Last Review:	-						
Summary risk							
There is a risk that the Trust does not achieve its activity, efficiency and income generation plans by March 2025. This may be caused by a lack of grip and control on spending and / or the inability to meet planned activity and growth targets due to demand and resource pressures. This will result in significant challenges in returning to financial balance by 25/26, further regulatory intervention and may result in an inability to invest in our services and people	*Risk graph to insert here*	**CURRENT RISK SCORE**			**TARGET RISK SCORE**		
		Likelihood	Impact	Score	Likelihood	Impact	Score
		TBC	*TBC*	*TBC*	*TBC*	*TBC*	*TBC*
Links to risks on the ORR:	2425 - Activity is not delivered in line with planned trajectories, leading to reduction in income – 16 2582 - Risk of ineffective and inefficient management of services due to availability and access to appropriate and timely BI - 12 2424 - Risk that efficiency requirements are not met - 16 2341 - 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**
Annual plan developed and in place		Efficiency plans not yet fully developed within each division and corporate area	Group Director of Finance & Digital	TBC		
Agreed budgets in place for each division and corporate area		New business case process not yet fully aligned with the business planning cycle	Group Director of Finance & Digital	TBC		
SFIs and Scheme of Delegation updated in 2024		New governance structure currently being implemented and requires time to fully launch and embed	Chief Nurse / Company Secretary	Sep-24		
Leading Indicators developed to support monitoring of performance		Capital plan for 24/25 not yet approved by Board. Capital plan to be presented for approval in June 24.	QEF Managing Director	Jun-24		
New business intelligence post in place						
Assurance (Level 1: Operational Oversight)		**Gaps in assurance and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Oversight meetings include review of financial performance						
Assurance (Level 2: Reports / metrics seen by Board / committee etc)						

Leading Indicators and finance report presented to F&P Committee	[redacted]					
QEF financial performance reported to F&P Committee						
Assurance (Level 3 – external)						

Strategic Aim 3: we will be a great organisation with a highly engaged workforce							
Strategic objective:	Review and revise the 22-25 Green Plan and align with the group structure by the end of Q2						
Executive Owner:	Managing Director, QE Facilities						
Board Committee Oversight:	Finance and Performance Committee						
Date of Last Review:	-						
Summary risk							
There is a risk that the Group does not deliver against the Green Plan. This may be caused by a lack of visibility on the Green Plan and its delivery through the governance structure and therefore a lack of strategic leadership and prioritisation of resources at a senior level. This may result in the Trust not meeting its environmental sustainability targets (locally and nationally). This impacts on the reputation of the Trust and its ability to demonstrate that it is well-led and socially responsible.	*Risk graph to insert here*	**CURRENT RISK SCORE**			**TARGET RISK SCORE**		
		Likelihood	Impact	Score	Likelihood	Impact	Score
		TBC	*TBC*	*TBC*	*TBC*	*TBC*	*TBC*
Links to risks on the ORR:	2272 - People may lose trust and confidence in our services - 12						

Controls		**Gap in controls and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
The Green Plan has been agreed by Board covering the period for 22-25.		The governance arrangements detailed in the Green Plan are not reflected in the new Governance arrangements - A new reporting structure is to be agreed.	QEF MD	Sep-24		
Board members received in-depth environmental sustainability training		There is no regular reporting taking place against the Targets detailed within the Green Plan - A standardised reporting process to be agreed.	QEF MD	Aug-24		
A clear set of targets, objectives and actions are detailed within the agreed Green Plan.		The SHEQ role is currently vacant. - The SHEQ post is to be recruited into.	QEF MD	Aug-24		
Identified senior management with specific responsibility for the Environment and sustainability.						
Assurance (Level 1: Operational Oversight)		**Gaps in assurance and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**

Quarterly monitoring of performance against the agreed metrics detailed in the Green Plan.		Green Plan no longer reported to Board or Finance and Performance Committee - to address reporting lines as part of the new governance structure	QEF MD / Company Secretary	Sep-24		
		The current governance arrangements do not include a group with specific responsibility for monitoring sustainability that includes cross Group membership. - An Environmental Sustainability Group to be incorporated in to the new Group governance arrangements.	QEF MD	Sep-24		
Assurance (Level 2: Reports / metrics seen by Board / committee etc)						
Quarterly update on progress against the targets detailed in the Green Plan to the Finance & Performance Committee.						
Assurance (Level 3 – external)						

Strategic Aim 4: we will be an effective partner and be ambitious in our commitment to improving health outcomes							
Strategic objective:	Work at place with public health, place partners and other providers to ensure that reductions in health inequalities are evidenced with a focus on women's health						
Executive Owner:	Medical Director						
Board Committee Oversight:	Quality Governance Committee						
Date of Last Review:	-						
Summary risk							
There is a risk that the Trust does not deliver its services in a manner which supports the reduction in health inequalities. This is caused by a lack of access to key data (which enables health inequalities to be identified sufficient early and patient outcomes to be tracked) plus a lack of resource and focus on tackling health inequalities. This results in poor patient outcomes and also an inability to deliver on our strategic intent to be a women's health centre of excellence and an outstanding district general hospital, therefore impacting upon our reputation		**CURRENT RISK SCORE**			**TARGET RISK SCORE**		
		Likelihood	Impact	Score	Likelihood	Impact	Score
		TBC	*TBC*	*TBC*	*TBC*	*TBC*	*TBC*
Links to risks on the ORR:	2272 - People may lose trust and confidence in our services - 12 2582 - Risk of ineffective and inefficient management of services due to availability and access to appropriate and timely BI - 12 4402 - Inability to support legislation and best practice associated with records management - 16						

Controls		**Gap in controls and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Health inequalities strategy approved by Quality Governance Committee		New governance structure currently being implemented and requires time to fully launch and embed	Chief Nurse / Company Secretary	Sep-24		
Public Health engagement and involvement in health inequalities within the Trust		Trust Health Inequalities Group to refine approach to focus on women's health issues	Medical Director	Sep-24		
Health inequalities gap analysis completed		Key data set incomplete and requires manual data collation whilst development of a comprehensive dashboard / reporting tool is developed	Medical Director / Deputy Director of Performance	Jan-25		
Health Inequalities Group in place						
Core20plus5 ambassadors in place						

Assurance (Level 1: Operational Oversight)		Gaps in assurance and corrective action	Owner	Timescale	Update	Action status
Health inequalities agenda to be embedded into operational business unit work schedules		Board visibility on health inequalities is limited - to consider how the profile can be raised at Board level to provide visible leadership on this agenda	Medical Director	Sep-24		
Operational business unit oversight meetings to specifically consider access, waiting well and health inequalities issues		Visibility of health inequalities management within the operational business units to be enhanced and embedded into business as usual reporting	Medical Director /Chief Operating Officer / Deputy Director of Performance	Jan-25		
Assurance (Level 2: Reports / metrics seen by Board / committee etc)						
Health Inequalities Board reports to Quality Governance Committee quarterly						
Assurance (Level 3 – external)						
Trust Health Inequalities Group represented within Gateshead Place Health and Wellbeing Board working towards shared agendas and strategy						

Strategic Aim 4: we will be an effective partner and be ambitious in our commitment to improving health outcomes							
Strategic objective:	Work collaboratively as part of the Gateshead system to improve health and care outcomes to the Gateshead population						
Executive Owner:	Medical Director						
Board Committee Oversight:	Quality Governance Committee						
Date of Last Review:	-						
Summary risk							
There is a risk that the health and care outcomes for the Gateshead population are not improved. This may be caused by the lack of appropriate engagement and involvement in collaborative working at place-level and the lack of effective use of funds and resources across Gateshead place. This may result in poor patient outcomes and an inability to deliver place-based plans.		**CURRENT RISK SCORE**			**TARGET RISK SCORE**		
		Likelihood	Impact	Score	Likelihood	Impact	Score
		TBC	*TBC*	*TBC*	*TBC*	*TBC*	*TBC*
Links to risks on the ORR:	2424 - Risk that efficiency requirements are not met - 16 2438 - Quality - Risk of quality failures in patient care due to external causes such as delayed discharges and external pressures – 8 2425 - Activity is not delivered in line with planned trajectories, leading to reduction in income – 16 2272 - People may lose trust and confidence in our services - 12						

Controls		Gap in controls and corrective action	Owner	Timescale	Update	Action status
Senior engagement in Gateshead Cares meetings		Review and monitor external meeting membership and attendance to ensure appropriate engagement	Medical Director / Company Secretary	Sep-24		
Appropriate director level attendance at Gateshead Overview and Scrutiny and Health and Wellbeing Boards						
Gateshead Health CEO chairing Gateshead Cares Board						
Assurance (Level 1: Operational Oversight)		**Gaps in assurance and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Operational business unit clinical delivery aligned to best practice, NICE and GIRFT recommendations		Enhance monitoring of external engagement activities via Quality Governance Committee and Executive Management team	Medical Director / Chief Nurse / Chief Operating Officer / Company Secretary	Sep-24		
Assurance (Level 2: Reports / metrics seen by Board / committee etc)						
Clinical outcome data and quality reports shared via Quality Governance Committee						
Clinical pathway developments within Gateshead Place and the GNHA and their innovation impacts reported Quality Governance Committee						
Assurance (Level 3 – external)						
Fully engage with and work into developing Great North Healthcare Alliance partnership arrangements to maximise potential population benefits						
Collaborate within the ICB population health agenda seeking innovative ways of healthcare provision and additional funding opportunities						

Strategic Aim 4: we will be an effective partner and be ambitious in our commitment to improving health outcomes							
Strategic objective:	Work collaboratively with partners in the Great North Healthcare Alliance to evidence an improvement in quality and access domains leading to an improvement in healthcare outcomes demonstrating 'better together'						
Executive Owner:	Group Chief Executive						
Board Committee Oversight:	Board of Directors						
Date of Last Review:	-						
Summary risk							
There is a risk that the Trust is unable to sufficiently influence key directions of travel re delivery of system performance metrics, financial frameworks (incl system medium term financial plan), workforce development and clinical strategy locally and across the system and Alliance footprint. This may be caused by a lack of appropriate engagement and involvement in key Alliance discussions and meetings. This may result in poorer patient outcomes and an inability to meet performance and finance targets, impacting upon sustainability	*Risk graph to insert here*	**CURRENT RISK SCORE**			**TARGET RISK SCORE**		
		Likelihood	Impact	Score	Likelihood	Impact	Score
		TBC	*TBC*	*TBC*	*TBC*	*TBC*	*TBC*
Links to risks on the ORR:	2424 - Risk that efficiency requirements are not met - 16 2425 - Activity is not delivered in line with planned trajectories, leading to reduction in income – 16 2272 - People may lose trust and confidence in our services - 12						

Controls		**Gap in controls and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Engagement and involvement in key Alliance meetings		Committees in Common model under development which will strengthen governance and accountability	Company Secretary	Jun-24		
Alliance Steering Group in place		Alliance risk management framework under development	Interim Director of Strategy, Planning and Partnerships	Jun-24		
Alliance Formation Team member in place - Interim Director of Strategy, Planning and Partnerships						
Weekly CEO meeting in place for Alliance						
Assurance (Level 1: Operational Oversight)		**Gaps in assurance and corrective**	**Owner**	**Timescale**	**Update**	**Action status**

Regular updates provided to internal leadership forums and to JCC/LNC etc	[redacted]					
Assurance (Level 2: Reports / metrics seen by Board / committee etc)						
Alliance updates provided at every Board meeting						
Alliance updates provided at Finance and Performance Committee						
Alliance updates provided to COG on quarterly basis						
Alliance update monthly at PLB						
Assurance (Level 3 – external)						

Strategic Aim 5: we will look to utilise our skills and expertise beyond Gateshead							
Strategic objective:	Contribute effectively as part of the Provider Collaborative to maximise the opportunities presented through the regional workforce programme						
Executive Owner:	Group Executive Director of People and OD						
Board Committee Oversight:	People and OD Committee						
Date of Last Review:	-						
Summary risk							
There is a risk that the Trust is unable to sufficiently influence key directions of travel re delivery of system performance metrics, financial frameworks (incl system medium term financial plan), workforce development and clinical strategy locally and across the regional system. This may be caused by a lack of appropriate engagement and involvement in key regional discussions and meetings. This may result in poorer patient outcomes and an inability to meet performance and finance targets, impacting upon sustainability	*Risk graph to insert here*	**CURRENT RISK SCORE**			**TARGET RISK SCORE**		
		Likelihood	Impact	Score	Likelihood	Impact	Score
		TBC	*TBC*	*TBC*	*TBC*	*TBC*	*TBC*
Links to risks on the ORR:	2424 - Risk that efficiency requirements are not met - 16 2425 - Activity is not delivered in line with planned trajectories, leading to reduction in income – 16 2272 - People may lose trust and confidence in our services - 12						

Controls	**Gap in controls and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
POD Director member of regional HRD Network	Lack of strategic intent and willing to discuss region wide approaches				
POD Director meeting with Alliance HRDs to discuss opportunities					
Gateshead CEO as regional Workforce Lead					
Workforce Sharing Agreement in Place					
Close working with ICB People team - members of HRD network and meet weekly					
Assurance (Level 1: Operational Oversight)	**Gaps in assurance and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Feedback from regional meetings to EMT					
Assurance (Level 2: Reports / metrics seen by Board / committee etc)					

Assurance (Level 3 – external)	[redacted]					
NHS England reports on an ad hoc basis						

Strategic Aim 5: we will continuously improve the quality and safety of our services for our patients								
Strategic objective:	Evidenced business growth by March 2025 with a specific focus on Diagnostics, Women's health and commercial opportunities							
Executive Owner:	Group Chief Operating Officer and QEF Managing Director							
Board Committee Oversight:	Finance and Performance Committee							
Date of Last Review:	-							
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. This may be caused by a lack of focus on innovation and emerging opportunities, resulting in increased pressures on existing funding and an inability to deliver our ambitions regarding being a centre of excellence for diagnostics and women's health	*Risk graph to insert here*	**CURRENT RISK SCORE**			**TARGET RISK SCORE**			
		Likelihood	Impact	Score	Likelihood	Impact	Score	
		TBC	*TBC*	*TBC*	*TBC*	*TBC*	*TBC*	
Links to risks on the ORR:	2424 - Risk that efficiency requirements are not met - 16 2272 - People may lose trust and confidence in our services - 12							

Controls	**Gap in controls and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Innovations Manager in place	Commercial strategy not in place	QEF Managing Director	Aug-24		
A Board Agreed QEF Business Development Strategy.	The existing Business Development Strategy has not been ratified by Board.	QEF Managing Director	Sep-24		
A 12 month Business Development Plan with a qualified opportunities pipeline.	There is no Business Development Plan in place for 2024 / 25. - A Business Development Plan for QEF to be developed and submitted to Finance & Performance Committee for ratification.	QEF Managing Director	Aug-24		

Senior management with specific responsibility for business growth.		The existing Business Development role within QEF is a dual role and is insufficient to support additional growth. - A review of the Business Development Management structure within QEF to be carried out.	QEF Managing Director	Jul-24		
Regular contract review meetings for existing contracts.		There is no standard process for carrying or recording contract review meetings. - A contract review process to be implemented.	QEF Managing Director	Sep-24		
Assurance (Level 1: Operational Oversight)		**Gaps in assurance and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
		No specific reporting on commercial opportunities within the governance structure	QEF Managing Director	TBC		
Assurance (Level 2: Reports / metrics seen by Board / committee etc)						
Assurance (Level 3 – external)						

Gateshead Health
NHS Foundation Trust

Chair's Report

Alison Marshall, Chair of the Board of Directors

5 June 2024

Governor and Member Updates

- The Council of Governors met on 15 May and formally ratified the appointment of Steve Connolly as Lead Governor and Michael Loome as Deputy Lead Governor for a period of one year effective from 19 May. Congratulations to both Steve and Michael on their appointments.
- On behalf of the Council and Board, we wish to formally record our sincere thanks to Abe Rabin for his contribution and commitment to the Lead Governor role over the last 2 years, and the Deputy role prior to this.
- The Council of Governors have shaped the development of the Quality Accounts for 2023/24 through two workshops. The Council provided feedback on the draft document and approved their statement, which will feature within the final document.
- The Council of Governors approved the process for the Chair and Non-Executive Director appraisals for 2023/24 on the recommendation of the Governor Remuneration Committee. This aligns with the NHS England Leadership Competency Framework.
- In terms of membership, our latest newsletter was published in May 2024 and we are planning our next Medicine for Members event. This will be held on 1 July and will provide an insight into our women's health services.
- We are promoting the benefits of membership to our local communities and patients. In collaboration with the Membership Strategy Group some new material has been developed to support us to raise the profile of membership.

Stakeholder Engagement

Gateshead Health NHS Foundation Trust

Since the last Board meeting there have been a number of opportunities to engage with colleagues and external stakeholders, including:

- A visit to our IVF department
- A visit to our mortuary
- Chairing a number of panels for consultant interviews including Geriatric Medicine and Cellular Pathology
- Attended a compassionate communities event hosted by our Palliative Care Team
- Attended a fundraising bake sale on Ward 27
- Attended an ICB hosted event for Chairs and CEOs to benefit from the knowledge that PwC have accumulated from working in other regions
- Meeting with other Chairs across the ICS
- Meeting with local MPs
- Meeting with the Chief Executive and Leader of Gateshead Council
- Regular meetings of the Great North Healthcare Alliance
- Governance seminar hosted by AuditOne

Partnership working

Gateshead Health NHS Foundation Trust

Great North Healthcare Alliance

- To support our Alliance partner, Newcastle-upon Tyne Hospitals NHS FT, one of our Gateshead Non-Executive Directors has been temporarily co-opted onto their Board of Directors.
- Anna Stabler will chair the Quality Committee until Newcastle can make new, permanent appointments in the next few months. Anna will continue in her current role in Gateshead during this time. She is joined at Newcastle by a colleague from Northumbria, who will chair the People Committee.
- Further information on the Alliance and its work is included in a separate paper on today's agenda.

Provider Collaborative

- The Chairs from providers across the North East and North Cumbria joined Chief Executives at a Provider Collaborative meeting to review the achievements of the Collaborative in 2023/24. This includes progress made towards the development of a new aseptic medicine production facility and well as a number of workstreams in relation to clinical programmes, clinical support and corporate areas such as workforce, capital and digital.

Star of the Month Nominations

March

- Janice McNall - QEF
- Molly Adamson - Audiology
- Kerry Donnelly – Rapid Response
- Katie Mulholland – Rapid Response
- Ray Harland – Volunteer Service
- Joanne Lane – South Locality
- Jill Robson – Radiology
- Vicky Bailey – Medical Education

April

- Lauren Nicod – Community
- Richard Thompson – Community
- Julie Lloyd - Community
- Michelle Newton – Community
- Chris Angus - Paediatrics
- Emma McNeil – Maternity
- Susan Dale – Maternity
- Emma Parkinson – Planning & Performance

March - TBC

You're a Star Winner

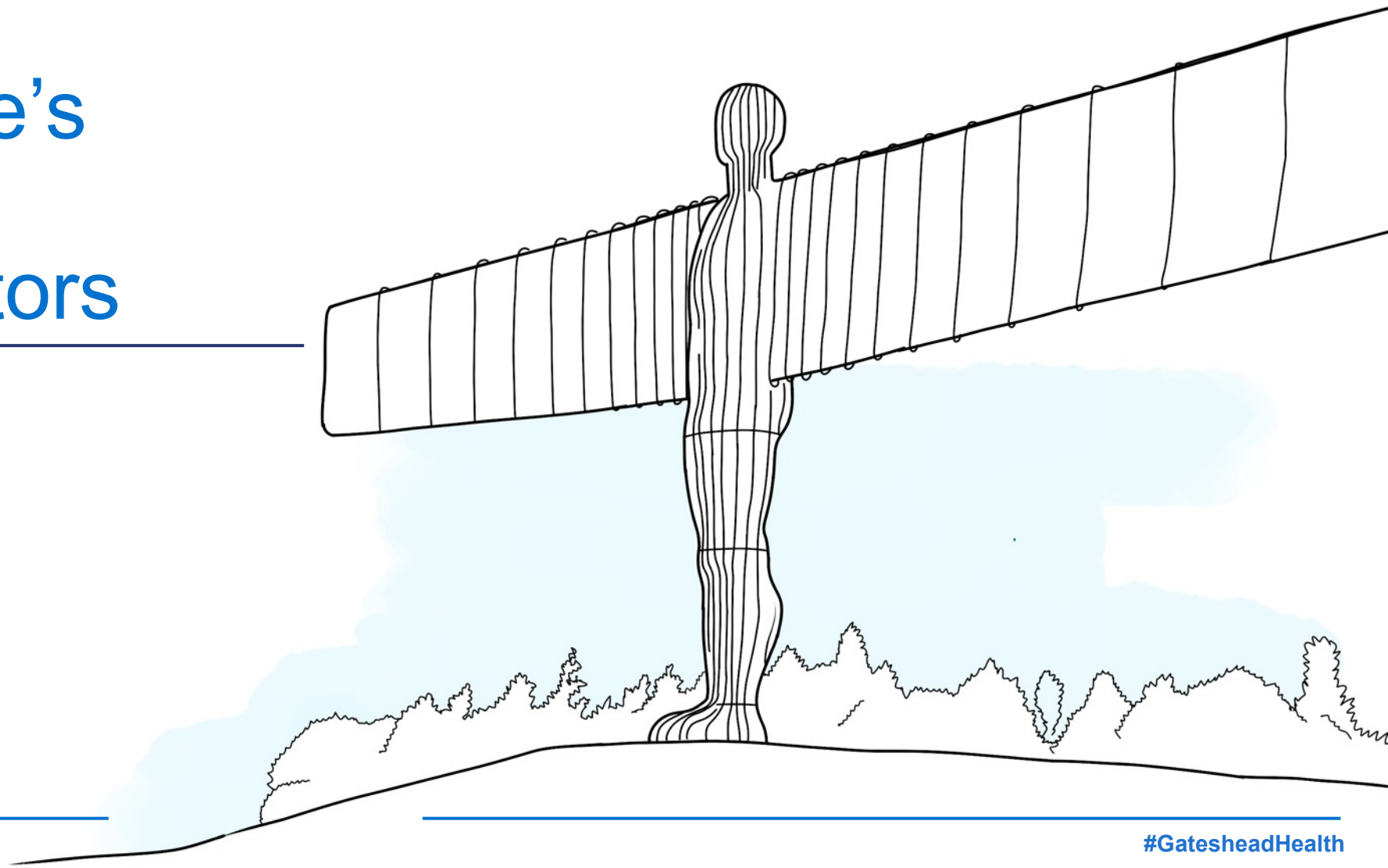
Chris Angus

NHS
Gateshead Health
NHS Foundation Trust

Chief Executive's Update to the Board of Directors

Trudie Davies, Chief Executive

5 June 2024



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

NHS Gateshead Health NHS Foundation Trust

- We took part in a **well-being event** in partnership with Future Dreams, a nationwide breast cancer charity. 50 local women came together to share their experiences of going through breast cancer treatment. The event empowered patients to focus on their physical and emotional well-being, as well as share their experiences with each other.
- The new **Sister Winifred Laver Centre** opened in March. The 60-bed centre in Felling offers short-term care for adults to help them regain the skills and confidence they need to go back to living their lives independently in their own homes. Colleagues can refer patients directly to the local authority so that the Centre Manager can consider our patients for admission.
- Our **Quality Account 2023/24** has been drafted and consulted upon with our valued partners, including our Governors. This will be considered by the Board at the end of June for approval before being submitted to NHS England prior to its formal publication.
- A sincere thank you to our team on ward 14a who fulfilled a patient's last wish and organised a wedding. Heather and her partner of 40 years, Paul, were able to get married with the support of our colleagues.

Engagement, involvement and visits:

- Visit to theatres
- Visit to the discharge liaison team

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

NHS Gateshead Health NHS Foundation Trust

- In May we celebrated both **International Day of the Midwife and International Nurses' Day**. This provided an excellent opportunity to highlight the positive contribution our valued nurses and midwives have made to the Trust and the wider health community.
- In May we also celebrated **Equality, Diversity and Human Rights Week**. We used our Team Brief to talk with our senior leaders about what zero tolerance means for us and hear the experiences and stories of those who have faced discrimination at work or at home.
- At Gateshead Health our message is simple – **we value and encourage diversity**. We recognise the importance of our differences and know how much we all have to learn and share because of our experiences. We know that our patients receive better care and have better outcomes when we embrace diversity and encourage inclusivity and innovation..
- We have successfully recruited to a number of **consultant posts** including paediatrics, histopathology, cardiology and radiology. This is great news for us and for our patients. Recruitment to our substantive **Medical Director** post is currently underway.
- Two of our colleagues who have made significant contributions to the health community had the opportunity to attend a **Royal Garden Party**. Congratulations to Kerry Waterfield and Ruth Sharrock!

Engagement, involvement and visits:

- Consultant interviews
- Health and wellbeing event in the Hub
- Executive Director development day
- Team Brief

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

NHS Gateshead Health NHS Foundation Trust

- We submitted our **annual plan** in early May following engagement with the Council of Governors and final approval by the Board of Directors. We received positive feedback from NHS England, the ICB and peers on the consistency of our draft plan – namely that the financial, performance and workforce elements all clearly interlink with each other.
- We have been invited to showcase the work we have done to deliver our **performance improvements and sustained reduced in ambulance handovers** in a number of forums. These include the System Winter Debrief event on 12 June, the wider regional team in Leeds on 17th June and an NHS England virtual workshop on ambulance handovers on 3 July (in partnership with colleagues at North East Ambulance Service).
- Our **draft accounts** were submitted on time to NHS England on 24 April. The external audit is now underway ahead of the deadline for the submission of final audited accounts and annual report on 28 June.
- We are delivering a **pilot project to reduce the amount of wasted medication** by empowering our patients to bring their medications with them when admitted to the hospital and letting us know what repeat medications they have at home before discharge. Patients can actively avoid being supplied with medication they already have at home or with them, reducing waste significantly and enabling patients to receive their usual medication in hospital without delay.
- Our Council of Governors heard an inspiring presentation from Jonathan Fenwick, our Senior Clinical Pharmacist for Lipid Management and Secondary Prevention. Gateshead is the only provider in the region with a **secondary prevention multi-disciplinary team**. Since the service was launched in September 2023, 401 patients have been reviewed. The lipid clinic waiting time has significantly decreased and we are seeing a much greater volume of secondary prevention initiatives (such as cholesterol, diabetes and blood pressure interventions), with the aim of keeping our patients well and preventing future admissions.
- Our **Research and Development team** have produced a fantastic newsletter to showcase the work they have undertaken over the last six months. Over 21 specialities are openly recruiting to research at the moment and the newsletter provides an insight into some of these studies. There are currently 251 trials open for recruitment and our Patient Research Experience Survey tells us that 93% of participants felt research staff valued their input into research. A copy of the newsletter is appended to this report.

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

- We have continued to work with colleagues at place, ICB level and also within the Great North Healthcare Alliance as this begins to develop further.
- Our charity, **Gateshead Health Charity**, launched its first corporate partnership with Radio Tyneside. Radio Tyneside will help to promote the work of the charity, contribute to events and help us to spread the reach of the charity. There are lots of fundraising opportunities coming up in the next few months.
- Our **partnership working with Gateshead College** has been featured as a case study on the NHS Employers website. The case study highlights the benefits of college tutors attending one-week placements at the Trust to help them understand and inform students and parents about placement opportunities.
- We hosted an excellent event on **compassionate communities**, developing a deeper understanding of how adopting a compassionate communities approach can transform the experience of patients and families at the end of their lives.

Engagement, involvement and visits:

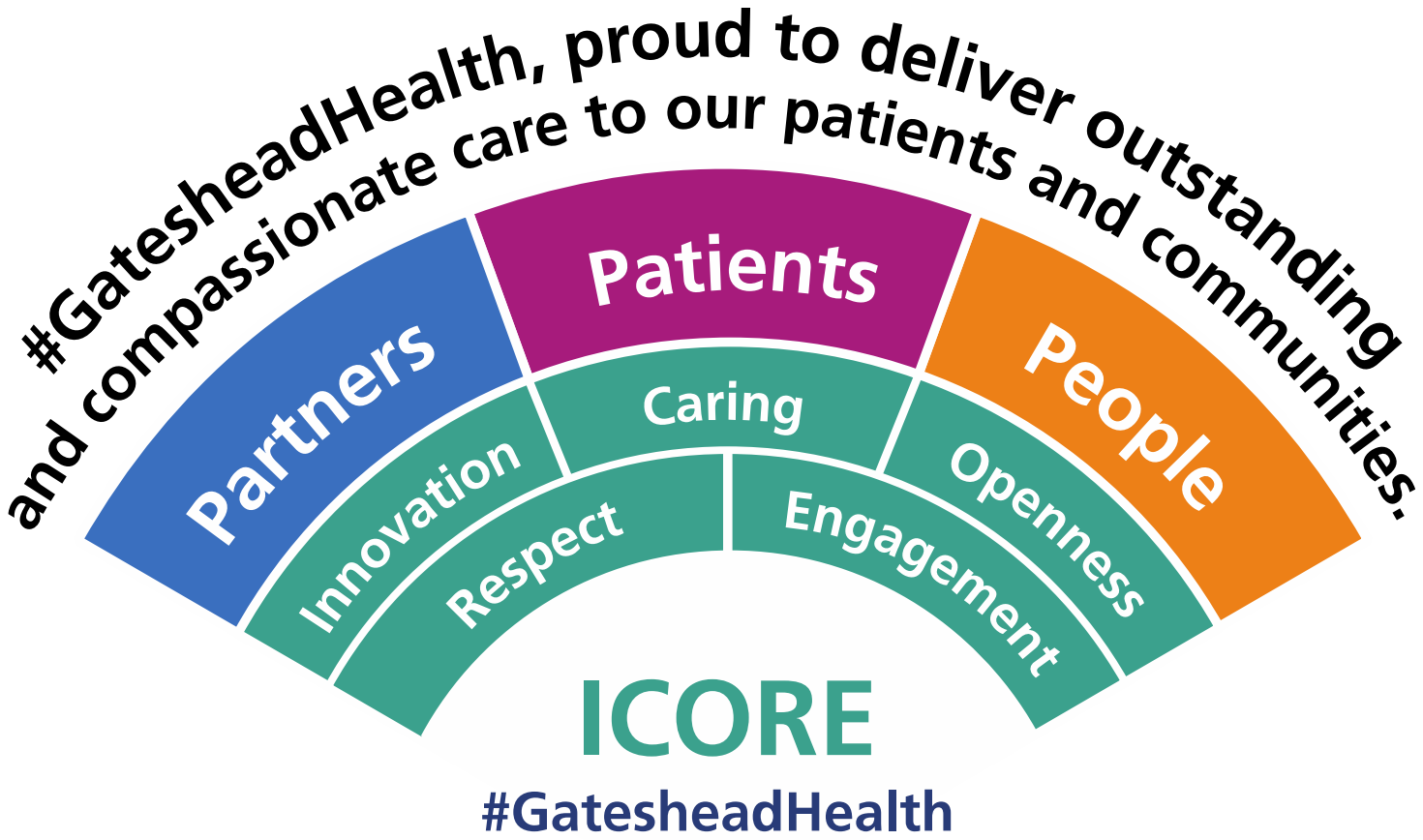
- Provider Collaborative workforce meetings
- Great North Healthcare Alliance meetings and conference
- ICS Chair and CEO workshop
- Place-based meetings
- Meetings with MPs
- Urology collaboration event
- Meeting with the Leader and CEO of Gateshead Council

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

Gateshead Health NHS Foundation Trust

- Building work continues for the new MetroCentre **Community Diagnostic Centre (CDC)** in partnership with Newcastle Hospitals. The CDC will provide imaging, respiratory investigations and cardiac investigations with the centre designed to create capacity for these services that are seeing increased referrals. Faster access to crucial diagnostic tests like MRIs, ultrasounds, and heart function tests will have a really positive impact on patients from both Trusts. The CDC will offer 145,000 appointments per year and create 134 jobs when it opens later this year.
- Our subsidiary company, **QE Facilities Ltd**, celebrated its 10th anniversary on 30 April. This is a significant milestone and speaks volumes about the dedication, expertise and support provided by QE Facilities.

Gateshead Health
NHS Foundation Trust



Research & Development Newsletter

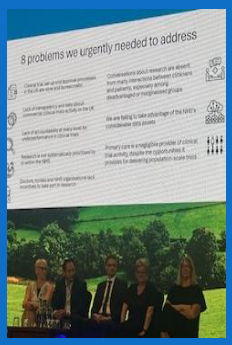
Volume 3 – 20th May 2024

Gateshead Health NHS Foundation Trust

Welcome to the May 2024 R&D newsletter, bringing you some updates from the last 6 months.

RD Forum 2024

On the 12th -14th May the R&D community came together to celebrate everything research at RD Forum 2024. There were a diverse range of workshops, posters, panel discussions and presentations including an overview from the HRA as well as Lord O' Shaughnessy, who gave an update on the 2023 report on Commercial Clinical Trials in the UK. We are now one year on from the report and he reflected on the headway that has already been made to date including the progress of the National Costing Value Review (NCVR) and the improvement in regulatory assessment timelines, however there is still much to do in strengthening research within the NHS. The event was closed by Professor Helen Bevan with her presentation on how we can make large scale change- lots of food for thought. We were inspired by the communities passion for tackling the challenges that we all face in ensuring that research is at the heart of patient care. We left the forum with a renewed enthusiasm and lots of ideas to apply to our own research.



Whilst International Clinical Trials Day celebrations are going to be more low key this year as we anticipate the report from the infected blood Inquiry the strong theme throughout this newsletter is one of thanks, thank you to all of you who support us to bring research to our patients. We couldn't do it without you!

Highlights:

A huge welcome to the team Olivia Queen who has joined us as our new clinical trials pharmacy technician

Research in a snapshot

NHS Gateshead Health NHS Foundation Trust

There are **251** trials open for recruitment here at the QE with a further **19** in set up to open soon!

93% of participants felt research staff valued their taking part in research

81% of participants would consider taking part in research again

93% of participants agreed that they were treated with courtesy and respect

Here's some of our recent patient feedback the Patient Research Experience Survey

Being able to do this in my home. The researcher was very pleasant and professional. I will consider helping again - anything to aid progress toward treatment/cure for PD

Being part of something that will hopefully improve treatment for those in the future

This is a great cause which will help others going through this in the future. Fabulous staff with good knowledge

I did not feel pressured to take part. Everything was explained fully and all questions i had were answered.

Both members of research team were both courteous and respectful and listened to my husband.

I was happy and excited to feel like I would be helping women in the future

Exciting news

What the QE Gateshead Research team has been up

NHS Gateshead Health NHS Foundation Trust

Date for your diary
#Red4Research is happening again this year on the 7th June the aim is to bring together all those who support health & social care research. Celebrate with us by wearing red & sending us your selfies. Keep an eye out on X to see what the team gets upto.

DETERMIND
WHAT IS DETERMIND?

A patient conference has been organised for **26th of June** for all **DETERMIND** participants. Invitations will be sent to everyone shortly

Great North Healthcare Alliance - 22nd March 2024

Gateshead, Newcastle Hospitals, Northumbria Healthcare and North Cumbria Integrated Care NHS FT, are looking to explore ways of working together to address some of the challenges that we all face and the possibility of formally establishing an Alliance.

The first focus for collaborative working was Urgent and Emergency Care.

The R&D Teams from each of the Trusts were invited to have a joint stall at the event to showcase the research that was happening within Urgent and Emergency Care.

A representative from each of the Trusts attended - Sean Scott (Newcastle) Bev McClelland (Gateshead), Yvonne Marriott (Gateshead) & Fiona Williams (NIHR / North Cumbria).

The stall proved to be very popular, particularly as no two Trusts were doing the same research, so there was a lot of note comparing !

We also had a visit from our lovely Chief Executive - Trudie Davies, who is very supportive of research.

Dementia Action week event 2024

The research team recently attended the annual ' Dementia Action Week' event held at Gateshead Library. The event gave members of the public and professionals the opportunity to explore the wide variety of services available for people living with dementia in Gateshead. A short talk was given by Bryony Storey to highlight the importance of research and to promote participation within the trust.

What's happening around the Trust?

Over 21 specialties are openly recruiting to research, here are some of the studies happening right now here in the QE!

Maternity research update

Our maternity research team have been incredibly busy over the last year delivering a number of studies. Here are just a couple of them:

INGR1D2  The INGR1D2 study began recruitment in summer 2022. The study aims to identify neonates at higher genetic risk of developing Type 1 Diabetes by adding on an additional screening test to the day 5 blood spot test/ heel prick test which is already offered to all babies and screens for a number of conditions. 1116 babies who were born at Gateshead Health NHS Foundation Trust were enrolled into the study between June 2022 and January 2024. Uptake has been really popular with many of our new parents and feedback has been very positive. The study has now re-opened to recruitment on the 1st May 2024.

CaPE At the end of January, the team opened recruitment to the CaPE trial. This trial aims to assess whether supplementation during pregnancy plus usual care is more effective than usual care alone in reducing pre-eclampsia in women who are considered to be at increased risk of this condition. Women less than 22 weeks gestation who are eligible are offered to take part in the study. Those who chose to take part are then randomised to either Calcium or placebo which they will take throughout pregnancy. Uptake in the first month of opening has been excellent and was amongst the highest in the country compared to other participating maternity units.

We are **proud** to say that the wider maternity team is instrumental to our research success, all of our doctors have completed research training (GCP) and are actively involved in patient recruitment. We also have several trainees who have joined the Associate PI scheme and are building on their research experience.

To hear more about what is currently on offer in maternity research, please contact the research midwives, Christine Moller-Christensen or Rachael Grant on ext 2144 or by email ghnt.research.midwives@nhs.net

Study Success in Gynaeoncology – The MCM5 Study




The research team excelled in recruiting 400 patients in to the MCM5 study! This could not be have been achieved without the assistance they receive from the supporting services. It has been a fantastic team effort! The study is still in follow up but we are looking forward to seeing the results and really hope this trial will make a huge difference to how we diagnose endometrial cancer in the future.

What's happening around the Trust?

NHS Gateshead Health NHS Foundation Trust

SPIROMAC is one of our new paediatric studies looking at using spirometry to guide the treatment of asthma and prevent asthma attacks in children with asthma. Hear from the research team below …..

Dr Ramphul - PI "I have been involved in paediatric research projects in the past as a trainee. I moved from Tees to join QEH in October 2021 and it has been refreshing to re-engage in research. I am very grateful to Sarah Wilkinson, Paediatric Nurse Practitioner for joining me on this journey and to the research team who has been very proactive and supportive (special thanks to Amanda Sanderson, Meraud Bird and Lucy Blackwell) and we hope to continue in this partnership…"

Sarah Wilkinson – "I was employed by the QE in May 2018 as an Advanced Paediatric Nurse Practitioner. I am new to the research role, I would like to thank the team for supporting me and I am happy to be part of this project."

This trials is looking at bone marrow samples to help work out the best treatment for patients with Myeloma. We have two patients doing incredibly well on the trial they are now both in remission. Find out more about the trial here: A trial looking at different combinations of treatment for newly diagnosed myeloma (RADAR, Myeloma XV) | Cancer Research UK

However we wouldn't be able to do this trial without the support and collaboration of the Chemo day unit and the wonderful Haematologists that we work with.

Chemo Day Unit Team

Haematology Secretaries

Thank you!

121 patients have now been recruited into the Genomics study! Well done to all involved

The SMALL Trial has recruited its 20th patient almost doubling expected recruitment. Well done to the team!

We now have over 500 followers on X!

Where to find us

Gateshead Health NHS Foundation Trust

Follow us on X for regular updates @QEHResearch

Talk to your team to see who the research lead is for your area
or
Contact us via Email at:

ghnt.researchanddevelopment@nhs.net

We look forward to working with you!

Associate Principle Investigator (API) Scheme

The API Scheme aims to develop health and care professionals to become PIs of the future. Several health care professionals in the trust have signed up and completed the scheme. Dr Victor Ohwo From Gynaeoncology & Obstetrics has completed the scheme.

Victor said "I became an Associate Principal Investigator (PI) in this outstanding research team to have the opportunity to collaborate with collaborate with incredible individuals in making significant contributions to ground-breaking discoveries and improvements in healthcare.

To find out more about becoming an Associate PI follow the link below: Associate Principal Investigator (PI) Scheme | NIHR

How to get involved

Have you participated in health research? - Share your story by emailing us and let others know why health research is important to you

Read more about the NIHR: Clinical Research Network | NIHR

What is healthcare without research: https://youtu.be/tQU2NRoJ15M

Follow the link to learn more about Good clinical practice (GCP): Good Clinical Practice (GCP) | NIHR

Board of Directors

Gateshead Health NHS Foundation Trust

Agenda Item: 10i

Report Title:	**Organisational Risk Register (ORR)**			
Name of Meeting:	Board of Directors			
Date of Meeting:	5th June 2024			
Author:	Marie Malone, Corporate and Clinical Risk Lead.			
Executive Sponsor:	Gill Findley, Chief Nurse and Professional Lead for Midwifery and Allied Health Professionals/Deputy CEO			
Report presented by:	Gill Findley, Chief Nurse and Professional Lead for Midwifery and Allied Health Professionals/Deputy CEO			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☒	**Assurance:** ☒	**Information:** ☐
	To ensure the Board and Committees are clearly sighted on those risks that have an organisational -wide impact, the organisational risk register is compiled by the Executive Risk Management Group (ERMG) of those risks that impact on the delivery of strategic aims and objectives. This includes risks included within the Board Assurance Framework (BAF) as well as risks identified by the Group for inclusion as having an organisational impact and impact on delivery of strategic aims and objectives. The supporting report shows the risk profile of the ORR, includes a full register, and provides details of review compliance, and risk movements.			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☒ *No gaps in assurance*	**Partially assured** ☐ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	The attached report is received in the Executive Team Meeting each week, and at the Executive Risk Management Group meeting every month.			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience*	Risks on the ORR were comprehensively discussed at previous ERMG meetings in April and May, and the following updates and movements agreed. The accompanying Report shows the following changes and is detailed within this report. -There were 2 risks added, 2 risks removed and 2 risks escalated during the period.			

<table>
<tr><td>

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

</td><td colspan="5">-Associated actions within the report are now presented as a percentage of completion – this is part of Inphase implementation and allows more detailed breakdown of progress to provide assurance that actions are progressing within agreed timescales.

-Risks are actively being reviewed and managed as per risk management framework timeframes.
Compliance with reviews sits at 81% for both risks and associated actions.</td></tr>
<tr><td>Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper</td><td colspan="5">The Board are asked to:

• Review the risks and actions 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 sighted on the top 3 risks for the organisation.</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">Each risk is linked to a corporate objective, see report.</td></tr>
<tr><td>Links to CQC KLOE</td><td>Safe
☒</td><td>Effective
☒</td><td>Caring
☒</td><td>Responsive
☒</td><td>Well-led
☒</td></tr>
<tr><td colspan="6">Risks / implications from this report (positive or negative):</td></tr>
<tr><td>Links to risks (identify significant risks and DATIX reference)</td><td colspan="5">Included in report</td></tr>
<tr><td>Has a Quality and Equality Impact Assessment (QEIA) been completed?</td><td colspan="2">Yes
☐</td><td colspan="2">No
☐</td><td>Not applicable
☒</td></tr>
</table>

Organisational Risk Register

Executive Summary

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

Good governance processes have been demonstrated throughout the period, with reviews of the ORR at ERMG, as well as appropriate committees as per Risk Management Framework.

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 19th March- 22nd May 2024 (extraction date for this report).

Organisational Risk Register

Movements:

Following ERMG meeting in April and May 2024, there has been 2 additions to the ORR, 2 escalations, 0 reductions and 2 removals.
There are currently 16 risks on the ORR, agreed by the group as per enclosed report.

New Risks:

- **4541 (CEO)** Risk of the failure of governance arrangements as we transition to a new governance structure. This may result in critical information being lost or missed and Executives being unaware of risks within the organisation. (16)

    - Assurances from each of the committees will be presented to Trust Board to ensure there is continued oversight and governance.
    - Remains a risk until full governance structure is implemented and embedded in the organisation.

- **4525 (POD)** Risk that the lack of a strategic workforce plan that delivers our specific future priorities (women's health, diagnostics, etc) leads to a lack of appropriate skilled staff and negative impacts on service delivery, patient safety and staff engagement and an increase in costs for temporary staffing. (12)

    - International recruitment team established
    - Operational workforce plan submitted as part of 2024/2025 operational planning

2 Risks increased:

- **2341 (QEF)** 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)

    - Risk increased from 12 to 16 with the likelihood upgraded from possible to likely in response to the backlog of maintenance work due to restrictions on capital programme.

- **2250 (CSS)** Risk of losing MRI provision due to temporary closure of department for essential refurbishment**.** (16)

    - Risk increased from 12 to 16 as there has been significant downtime with the scanner. Full reliance on the mobile scanner QEH until 28/5/24, which places the service at an increased risk of failure.
    - Dynamic risk likely to reduce once MRI department reopens.

0 Risks reduced:

0 risk have reduced in period.

Risks removed and closed in period:

2 Risks closed:

- **2266 (P+P)** Risk that the Trust will not achieve zero > 52 week waiters by March 2024.

    - Risk relates to planning year 23/24 and therefore no longer relevant to dynamic risk methodology.
    - New risk scoped for 2024/25

- **2763 (POD)** Risk of not having clearly agreed workforce plans for the next 3, 5 and 10 years.

    - Risk closed and new, more relevant risk has been scoped out taking into consideration the changing landscape of the organisation.

Top 3 Risks:

The following 3 risks were agreed as the top organisational risks at the last 2 meetings:

1- Finance- CRP – lack of delivery of operating plan. Work remains on track to quantify the delivery of the plan.

With financial risks on the ORR with high scores of 16, there is significant emphasis on financial implications as an organisation.

2- POD- Strategic Workforce – lack of a strategic workforce plan that delivers our future priorities. This includes short-term risks in relation to current gaps and long / medium term risks relating to apprenticeships.

3- CEO- Implementation of the new governance structure, including ensuring appropriate quality impact assessment.

Current compliance with Risk reviews:

Good governance processes have been demonstrated throughout the period, with reviews of the ORR at ERMG, as well as relevant committees.

Risk review compliance is currently at 81%. This is an improvement on last reporting period. Action review compliance is 81%. This is a decline from last reporting period. Support with reviews continue to be offered by Corporate and Clinical Risk Lead where able.
The Board are asked to note that we have now fully implemented Inphase management system and all risk data is extracted from this system moving forwards.

Recommendations

The Board of Directors are asked to:

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

ORR Report - Board

Total Risks (Current/Managed)

16

People

3

Risk Sub Type	Business Unit	Risk Id	Risk Title	Rating
Staff Safety	People & OD	3132	Exposure to incidents of violence and aggression in ECC	15
Resources	People & OD	4525	risk of Lack of a strategic workforce planning	12
Wellbeing	People & OD	4417	Increase in incivility and disrespectful behaviours being reported	12

Quality

5

Risk Sub Type	Business Unit	Risk Id	Risk Title	Rating
Effectiveness	Clinical Support & Screening	2250	Risk of no MRI facility in the hospital	16
Effectiveness	Medical Services	2545	Risk of delayed transfers of care and increased hospital lengths of stay	8
Safety	People & OD	2432	Risk of Significant, unprecidented service disruption due to industrial action	16
Safety	Surgical Services	3107	ALARP- Risk that MDT are delayed to a maternity emergency/delayed CCU transfers for maternity patients due to separate buildings	15
Safety	Nursing, Midwifery & Quality	2438	Quality - Risk of quality failures in patient care due to external causes such as delayed discharges and external pressures.	8

Finance

4

Risk Sub Type	Business Unit	Risk Id	Risk Title	Rating
Business Continuity	QE Facilities	2341	There is a risk to ongoing business continuity of service provision due to ageing trust estate	16
Finance	Finance	2424	Risk that efficiency requirements are not met.	16
Finance	Finance	2425	Activity is not deliverved in line with planned trajectories, leading to reduction in income	16
Effectiveness	Planning & Performance	2582	Risk of ineffective and inefficient management of services due to availability and access to appropriate and timely BI.	12

Regulation

3

Risk Sub Type	Business Unit	Risk Id	Risk Title	Rating
Compliance	Digital	4402	Inability to support legislation and best practice associated with records management	16
Compliance	Digital	4405	Risk that data is not accessed appropriately, leading to misuse or inappropriate disclosure.	16
Compliance	Nursing, Midwifery & Quality	4541	Risk of governance failure as we transition to new governance arrangements	16

Reputation

1

Risk Sub Type	Business Unit	Risk Id	Risk Title	Rating
Reputation	Chief Executive Office	2272	People may lose trust an confidence in our services	12

Organisational Risk Register (Current/Managed)

16

Risk Id	Report Inclusion Summary	Risk Description	Risk Owner	Business Unit	Service	Existing Controls	Latest Progress Notes	Which Strategic Objectives are threatened by this risk? Summary	Initial Risk Rating	Rating	Target Rating	Date moved to current risk	Next review Date	Stage	Oper Form
2250	BU Dir. Governance Meeting COO Health & Safety Committee Organisational Risk Quality Governance Committee Finance & Performance Committee	Risk of losing MRI provision due to temporary closure of department for essential refurbishment. This will result in reduced capacity and productivity. This could have significant consequences for inpatients requiring an MRI scan, and will increase waiting times for outpatient scans. This could have consequences for a number of patient pathways,including FDS pathways.	Katy-Jo Wilkinson	Clinical Support & Screening	Diagnostics	Recovering scanning capacity from NuTH on the mobile provision at BPCC. Negotiating reducing onsite scanner downtime with contractors. Mobile scanner will be on site for 19 weeks. Tunnel erected by QEF to connect Mobile unit to hospital. full assessment by engineer underway 16/01/2024	risk increased- actions added to support mitigation	SA1.2 Continuous Quality improvement plan 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	20	16	8	11 Sep 2023	09 Jun 2024	Current Risk	
2341	BU Dir. Governance Meeting Finance & Performance Committee Health & Safety Committee Organisational Risk	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.	Philip Glasgow	QE Facilities	Estates	Clinically led estates strategy developed and prioritsied on priority versus affordability	Capital programme submission provided for 2024-25 with prioritised list.	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	16	16	4	20 Feb 2023	07 Jun 2024	Current Risk	
2424	BU Dir. Governance Meeting COO Finance & Performance Committee Organisational Risk	Efficiency requirements are not achieved.	Kris MacKenzie	Finance	Finance	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.	No changes to score or profile. To remain on the ORR	SA3.2 Achieving financial sustainability	20	16	8	22 Aug 2022	17 May 2024	Current Risk	
2425	BU Dir. Governance Meeting Finance & Performance Committee Organisational Risk	Activity is not delivered in line with planned trajectories, resulting in the Trust having reduced access to core funding.	Kris MacKenzie	Finance	Finance	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.	No change to score or profile. To remain on ORR	SA3.2 Achieving financial sustainability	20	16	4	22 Aug 2022	17 May 2024	Current Risk	

Risk Id	Report Inclusion Summary	Risk Description	Risk Owner	Business Unit	Service	Existing Controls	Latest Progress Notes	Which Strategic Objectives are threatened by this risk? Summary	Initial Risk Rating	Rating	Target Rating	Date moved to current risk	Next review Date	Stage	Oper Form
2432	BU Dir. Governance Meeting Organisational Risk People and Organisational Development Quality Governance Committee	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.	Amanda Venner	People & OD	Workforce Development	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.	reviewed with AV. no change	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	20	16	8	07 Nov 2022	22 Jun 2024	Current Risk	
4402	BU Dir. Governance Meeting Digital Committee Organisational Risk	Risk of breaching legislative requirements due to lack of long term strategic approach to the management and storage of health records [both digital and paper]. This could lead to regulatory and reputational harm.	Catherine Bright	Digital	Digital Transformatic and Assuranc	Action to scope and procure an EPR to support robust record management requirements [Record Lifecycle - creation to destruction]	Following market engagement activity, the trust have established a multi disciplinary team to drive the development of the EPR procurement approach and subsequent implementation plan. Reply	SA1.3 Digital where it makes a difference	20	16	8	24 Nov 2023	26 May 2024	Current Risk	
4405	BAF BU Dir. Governance Meeting Digital Committee Organisational Risk	Risk of data mismanagement, leading to inappropriate access, misuse or inappropriate disclosures. Due to failure to incorporate best practices in the management of information across the organisation. Resulting in patient harm and/or failure to comply with UK law, national standards and contractual requirements.	Dianne Ridsdale	Digital	Digital Transformatic and Assuranc	Trust Policies, procedures, guides, materials and tools. Staff training, awareness and communication programmes Internal and external auditing and IG spot check programme	actions reviewed and updated	SA1.3 Digital where it makes a difference	20	16	4	24 Nov 2023	27 May 2024	Current Risk	
4541	BU Dir. Governance Meeting Finance & Performance Committee Quality Governance Committee Organisational Risk	There is a risk of the failure of governance arrangements as we transition to a new governance structure. This may result in critical information being lost or missed and Executives being unaware of risks within the organisation.	Gill Findley	Nursing, Midwifery & Quality	Corporate Nursing	Date to be agreed for start of new meeting structure. This will not take place until all controls and actions are in place. Cycles of business for existing committees continue to be followed until the date of transfer.		SA1.2 Continuous Quality improvement plan	20	16	4	13 May 2024	13 Jun 2024	Current Risk	
3107	BAF BU Dir. Governance Meeting COO Organisational Risk Quality Governance Committee	ALARP-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.	Kate Hewitson	Surgical Services	Surg 2	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. major haemorrhage protocols in place	D/W RP no change	SA1.1 Continue to improve our maternity services in line with the wider learning from the Ockenden review SA1.2 Continuous Quality improvement plan	20	15	5	28 Dec 2018	01 Jun 2024	Current Risk	

Risk Id	Report Inclusion Summary	Risk Description	Risk Owner	Business Unit	Service	Existing Controls	Latest Progress Notes	Which Strategic Objectives are threatened by this risk? Summary	Initial Risk Rating	Rating	Target Rating	Date moved to current risk	Next review Date	Stage	Oper Form
3132	BU Dir. Governance Meeting Health & Safety Committee Organisational Risk People and Organisational Development Quality Governance Committee	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	Laura Farrington	People & OD	Workforce Development	policies in place to support staff training available reporting tools available forums for debrief/discussion and support available	update received from LF- current policy has been updated, with a clear focus on bullying, harassment, discrimination and abuse and detailed actions for staff to follow when instances occur. The Violence Reduction Group has also been reinstated, with the first meeting taking place on the 13 May. no change to score	SA2.1 Protect and understand the health and well-being of our staff by looking after our workforce	20	15	6	27 Oct 2021	26 May 2024	Current Risk	
2272	BU Dir. Governance Meeting Organisational Risk Quality Governance Committee	There is a potential for people to lose trust and confidence in our services as a result of recent reports and incidents.	Gill Findley	Chief Executive Office	Chief Executive Office	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. Plan is for enhanced surveillance to be stood down after next meeting.	Work has progressed and a culture review has been commissioned that will inform improvement plans	SA1.2 Continuous Quality improvement plan	20	12	8	27 Jun 2023	02 Jun 2024	Current Risk	
2582	BU Dir. Governance Meeting Finance & Performance Committee Organisational Risk	Risk of ineffective and inefficient management of services due to availability and access to appropriate and timely business intelligence to deliver and improve services	Debbie Renwick	Planning & Performance	Planning & Performance			SA3.1 Improve the productivity and efficiency of our operational services through the delivery of the New Operating Model and associated transformation plans	15	12	3	13 Oct 2021	23 May 2024	Current Risk	

Risk Id	Report Inclusion Summary	Risk Description	Risk Owner	Business Unit	Service	Existing Controls	Latest Progress Notes	Which Strategic Objectives are threatened by this risk? Summary	Initial Risk Rating	Rating	Target Rating	Date moved to current risk	Next review Date	Stage	Oper Form
						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 update January 2024- Activity Plan & Operational Recovery Monitoring: Information Team produce weekly and monthly activity against plans, excel manipulation required to produce business unit and Board level reporting views from weekly and monthly outputs. Business partners realign outputs to support business unit need. Key Performance & Recovery Reporting: Information Team produce weekly PTL views for DM01, RTT and Cancer WLs from weekly WLMS reporting submissions. Business partners collate & manipulate views for weekly Access & Performance meetings. Realtime cancer performance dashboards developed in line with revised cancer standards for FDS, 31 Day, and 62 Day Treatments. SItRep Reporting: Outputs from Sit-reps are shared in PPAI platform: Manual review and manipulation is then available to the end user. Integrated Board Reporting: Manual compilation from existing excel outputs (from various sources) and co-ordination by Planning & Performance Team. Leading Indicators: Manual compilation from existing excel outputs (from various sources) and co-ordination by Planning & Performance Team. Health Inequalities Data: Information team produce HIE view of RTT and Cancer PTL's on a monthly basis. Deprivation Scores and Protected characteristics are available on PTLs for operational review. Real-time UEC Dashboards Real-time Length of Stay Dashboard 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								

Risk Id	Report Inclusion Summary	Risk Description	Risk Owner	Business Unit	Service	Existing Controls	Latest Progress Notes	Which Strategic Objectives are threatened by this risk? Summary	Initial Risk Rating	Rating	Target Rating	Date moved to current risk	Next review Date	Stage	Oper Form
4417	BU Dir. Governance Meeting Organisational Risk People and Organisational Development	There is a risk that promoting an environment that encourages speaking out and creating a psychologically safe culture may lead to increased reports of poor behaviour. This could have a negative impact on staff and require addiitional time and capacity to appropriately address the concerns. This could result in further health and well being concerns and staff absence.	Amanda Venner	People & OD	Workforce Development	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.	Reviewed with AV. no change	SA2.1 Protect and understand the health and well-being of our staff by looking after our workforce	15	12	6	26 Oct 2023	24 May 2024	Current Risk	
4525	BU Dir. Governance Meeting Organisational Risk People and OD Committee	There is a risk that the lack of a strategic workforce plan that delivers our specific future priorities (women's health, diagnostics, etc) leads to a lack of appropriate skilled staff and negative impacts on service delivery, patient safety and staff engagement and an increase in costs for temporary staffing.	Sophia Grainger	People & OD	Human Resources	International recruitment team established Refreshed absence management policy oversight meetings with BUs around WTEs Operational workforce plan submitted as part of the 2024/2025 Operating Planning submission NHS Long Term Workforce Plan published to set a direction of travel and commit to an ongoing programme of strategic workforce planning	risk closed user error. re-opened and reviewed by owner.	SA1.2 Continuous Quality improvement plan SA2.2 Growing and developing our workforce	16	12	8	26 Mar 2024	23 Jun 2024	Current Risk	
2438	BAF BU Dir. Governance Meeting Organisational Risk Quality Governance Committee	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	Gill Findley	Nursing, Midwifery & Quality	Quality Governance	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. surge plan is in place and is being managed	risk reduced as overall position within Gateshead has improved. there is still a risk of harm from delays in other Local Authority areas, which is being managed by the discharge teams. no change to score	SA1.2 Continuous Quality improvement plan	15	8	4	16 Aug 2022	02 Jul 2024	Current Risk	
2545	BAF BU Dir. Governance Meeting COO Finance & Performance Committee Organisational Risk	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.	Mark Dale	Medical Services	Medical Services - Divisional Management	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 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 ICB representative. Medically Optimised meeting 2x week, passed to IPC/ICB Pilot on 2 wards re improving discharges.	Continues to be risk, system work continues to reduce delays	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	20	8	4	07 Dec 2021	10 Jul 2024	Current Risk	

Risks Moved to Managed in Period

This report does not contain any data

Risks Closed in Period

2

Risk Id	Report Inclusion Summary	Risk Description	Risk Owner	Business Unit	Service	Existing Controls	Latest Progress Note	Which Strategic Objectives are threatened by this risk? Summary	Initial Risk Rating	Rating	Target Rating	Closed date	Next review Date	Stage	Oper Form
2266	BU Dir. Governance Meeting Organisational Risk	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.	Debbie Renwick	Planning & Performance	Planning & Performance	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.		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	20	12	8	12 Apr 2024	25 Feb 2024	Closed Risk	
2763	BU Dir. Governance Meeting	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.	Sophia Grainger	People & OD	Human Resources	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		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	20	8	8	10 Apr 2024	06 Mar 2024	Closed Risk	

Risks Added to ORR in Period (all levels) 2

Risk Id	Report Inclusion Summary	Risk Description	Risk Owner	Business Unit	Service	Existing Controls	Latest Progress Note	Which Strategic Objectives are threatened by this risk? Summary	Initial Risk Rating	Rating	Target Rating	Date added to ORR	Next review Date	Stage	Oper Form
4541	BU Dir. Governance Meeting Finance & Performance Committee Quality Governance Committee Organisational Risk	There is a risk of the failure of governance arrangements as we transition to a new governance structure. This may result in critical information being lost or missed and Executives being unaware of risks within the organisation.	Gill Findley	Nursing, Midwifery & Quality	Corporate Nursing	Date to be agreed for start of new meeting structure. This will not take place until all controls and actions are in place. Cycles of business for existing committees continue to be followed until the date of transfer.		SA1.2 Continuous Quality improvement plan	20	16	4	13 May 2024	13 Jun 2024	Current Risk	
4525	BU Dir. Governance Meeting Organisational Risk People and OD Committee	There is a risk that the lack of a strategic workforce plan that delivers our specific future priorities (women's health, diagnostics, etc) leads to a lack of appropriate skilled staff and negative impacts on service delivery, patient safety and staff engagement and an increase in costs for temporary staffing.	Sophia Grainger	People & OD	Human Resources	International recruitment team established Refreshed absence management policy oversight meetings with BUs around WTEs Operational workforce plan submitted as part of the 2024/2025 Operating Planning submission NHS Long Term Workforce Plan published to set a direction of travel and commit to an ongoing programme of strategic workforce planning	risk closed user error. re-opened and reviewed by owner.	SA1.2 Continuous Quality improvement plan SA2.2 Growing and developing our workforce	16	12	8	22 May 2024	23 Jun 2024	Current Risk	

Risks Removed from ORR in Period (all levels) 2

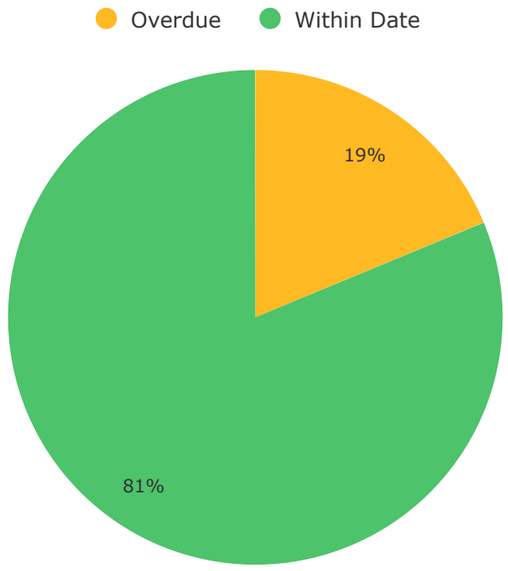
Risk Id	Report Inclusion Summary	Risk Description	Risk Owner	Business Unit	Service	Existing Controls	Latest Progress Note	Which Strategic Objectives are threatened by this risk? Summary	Initial Risk Rating	Rating	Target Rating	Date Removed from ORR	Next review Date	Stage	Open Form
2266	BU Dir. Governance Meeting Organisational Risk	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.	Debbie Renwick	Planning & Performance	Planning & Performance	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.		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	20	12	8	12 Apr 2024	25 Feb 2024	Closed Risk	
2763	BU Dir. Governance Meeting	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.	Sophia Grainger	People & OD	Human Resources	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		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	20	8	8	09 Apr 2024	06 Mar 2024	Closed Risk	

Risk ID	Risk Stage	Open	Risk Title	Owner	Business Unit	Service	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024
2250	Current Risk		Risk of no MRI facility in the hospital	Katy-Jo Wilkinson	Clinical Support & Screening	Diagnostics			12	12	12	16
2341	Current Risk		There is a risk to ongoing business continuity of service provision due to ageing trust estate	Philip Glasgow	QE Facilities	Estates			12	12	12	16
2424	Current Risk		Risk that efficiency requirements are not met.	Kris Mackenzie	Finance	Finance			16	16	16	16
2425	Current Risk		Activity is not deliverved in line with planned trajectories, leading to reduction in income	Kris Mackenzie	Finance	Finance			16	16	16	16
2432	Current Risk		Risk of Significant, unprecidented service disruption due to industrial action	Amanda Venner	People and OD	Workforce Development			16	16	16	16
4402	Current Risk		Inability to support legislation and best practice associated with records management	Catherine Bright	Digital	Digital Transformation and Assurance			16	16	16	16
4405	Current Risk		Risk that data is not accessed appropriately, leading to misuse or inappropriate disclosure.	Dianne Ridsdale	Digital	Digital Transformation and Assurance			16	16	16	16
4541	Current Risk		Risk of governance failure as we transition to new governance arrangements	Gill Findley	Nursing, Midwifery & Quality	Corporate Nursing						16
3107	Current Risk		ALARP- Risk that MDT are delayed to a maternity emergency/delayed CCU transfers for maternity patients due to separate buildings	Kate Hewitson	Surgical Services	Obstetrics			15	15	15	15
3132	Current Risk		Exposure to incidents of violence and aggression in ECC	Laura Farrington	People and OD	Workforce Development			15	15	15	15
2272	Current Risk		People may lose trust an confidence in our services	Gill Findley	Chief Executive Office	Chief Executive Office			12	12	12	12
2582	Current Risk		Risk of ineffective and inefficient management of services due to availability and access to appropriate and timely BI.	Debbie Renwick	Planning & Performance	Planning & Performance			12	12	12	12
4417	Current Risk		Increase in incivility and disrespectful behaviours being reported	Amanda Venner	People and OD	Workforce Development			12	12	12	12
4525	Current Risk		risk of Lack of a strategic workforce planning	Sophia Grainger	People & OD	Human Resources					9	12
2438	Current Risk		Quality - Risk of quality failures in patient care due to external causes such as delayed discharges and external pressures.	Gill Findley	Nursing, Midwifery & Quality	Quality Governance			12	8	8	8
2545	Current Risk		Risk of delayed transfers of care and increased hospital lengths of stay	Mark Dale	Medical Services	Medical Services - Divisional Management			16	8	8	8

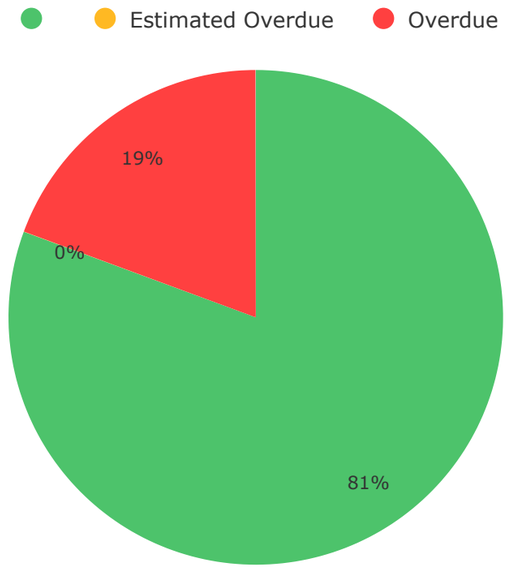
Risk ID	Risk Description	Priority	Total Actions	Action Description	Action Stage	Details	Owner	Owner Dept	Overdue	% Complete	Start Date	Due Date
Risk 00002250	Risk of losing MRI provision due to temporary closure of department for essential refurbishment. This will result in reduced capacity and productivity. This could have significant consequences for inpatients requiring an MRI scan, and will increase waiting times for outpatient scans. This could have consequences for a number of patient pathways,including FDS pathways.	Normal	2	weekly meeting with company/contractors (TIC)	In Progress		Katy-Jo Wilkinson	Clinical Support & Screening		20%	13/05/2024	30/06/2024
				weekly team meetings to support patient flow and maximise activity	In Progress		Katy-Jo Wilkinson	Clinical Support & Screening		30%	13/05/2024	30/06/2024
Risk 00002272	There is a potential for people to lose trust and confidence in our services as a result of recent reports and incidents.	Normal	1	monitor implementation of thematic review delivery plan	In Progress		Gill Findley	Nursing, Midwifery & Quality		10%	30/06/2023	31/05/2024
Risk 00002341	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.	Normal	1	commission full estates review as part of Bensham retraction programme	In Progress		Anthony Pratt	QE Facilities		10%	31/03/2023	31/05/2024
Risk 00002424	Efficiency requirements are not achieved.	Normal	1	delivery oversight group and finance focus sessions	In Progress		Kris Mackenzie	Finance		30%	07/11/2023	30/06/2024
Risk 00002425	Activity is not delivered in line with planned trajectories, resulting in the Trust having reduced access to core funding.	Normal	2	Counting and Coding Review	In Progress		Kris Mackenzie	Finance	Overdue	20%	31/05/2023	30/04/2024
				Timley and detailed reporting information	In Progress		Jane Fay	Finance	Overdue	0%	17/03/2023	30/04/2024
Risk 00002432	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.	Normal	1	Support twice weekly co-ordination cell and fortnightly industrial action Trust wide working group.	In Progress		Amanda Venner	People and OD		40%	18/10/2022	31/05/2024
Risk 00002545	▪ 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.	Normal	1	Weekly stranded patient meeting	In Progress		Rachel Thompson	Medical Business Unit	Estimated Overdue	30%	31/05/2024	31/05/2024
Risk 00002582	Risk of ineffective and inefficient management of services due to availability and access to appropriate and timely business intelligence to deliver and improve services	Normal	1	Work with the BU managers looking at what is available and start to build what is needed and get rid	In Progress		Debbie Renwick	Planning and Performance	Overdue	0%	01/09/2021	31/03/2024
Risk 00003107	▪ ALARP-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.	Normal	1	looking into estate options	In Progress		Kate Hewitson	surg 2		10%	29/04/2021	30/06/2024
Risk 00003132	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	Normal	1	Policy review -to include clinical teams, group policy	In Progress		Lee Taylor	People and OD		70%	24/11/2023	31/05/2024
Risk 00004402	Risk of breaching legislative requirements due to lack of long term strategic approach to the management and storage of health records [both digital and paper]. This could lead to regulatory and reputational harm.	Normal	2	develop FBC for integrated EPR	Not Started		Catherine Bright	Digital		0%	29/11/2023	31/03/2025
				Establish the scope and procurement options for an EPR	In Progress		Catherine Bright	Digital		20%	30/11/2023	31/12/2024

Risk ID	Risk Description	Priority	Total Actions	Action Description	Action Stage	Details	Owner	Owner Dept	Overdue	% Complete	Start Date	Due Date
Risk 00004405	▪ Risk of data mismanagement, leading to inappropriate access, misuse or inappropriate disclosures. ▪ Due to failure to incorporate best practices in the management of information across the organisation. ▪ Resulting in patient harm and/or failure to comply with UK law, national standards and contractual requirements.	Normal	4	Development of role of IAO/IAA	In Progress		Catherine Bright	Digital		75%	01/02/2024	30/06/2024
				Esablish IAO network with link to SIRO	In Progress		Catherine Bright	Digital		40%	02/02/2024	30/06/2024
				Provide compliance reporting to business units	In Progress		Catherine Bright	Digital		80%	01/02/2024	31/05/2024
				Review process by which the asset registers and data flows are managed - investigate options for sim	Parked		Dianne Ridsdale	Digital		50%	02/02/2024	31/01/2025
Risk 00004417	There is a risk that promoting an environment that encourages speaking out and creating a psychologically safe culture may lead to increased reports of poor behaviour. This could have a negative impact on staff and require addiitional time and capacity to appropriately address the concerns. This could result in further health and well being concerns and staff absence.	Normal	5	Create a zero-tolerance campaign	In Progress		Laura Farrington	People and OD		50%	26/10/2023	31/10/2024
				EDI strategy to be developed	In Progress		Kuldip Sohanpal	People and OD		0%	30/12/2023	31/05/2024
				Embed FTSU Champions within the Organisation	In Progress		Tracy Healy	People and OD	Overdue	10%	31/10/2023	30/04/2024
				ICS EDI programme to be fully scoped and network chairs supported	In Progress		Kuldip Sohanpal	People and OD		0%	31/12/2023	31/05/2024
				Review existing Bullying & Harassment policy	In Progress		Laura Farrington	People and OD		50%	26/10/2023	30/08/2024
Risk 00004525	There is a risk that the lack of a strategic workforce plan that delivers our specific future priorities (women's health, diagnostics, etc) leads to a lack of appropriate skilled staff and negative impacts on service delivery, patient safety and staff engagement and an increase in costs for temporary staffing.	Normal	8	1. Workforce planning	Not Started		Amanda Venner	People and OD		0%	22/05/2024	31/10/2024
				Develop and ensure good rostering practice across the organisation	Not Started		Laura Edgar	People and OD		0%	26/03/2024	30/10/2024
				Develop systems, processes ,comms to support increasing exit interview completion rates across trust	In Progress		Sophia Grainger	People and OD		20%	26/03/2024	02/06/2024
				Education, learning and Workforce development group to continue work on the implications of the LTWF	In Progress		Sarah Neilson	People and OD	Overdue	0%	26/03/2024	30/04/2024
				Focus on absence management	Not Started		Carol O'Flaherty	People and OD		0%	26/03/2024	30/06/2024
				Reduce turnover in line with the leading indicator target of 9.7% with a focus on retention	In Progress		Sophia Grainger	People and OD		5%	22/04/2024	12/03/2025
				robust management of leading indicators for WTE	In Progress		Amanda Venner	People and OD		0%	26/03/2024	31/03/2025
				Work with Director of Strategy, Planning and Partnerships to explore broader approach to planning	In Progress		Sophia Grainger	People and OD	Overdue	20%	26/03/2024	30/04/2024
Risk 00004541	There is a risk of the failure of governance arrangements as we transition to a new governance structure. This may result in critical information being lost or missed and Executives being unaware of risks within the organisation.	Normal	1	implementation plan	In Progress		Gill Findley	Nursing, Midwifery & Quality		0%	13/05/2024	31/05/2024

Risk Review Compliance



Risk Action Compliance



Committee Escalation and Assurance Report

Name of Board Committee	Finance and Performance Committee
Date of Board Committee:	26 February 2024
Chair of Board Committee:	Mr Mike Robson

Alert
(matters of significant concern requiring escalation to the Board for further action)

- There were no issues identified as requiring escalation to the Board for further action.

Advise
(areas subject to ongoing monitoring where some assurance has been noted / further assurance sought or emerging developments that the Committee is seeking assurance over)

Budget Setting - the Committee approved the budget for referral to the Board but noted the level of risk. There is limited assurance due to the lack of planning guidance. The Committee identified the need for more detailed reporting and monitoring of the CRP.

Mutual Aid – It was noted that the impact will continue to be monitored in terms of the number of offers and receipts.

Culture Change – the Committee noted a need for culture change across the organisation in relation to finance and delegated budgets.

Capital Steering Group (CSG) – the Committee are not fully assured but do not need to escalate at this stage.

Assure
(key assurances received and any highlights of note for the Board)

Positive assurances were agreed in relation to:

- ICS Digital Diagnostics
- Financial Revenue Report
- Budget setting
- Performance metrics – positive movement seen on a number of metrics in the Leading Indicator report

Risks (any new risks / proposed changes to risk scores)

Risk 3261 - 52 week waiters - it was noted that the zero target will not be achieved and risk for 2024-25 to be amended accordingly.

Risk 3127 - Finance – current risk rating to be recorded in line with target risk of 4.

Committee Escalation and Assurance Report

Name of Board Committee	Finance and Performance Committee
Date of Board Committee:	30 April 2024
Chair of Board Committee:	Mr Mike Robson

Alert
(matters of significant concern requiring escalation to the Board for further action)

- There were no issues identified as requiring escalation to the Board for further action.

Advise
(areas subject to ongoing monitoring where some assurance has been noted / further assurance sought or emerging developments that the Committee is seeking assurance over)

To highlight that the delivery of the CDC is on plan and there is a further opportunity for phase 2 linked to women's health, with funding for this recently agreed.

Internal Audit - the Committee agreed to look at internal audit actions more frequently as part of the transition into the new governance structure.

Leading Indicators - moving forward there will be a focus on out-patients work.

Finance Report - there will be a review of the increase in annual leave carry forward and this will be cross referenced to POD Committee.

Assure
(key assurances received and any highlights of note for the Board)

Positive assurances were agreed in relation to:

- Achieving delivery of the Financial Plan, whilst recognising slippage on the delivery of the Capital Plan
- Leading indicators – Maintained or improved performance on a range of indicators including ambulance handovers, waiting times and long waiters.
- Progress with delivery of the CDC

Risks (any new risks / proposed changes to risk scores)

There were no changes to risks.

Committee Escalation and Assurance Report

Name of Board Committee	Finance and Performance Committee
Date of Board Committee:	28 May 2024
Chair of Board Committee:	Mr Mike Robson

Alert
(matters of significant concern requiring escalation to the Board for further action)

- The Committee received a presentation which set out a clear picture of the financial position and the immediate actions that are being put in place. The Committee had a detailed discussion following the presentation and agreed the important role for NEDs on all committees to provide challenge in linking finance and sustainability to the work of those committees.

- The committee considered a report on the decision taken by the May Supply and Procurement Committee and EMT to waiver Standing Orders and contract award to Philips for the provision of a PACS/RIS/VNA service at a total cost of £1.251m including VAT. The Committee agreed a small amendment to the report to include reference to the in-year/cumulative savings figure of £99,500, and recommended the amended report be submitted to the Board to be ratified.

Advise
(areas subject to ongoing monitoring where some assurance has been noted / further assurance sought or emerging developments that the Committee is seeking assurance over)

The ICB has agreed to award the Community Services Contract to Gateshead for a further two years from September 2024, although written confirmation has not yet been received. The Committee will start to receive monthly progress reports on the contract to ensure appropriate oversight.

The Committee received an update on the CDC but had not received minutes from the Steering Group as it had not met in advance of the Committee. The Committee will receive more formal reporting on the CDC going forward.

Assure
(key assurances received and any highlights of note for the Board)

The Committee noted the strong performance against leading indicators and thanked Mrs J Halliwell and the team for this. In particular, recognition was given to the role of Surgery and the work undertaken on outpatient pathways which has fed into the improved position.

Risks (any new risks / proposed changes to risk scores)
It was noted that the risk rating had increased from 12 to 16 for two risks: Risk of losing MRI provision due to temporary closure of department for essential refurbishment; and risks to maintaining business continuity of services due to the estate infrastructure, age and backlog maintenance requirements which exceed the Trusts capital allocation (QEF). A new risk had been added in relation to the new governance arrangements and ensuring that critical information is not lost or missed during the transition from the current to the new arrangements.

Committee Escalation and Assurance Report

Name of Board Committee	Quality Governance Committee
Date of Board Committee:	30 April 2024
Chair of Board Committee:	Mrs A Stabler

Alert
(matters of significant concern requiring escalation to the Board for further action)

- There were no issues to escalate to the Board.

Advise
(areas subject to ongoing monitoring where some assurance has been noted / further assurance sought or emerging developments that the Committee is seeking assurance over)

- Patient Safety Team fragility – it was noted that there are some vulnerabilities in the team due to staff sickness. Arrangements are being put in place for a previous deputy director of nursing at the Trust to provide short term cover. In addition, the Freedom to Speak Up Guardian is assisting with cover two days per week.

- Quality Account – The Quality Account was reviewed in detail. The Committee made a number of comments to be taken on board by Dr G Findley before the document is finalised.

- DNACPR Internal Audit Action – the Committee agreed to set a target of 95% compliance and agreed to keep the action open until compliance is nearer to the target.

- The Committee noted that the Medical Examiner has identified a cluster of fracture neck of femur repair deaths and has been in contact with the Regional Medical Director.

Assure
(key assurances received and any highlights of note for the Board)

- WHO Checklist Internal Audit Action – action has been closed

- Positive assurances were agreed in relation to:

  Maternity Oversight Report
  Older Persons Mental Health Report

Leading Indicators and Elective Recovery Report Learning from Deaths Update Strategic Safeguarding Group Report Health Inequalities Patient Experience QEF Pharmacy Quality, Safety and Performance Report Health and Safety Quarterly Update Staffing Reports Clinical Audit Programme 2023-24
Risks (any new risks / proposed changes to risk scores)
• There were no changes to risks.

Committee Escalation and Assurance Report

Name of Board Committee	Digital Committee
Date of Board Committee:	15 May 2024
Chair of Board Committee:	Mr A Moffat

Alert
(matters of significant concern requiring escalation to the Board for further action)

The Committee agreed to escalate the following items to the Board for action:

- Information Asset Owners (IAOs) - there are 3 KPIs rated as red relating to IAOs. The Committee is concerned that not enough improvement is being seen in this area and this is a risk to the organisation. The digital team have implemented actions, but IAOs across the organisation need to ensure compliance to improve performance towards the target.

- Freedom of Information (FoI) and Subject Access Requests (SARs) – response rates are continuing to be significantly below the statutory deadlines and the Committee has concerns about the consequences for the organisation. Consequences need to be confirmed and consideration given as to whether further action or resources are needed. The Committee agreed to add this as a risk to the ORR.

Advise
(areas subject to ongoing monitoring where some assurance has been noted / further assurance sought or emerging developments that the Committee is seeking assurance over)

- Digital Objectives - to highlight that the outstanding objectives from 2023-24 will not be closed off, but will be rolled over into 2024-25 as sub-actions of the two 2024-25 objectives. This will ensure that the roll-over of these actions is documented.

- Assurances - there has been an improvement in the work that the Digital Team are doing and the reporting to the Committee. The Committee is looking for greater assurance in some areas going forward, particularly in relation to the EPR and KPIs.

- EPR - the Committee is partially assured about the work underway, but does not have a complete understanding of the plan to achieve it.

- KPIs – The Committee would like to see more information included in the report in relation to those KPIs that are rated as red and amber to set out when improvements are expected to be made, what they will be, and to clarify any risks.

Assure
(key assurances received and any highlights of note for the Board)

The Committee was assured that:

- KPIs are being used to challenge effectively.
- Outstanding Internal Audit actions are now complete.
- Reporting to the Committee is improving, and more assurance will be provided to the Committee if actions can be made more 'smart'.
- Cross-referral from the Finance and Performance Committee – Server upgrades – the Committee was assured that action had been taken to mitigate this risk.

Risks (any new risks / proposed changes to risk scores)

The Committee agreed a new risk to be added to the ORR in relation to compliance with FoI and SAR statutory deadlines.

Committee Escalation and Assurance Report

Name of Board Committee	People & OD
Date of Board Committee:	21/05/24
Chair of Board Committee:	Maggie Pavlou (Adam Crampsie covering)

Alert
(matters of significant concern requiring escalation to the Board for further action)

- Pre-employment check backlog is still not cleared with 189 staff still to provide all ID documentation, and 143 who are required to submit partial ID to close the gap, 48 of those are on long term sick or maternity (who will be followed up with on return to work). Outstanding staff have been written to to inform them of the consequences of non-compliance if they do not submit by the end of the month.

Advise
(areas subject to ongoing monitoring where some assurance has been noted / further assurance sought or emerging developments that the Committee is seeking assurance over)

- Senior medical staffing internal audit report remains red in two areas with overdue actions. It was acknowledged that the actions and the deadlines for completion were not achievable. Work is underway on the two items but they will take further time to embed before becoming BAU on a rolling basis so will remain red, likely until Q3. Further assurances to be given to Audit Committee.

- A reduction in engagement score following pulse survey, however the response rate remains very low (31). Further work is done on the overall engagement with pulse surveys to give a more statistically significant sample size and meaningful data.

- Healthcare assistant band 2-3 regrade remains a risk due to ongoing negotiations and the threat of industrial action

- Further monitoring is required by the committee on how the investment in increased staffing across the Trust flows through to a reduction in bank and agency spend to show return on investment

Assure
(key assurances received and any highlights of note for the Board)

- Good assurance received on improving sickness absence position

- EDI strategy KPIs presented – early stage but positive move forward on reporting and metrics to be measured for assurance

• Strategic workforce plan presented – positive to see this taking shape. Will require full organisational buy in and leadership upskilling on defining the workforce of the future, will return in 6 months for an update • Group gender pay gap reporting returned with final data, whilst the gap is larger than we would like, plans are in place to address this. Further assurances will be presented in 6 month's time on the progress against the plan.
Risks (any new risks / proposed changes to risk scores)
• None

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 12i

Report Title:	Combined Leading Indicators & Elective Recovery Report Closedown Report			
Name of Meeting:	Trust Board			
Date of Meeting:	5th June 2024			
Author:	Deborah Renwick, Deputy Director of Planning, Performance and Information			
Executive Sponsor:	Kris Mackenzie, Group Director of Finance and Digital			
Report presented by:	Kris Mackenzie, Group Director of Finance and Digital			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☒	**Assurance:** ☒	**Information:** ☒
	This report presents progress, risk and assurance in relation to the Trust's Leading Indicators and Elective Recovery Programme for the reporting period of March 2024.			
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*	Senior Management Team Finance and Performance Committee			

Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format*
 	
Consider key implications e.g.
• *Finance*
• *Patient outcomes / experience*
• *Quality and safety*
• *People and organisational development*
• *Governance and legal*
	Leading Indicator Summary:
	
	Will continually improve the quality and safety of our services for our patients:
	Risks continued within Quality and Safety Domains:
	• The number of C.Difficile cases totalled 37 across the year, 14 cases in excess of the annual stretch allowance of 23
	• Falls harm rates ended the year with 2.64 falls per 1,000 bed below the upper control limit in March. Falls investigations continue at ward level in line with PSIRF.
	• Progress against the CQC Quality Improvement plan remains fairly stable ending with 88% of actions closed or on plan.
	  • One action overdue.
	  • Risk of plans not achieving remains has reduced from 3 to 3 actions.
	
	We will improve productivity and efficiency of our operational services			

• *Equality, diversity and inclusion*	• The Trust's annually reported total remains static at 98. Representing a huge improvement in the reduction of patients waiting for a bed, in the same period last year 1,582 patients waited longer than 12 hours for bed.
	• The Trust's supporting break through objective, and national focus area of minimising ambulance handover delays is also continued to perform well across Q4.
	  ○ Ambulance conveyances were handed over within 15 mins improved from 40% to 60% in Q4.
	  ○ 100% were handed over within 30 mins.
	  ○ Zero 60 minute+ handovers since the 3rd January.
	• Whilst the 4-hr target is not part of the LI's or breakthrough objective metrics – the Committee should also note that performance is improving towards the year end, with March's performance at 72.18% and year to date at 71.09%.
	• RTT 52 week waiters have continued to improve, with 76 patients waiting longer than 52 weeks at year end, with Zero over 65 week waiters.
	
	We will be a great organisation with a highly engaged workforce
	• Staff survey results have deteriorated from staff engagement score of 7 in the staff survey to 6.6 in the Pulse survey.
	• Group sickness absence rates improved in month from 5.6% to 5.2%
	• Vacancy rates have deteriorated slightly from 2.2% to 2.4%
	
	We will achieve financial sustainability:
	Risks remain within CRP and Pay and non-pay spend, Over-all plan is demonstrating a positive variance.
	• CRP adverse variance of £2.6m.
	• Pay spend over planned levels with an adverse variance £20.4m.
	• Non pay spend over planned levels adverse variance YTD of £9.6m
	• Plan improved at year end with a £63k positive variance against plan.
	
	Elective Recovery Summary:
	
	Elective and diagnostic activity continued to over-perform, whilst new outpatients and follow-up outpatients are below required levels:
	
	M12: Year end summary against activity plan: 107% delivered.
	• New Outpatients: 95% (107% of 2019/20 activity)
	• Follow-up Outpatients:116% (94% of 2019/20 activity)
	• Daycase: 104.2% (107% of 2019/20 activity)
	• Inpatient: 95.4% (79% of 2019/20 activity)
	• Diagnostics 102.6% (112% of 2019/20 activity)
	Year end DM01 performance is at 91.2% -0.7% difference against forecast position of 91.9%

<table>
<tr><td></td><td colspan="2">
MRI capacity reduction, audiology capacity and workforce issues and echocardiology workforce issues have impacted on recovery plans.
Continued delivery oversight at Access & Performance to support mitigating current capacity and workforce risks to deliver within target trajectories in 2024/25.

Despite Industrial Action significant improvements continue to be made in reducing our RTT long waiters:

Overall PTL size is below planned levels at 11,825
Zero > 104 week waiters
Forecast > 52 week breaches were reduced to 75; the trust reported 76 patients waiting longer than 52 weeks.
No patients waiting >65 weeks.

The Trust achieved the validation target of 90% of RTT patients waiting over 12 weeks validated by 31st December. This position has been maintained during Q4 with current performance at 98%.

Cancer continues to perform well across faster diagnosis, 31 day & 62 day treatments whilst also reducing our long waiters: All cancer targets were achieved in March.

Specific tumour groups undertake deep dives to review issues report into Access and Performance meetings where commissioned workstreams are tasked to undertake improvement work. Issues remain within our challenged shared pathways, where collaborative discussions are underway to resolve issues. Partnership working and balancing tumour specific performance within the Trust and within the Alliance remains a priority.
</td></tr>
<tr><td>Recommended actions for this meeting:</td><td colspan="2">Board are asked to receive this formal report for the year ending March 2024 and discuss the potential implications and note the improvement or challenge in key areas.</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:</td><td>Aim 1
☒</td><td>We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>Aim 2
☒</td><td>We will be a great organisation with a highly engaged workforce</td></tr>
<tr><td>Aim 3
☒</td><td>We will enhance our productivity and efficiency to make the best use of resources</td></tr>
<tr><td>Aim 4
☒</td><td>We will be an effective partner and be ambitious in our commitment to improving health outcomes</td></tr>
<tr><td>Aim 5
☐</td><td>We will develop and expand our services within and beyond Gateshead</td></tr>
<tr><td>Trust corporate objectives that the report relates to:</td><td colspan="2">

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

</td></tr>
</table>

	• 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)	• Elective activity: 3102 (Positive) • Cancer: 1784 Long waiters: (Positive) • RTT 52 week waiters: 3261 (Positive) • DM01 MRI Scanner: 3277 (Same) * new risk Audiology • Waiting List/Validation/DQ: 2689 (Positive)				
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒		

NHS
Gateshead Health
NHS Foundation Trust

Leading Indicators & Elective Recovery Combined Report

Yearend Closedown/Annual Review 2024

May 2024 reporting

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Gateshead Health NHS Foundation Trust

Leading Indicator Yearend Summary

Gateshead Health NHS Foundation Trust

Section 1: Leading Indicators

Yearend closedown report

THIS PACK IS BEST VIEWED ON SCREEN IN SLIDESHOW MODE

Leading Indicator Year End Summary

Gateshead Health NHS Foundation Trust

We will improve our productivity & efficiency:

Urgent & Emergency Care: We have made some remarkable improvements in reducing our 12-hour trolley waits – we achieved zero 12- hour delays for admission in 6 months of the year with a total of 1,484 fewer patients waiting more than 12 hours for admission, equating to a 94% improvement rate on 2023/24.

In December, all ambulance handovers were subject to national focus. Nationally delays were incurred whilst ambulance crews were stuck waiting for hospital hand-over resulting in fewer crews being able to respond to new calls, and less available ambulances. The Trust responded to the challenge and in Q4 have remained one of top performers in the ICS with fewer hours lost at Gateshead in ambulance handovers. Our ambulance handovers within 15 mins improved from 40% in Q1-Q3 to 60% in Q4.

Elective Care: Our overall wating list reduction was much greater than planned for levels: our RTT waiting list reduced by 11.6% in year and was reduced by 2,195 patients against planned for levels. This overall reduction has been supported by focused efforts in validation and additional elective capacity created from our efficiency and productivity gains from our theatre roadmap. Whilst we didn't achieve our internal stretch target of zero 52 week waiters at year end, we did reduce our overall RTT long waiters to 76, representing a reduction in-line with the national objective despite lost capacity due to industrial action. Internal stretch targets for 2024/25 will support further targeted improvements within these areas.

We will continually improve the quality & safety our services for our patients:

Quality & Safety: Unfortunately, we didn't achieve our challenging C.Difficile target of no more than 23 cases in the year – this was always going to be a stretch for us, but we did close more actions on the CQC action plan with 88% of actions closed or on plan to achieve. Harm rates from falls increased during the year, and continues to be reviewed at ward level in line with PSIRF framework to focus on prevention and quality improvement work. AFLOAT (Avoiding falls level of observation toolkit) is planned to replace the daily falls assessment to ensure staff are continually risk assessing patients at risk of falls. Our indicators monitoring mortality (SHMI and HSMR) are also demonstrating negative trends towards the end of the year.

We will be a great Organisation with a highly engaged workforce:

Our **staff engagement** score increased to 7 in the staff survey this year. Our vacancy rates have been below or within tolerance. However, sickness absence levels have exceeded our planned levels of ≤ 4% despite focused POD support, in 11 months of the year our Group rate remained over planned for levels and remains a key focus area going into 2024/25.

We will achieve financial sustainability:

We achieved our **financial annual plan** with a £63K positive variance. Cost reduction plans and expenditure plans both struggled in year and demonstrated negative variances at year end. Targeted work through the Trust's revised governance programme, headed by the Trust's financial sustainability group is underway to enable delivery in 2024/25.

Yearend Leading Indicator Summary

NHS Gateshead Health NHS Foundation Trust

Objectives:
We will improve productivity and efficiency of our operational services:
Achieve Zero tollerence to 12-hr trolley waits each month
65% of Ambulance Handovers with 15 mins of arrival
Timely Access to a Bed (60% within 1 hr)
Reduce Ward Moves Per Patient
Reduce the number of patients who don't meet the criteria to reside to < 18
Reduce the days bewteen medical optimisation and discharge
Reduce 52 week waiters to Zero by March 2025
Reduce Outpatients Waiting List
Reduce LoS tpo< 4 days to top quartile performing Trusts
Reduce Readmission Rates / keep within expected ranges
We will continually improve the quality and safety of our services for our patients:
Make Progress on the CQC Action Plans (No of actions completed)
C.Difficile Reduction < 23 and or per bed day
Reduction in Harm Rates from Falls per 1,000 bed days
HSMR: Within expected range 100 = Average
SHMI: Within expected range 1 = expected (95% upper and lower confidence levels)
We will be a great organisation with a highly engaged workforce:
Staff Survey Results to > 6.9
Sickness Absence rates < 5%
Vacancy Rates <5%
We will achieve financial sustainability:
Achieve a CRP plan of £15.9m
Achieve Pay Spend Plan
Achieve Non Pay Spend Plan
Deliver Trust Plan Deficit < £ 7,952m (£12.5m)

Performance Summary

Indicator	Start	End	Average	Trend	Achieved	Status
LI	1,582	98	7.5	↑	6 out of 12	Improving
LI	48.0%	59.2%	48.49%	↑	0 out of 12	Improving
LI	11.01%	13.61%	11.01%	↔	0 out of 12	Same
BO	1.73	1.72	1.74	↔	Same*	Same
BO	40	36	42	↓	Not achieved*	Improving
BO	1,783	1,511	1,968	↓	Achieved	Improving
LI	100	76	323	↓	Not achieved	Improving
BO	10,146	8,844	-1,302	↓	Achieved	Improving
LI	4.68	4.07	4.65	↓	Not achieved	Improving
BO	16.40%	12.10%	14%	↓	Achieved	Improving

Indicator	Start	End	Average	Trend	Achieved	Status
LI	4	10	6.3	↑	Achieved	Improving
LI	<23	37	3	↑	Not achieved	Deteriorating
BO	1.67	2.64	2.66	↑	Not achieved	Improving
BO	101.1	110.6	105.35	↑	3 out of 12	Higher than expected
BO	0.87	0.96	0.91	↑	Achieved	Within Expected

Indicator	Plan	2024/25	Average	Trend	Achieved	Status
LI	>6.9	6.6	6.57	↔	1 out of 4	Deteriorating
BO	<5%	5.2%	5.6%	↑	1 out of 12	Improving
BO	<5%	2.4%	2.6%	↑	12 ot of 12	Same

Indicator	£ Plan 000	£ Achieved 000	Variance 000	Trend	Achieved	Status
LI	15,900	13,237	-2,663	↓	5 out of 12	Under Achieved
BO	249,811	270,223	20,412	↓	2 out of 12	Under Achieved
BO	132,424	142,024	9,600	↓	3 out of 12	Under Achieved
Add	7,952	7,889	-63	↑	8 out of 12	Achieved

Gateshead Health NHS Foundation Trust

Section 2: Elective Recovery

March Closedown/Annual Review 2024

May 2024 reporting

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Priorities: Elective Recovery & Transformation

NHS Gateshead Health NHS Foundation Trust

In 2023/24 we were committed to recovering activity/service levels to pre-covid and better, whilst reducing waiting times and back-log of patients waiting by transforming clinical pathways & services to ensure resilience and sustainability. We'd said we would deliver and support the following programmes of work:

Waiting List Management:

- Elimination of 104+ week waiters & 78 week waiters whilst sustaining the position to reduce 65 and 52 weeks over the course of the year: Zero 52 weeks by March 2024.
- 25% Outpatient Follow-up (OPFU) reduction
- Reduce > 62 day waiters on an active cancer pathway
- Implement risk stratification and harm reviews linked to extended waiting times
- Waiting well initiatives providing support to patients (inc. mutual aid)
- Advice & Guidance (A&G) digital and patient initiated follow up (PIFU) workstreams to support outpatient waiting lists

System Resources:

- Equal prioritisation of elective care with ring fenced Trauma & Orthopaedic beds
- Maximising Independent Sector / Mutual Aid opportunities
- Moving towards system level patient treatment lists (PTL's) to support equity of care
- Implementing Getting it Right First Time (GIRFT) best practice
- Digital Mutual Aid System (DMAS) / Patient Initiated Mutual Aid System (PIDMAS) Digital solutions to support transparent waits across the system

Back to Basics:

- Data quality & validation: Validate 90% of patients waiting over 12 weeks with multiple pathway reviews
- Review evidence based compliance with evidence based interventions programme
- Streamlining booking processes to support patient care

Productivity:

- Reducing unnecessary follow-up outpatient activity and converting activity to areas which add value to patient care
- Theatre productivity to ensure effective & efficient use of theatre resources

Transforming Clinical Pathways:

- Implementing FIT Testing & Best Practice Timed Pathways to support achieving Faster Diagnosis Standards

Yearend review against our recovery ambitions

Activity Referrals continued to grow circa 3% over planned for levels, with some exceptional increases in breast cancer services 110% increase on last year. Despite Industrial Action challenges the Trust delivered 107% against our elective delivery plans. Areas of over performance include: Daycases 107%, Diagnostics 103%, and follow-up outpatient activity (116%), inpatient overnight activity and new outpatients were both at 95% of planned levels.

Diagnostics & DM01 Performance against the DM01 has continued below the national target of 95% in 2023/24 due to pressures in MRI (scanning capacity) and Audiology (workforce capacity). Current plans forecast trust recovery in Q2 (July - MRI) & (August - Audiology) of 2024/25. Areas continuing to achieve 95% include Barium, CT, Non-Obstetric ultrasound, gastroscopy, and echocardiology.

Cancer Our cancer performance continued to improve during the year, and by Q4 we were achieving all of our cancer performance standards, as well as reducing the volume of patients waiting longer. Internally operational teams have worked in partnerships to support faster and smoother LGI and UGI pathways and better utilisation of endoscopy services which ultimately improving our waiting times for patients awaiting a diagnosis. Plans are also underway to differentiate capacity and service lines in Obstetrics and Gynae services and we have recently implemented Cancer clinical harm reviews to support shared learning and improvements going forward. Shared pathway challenges and outpatient/direct to test capacity have been our biggest risks in 2023/24, although we do continue to perform and benchmark well across NENC in the suite of cancer recovery measures. Regional collaboration work is ongoing to improve shared pathways and reduce delays as does partnership working with primary care to support compliance with FIT tests for Lower GI referrals and remain at circa 90%. Cancer CQUIN target measure, linked in with Best Practice timed pathways improved dramatically in Q3 and Q4 following a programmed review of data, and a thorough validation exercise with clinical sign-off across all Tumour groups. Performance improved from 23% in Q1 to 41% in Q4 (with Q3 and Q4 compliant with the quality improvement standard.)

18 Weeks Referral to Treatment In 2023/24 we have seen a significant reduction in the volume of patients waiting on the RTT PTL during the year. This hasn't improved the performance percentages of those waiting >18 weeks but we have seen some dramatic improvements across recovery performance metrics with zero patients waiting over 65 weeks and 76 patients waiting over 52 weeks at year end. Our main specialty challenges going into 2024/25 are T&O (lower limb capacity), Urology (shared capacity) and Gynaecology (outpatient capacity).

Partnerships & System Resources The Trust has continued to remain a prominent partner organisation in supporting Great North Health Alliance and NENC pressures via mutual aid programmes including direct capacity support in MRI and CT, Rheumatology and more recently in Pain services. During the year we have also supported the patient choice and wellbeing agenda via national programmes such as PIDMAS and Waiting Well. Participation in ongoing Alliance work continues to improve local pathways and work towards financial and operational sustainability whilst supporting vulnerable services across Trusts. Building work has commenced in the Metro-centre to provide further capacity in imaging, respiratory and cardiac investigations and state of the art care to the health community.

Back to Basics During the year we have rolled out weekly demand and capacity reviews across all specialties in support of data driven decisions and sound defendable investments. We have addressed some major capacity challenges within our surgical specialties, endoscopy and echocardiology and seen performance improvements as a direct result. Over the year the Theatre roadmap programme has supported productivity and efficiency gains particularly in orthopaedics and elective care and will remain a critical workstream in delivering our 2024/25 plans.

The Trust continues to exceed RTT validation expectations of 90% of all patients waiting over 12 weeks undergoing technical and clinical validation. During the year we have embarked on reinstating partial booking for patients in outpatients, to ensure we see patients in datal order and ultimately gives patients an element of control with their appointment times. We have already seen productivity increases and reduced the amount of admin rework in rebooking and rescheduling appointments. Our Value Based Commissioning process was also reinstated process to maintain good governance in ensuring all elective procedures are supported and funded with Commissioner approval. Counting and coding workstreams have continued in outpatients and with strengthen activity delivery plans and support the new metrics in 2024/25 looking at increasing value-added activity in outpatient procedure capture.

Transforming Clinical Pathways: We clinically led a review of our Autism Assessment pathways with a new pathway and delivery model to commence in 2024/25, supported by ICB funding which will reap waiting time benefits in 2024/25. A review of the lung cancer pathway with support from the navigator to co-ordinators has improved Lung waiting times and improved co-ordination of care for patients. Audiology also underwent an RPIW in 2024/25 in support of challenged pathways

Gateshead Health NHS Foundation Trust

Yearend Elective Recovery Summary

Elective Recovery Areas

Activity Plans

Performance Summary

Activity Plans	Measurement	Plan	Actual	Variation Plan	Variation 2019/20	Trend	Performance	Status
Demand Plan	Plans	48,345	49,864	103%	103%			
Elective Activity Plan	Plans	340,507	366,829	107.7%	107%		Achieved 11/12m	Improving
Inpatients	Plans	3,218	3,070	95.4%	79%		Achieved 6/12m	Under delivered
Daycases	Plans	30,215	31,477	104.2%	107%		Achieved 8/12m	Delivered
New Outpatients	Plans	68,216	66,238	95.1%	107%		Achieved 4/12m	Under delivered
Follow-up Activity	Plans	156,388	181,428	116%	94%		Achieved zero/12m	Under delivered
Diagnostic Activity	Plans	82,492	84,616	102.6%	112%		Achieved 8/12m	Delivered

Performance Cancer	Targets	Start	End	Assurance	Variation	Trend	Performance	Status
Achieve Faster Diagnosis Standard	75%	80.6%	82.0%				Achieved 11/12m	Consistently achieved
Achieve 31 Day Treatment Target	96%	97.3%	97.3%				Achieved 10/12m	Consistently achieved
62 Day Treatments (70% at year end)	70%	72.7%	76.8%				Achieved 3/12m	Achieved Year end & Q4.
Achieve Cancer 62 day waits reduction plans	Plan	42	45				Achieved 11/12m	Reduced by 30% in year

Perforamnce DM01	Target	Start	End	Assurance	Variation	Trend	Performance	Status
Diagnostics	95%	95%	91.2%				Not achieved	Deteriorating

Performance: Recovery in RTT Waiting Lists	Indicator	Start	End	Assurance	Variation	Trend	Performance	Status
Waiting list Plans	Reduce per plan	13,389	11,825				Achieved	Consistently achieved
No Patients waiting >104 Weeks	Zero	Zero	Zero				Achieved	Maintaining
No Patients waiting >78 Weeks	Zero	Zero	Zero				Achieved	Maintaining
Reduce Patients waiting > 65 weeks (internal stretch at zero year end)	Minimise	6	Zero				Achieved	Maintaining
Reduce Patients waiting > 52 weeks (internal stretch at zero year end)	Minimise	98	76				Failed Stretch	Achieved national
RTT Validation 90% validated within previous 12 weeks by 31st Dec 2023	90%	50%	92%				Achieved	Consistently achieved

Gateshead Health NHS Foundation Trust

Elective Recovery Headlines: April 2024/25

Activity All activity points of delivery are doing well against planned for levels: On aggregate across all specialties, New outpatients delivered 100%, follow-up outpatients delivered 99%, day cases are at 127% and elective inpatients are at 103% of planned for levels. Diagnostics are at 102% of planned for levels. The new outpatient metric to deliver more outpatient procedures is at 28.3% - the requirement is to achieve 33% of all outpatient attendances.

Diagnostics & DM01

Performance against the DM01 Diagnostic waiting time expectation and national targets of 95% has deteriorated in April with validated performance at 88.8% due to ongoing pressures in MRI, 69.1% (scanning capacity) and Audiology at 55.4% (workforce capacity). Full MRI capacity will be reinstated from July 2024, with improvements in performance forecast at the end of July/beginning of August. Audiology are currently reforecasting their improvement plans.

Areas continuing to achieve 95% include Barium, CT, Non Obstetric Ultrasound, Dexa, gastroscopy, and echocardiology.

Cancer

Cancer performance continues to improve during April with the Trust continuing to achieve against all 3 cancer performance standards: FDS 80.6%, 31 Day treatments at 97.3% and Combined 62 Day performance at 72.7%. Long waiters have also reduced from 45 patients waiting to 42 patients waiting over 62 days at the end of April.

Shared pathway challenges and outpatient new/direct to test capacity continues to be our biggest risks going into 2024/25, although we continue to perform and benchmark well across NENC in the suite of cancer recovery measures. Regional work is ongoing to improve shared pathways delays.

18 Weeks Referral to Treatment

RTT waiters are at 68.9% waiting within 18 weeks (highest since Aug-23) and our RTT waiting list continues to reduce to 11,789 patients waiting, a reduction of 36 from last month and 3% below planned for levels of 12,158. There were 72 patients waiting over 52 weeks at the end April 14 patients over planned levels of 58 . Current month end forecasts for May and June are placing our internal stretch targets at risk of delivery in Q1. There continues to be long waiters in pain; as the Trust alongside Newcastle Hospitals supports pressures across the Alliance and we have more waiters than planned levels in Lower Limb, Gynaecology and Urology. Elective activity in all of the above areas were below inpatient planned levels except for Trauma & Orthopaedics.

Validation

The Trust continues to maintain RTT validation expectations with 90% of all patients waiting over 12 weeks undergoing technical and clinical validation and patient call reminder system to support better productivity.

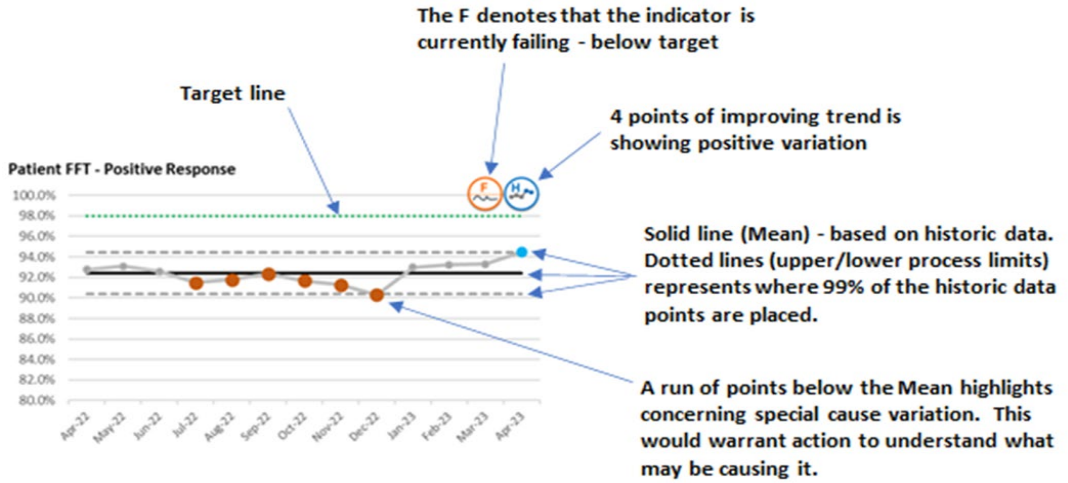
Gateshead Health NHS Foundation Trust

SPC Icons & Charts

The Trust has adopted the NHSEI 'Making Data Count' methodology and standard templates which demonstrates where historic performance/activity is subject to natural variation or where action may need to be taken where there may be cause for concern.

What are Statistical Process Control (SPC) charts

Statistical process control is a methodology used to look at data over time and identify if anything in an observed process is changing. All processes have normal variation which we refer to as "common cause" variation, but sometimes the variation is due to a change in the process. We call this type of variation "special cause" variation. We need to be able to tell which sort of variation we are observing. SPC charts enable us to do this.



Assurance	Variation
Variation indicates inconsistency hitting, passing and falling short of the target.	Common cause - no significant change.
Variation indicates consistency (P)assing the target.	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values.
Variation indicates consistency (F)alling short of the target.	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values.

Icon Colours Explained

Variation icons: Orange indicates concerning special cause variation requiring action. Blue indicates where improvement appears to lie, and Grey indicates no significant change (common cause variation).

Assurance icons: Blue indicates that you would consistently expect to achieve a target. Orange indicators that you would consistently expect to miss the target. A Grey icon tells you that sometimes the target will be met and sometimes missed due to random variation - in a RAG report this indicator would flip between red and green.

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 12ii

Report Title:	2024/25 Performance Reporting Metrics			
Name of Meeting:	Trust Board			
Date of Meeting:	5th June 2024			
Author:	Jo Halliwell, Chief Operating Officer			
Executive Sponsor:	Jo Halliwell, Chief Operating Officer, Kris Mackenzie, Group Director of Finance and Digital			
Report presented by:	Kris Mackenzie, Group Director of Finance and Digital			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☒	**Discussion:** ☒	**Assurance:** ☒	**Information:** ☒
	This report presents the performance reporting metrics 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 Trust Board – Strategy Session			
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*	The proposal is to retain the five organisational strategic aims that have been used in the previous reporting period. Underneath each aim is linked a set of organisational objectives with performance monitoring supported by a suite of leading indicators and breakthrough objectives. The proposed performance metrics are developed from the original set used in 2023/24 but have been developed in a number of ways. There are now 15 objectives which provide a more comprehensive oversight of quality, performance, workforce and finance. There is now separate reference to the Green Plan and some complimentary objectives for QEF. The leading indicators and breakthrough objectives link back to the strategic aims, with the measurement of achievement and progress being more clearly defined.			

<table>
<tr><td>

- *Equality, diversity and inclusion*

</td><td colspan="5"></td></tr>
<tr><td>Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper</td><td colspan="5">Trust Board is asked to formally approve the strategic aims and leading indicators which will be supported by the breakthrough objectives.</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">

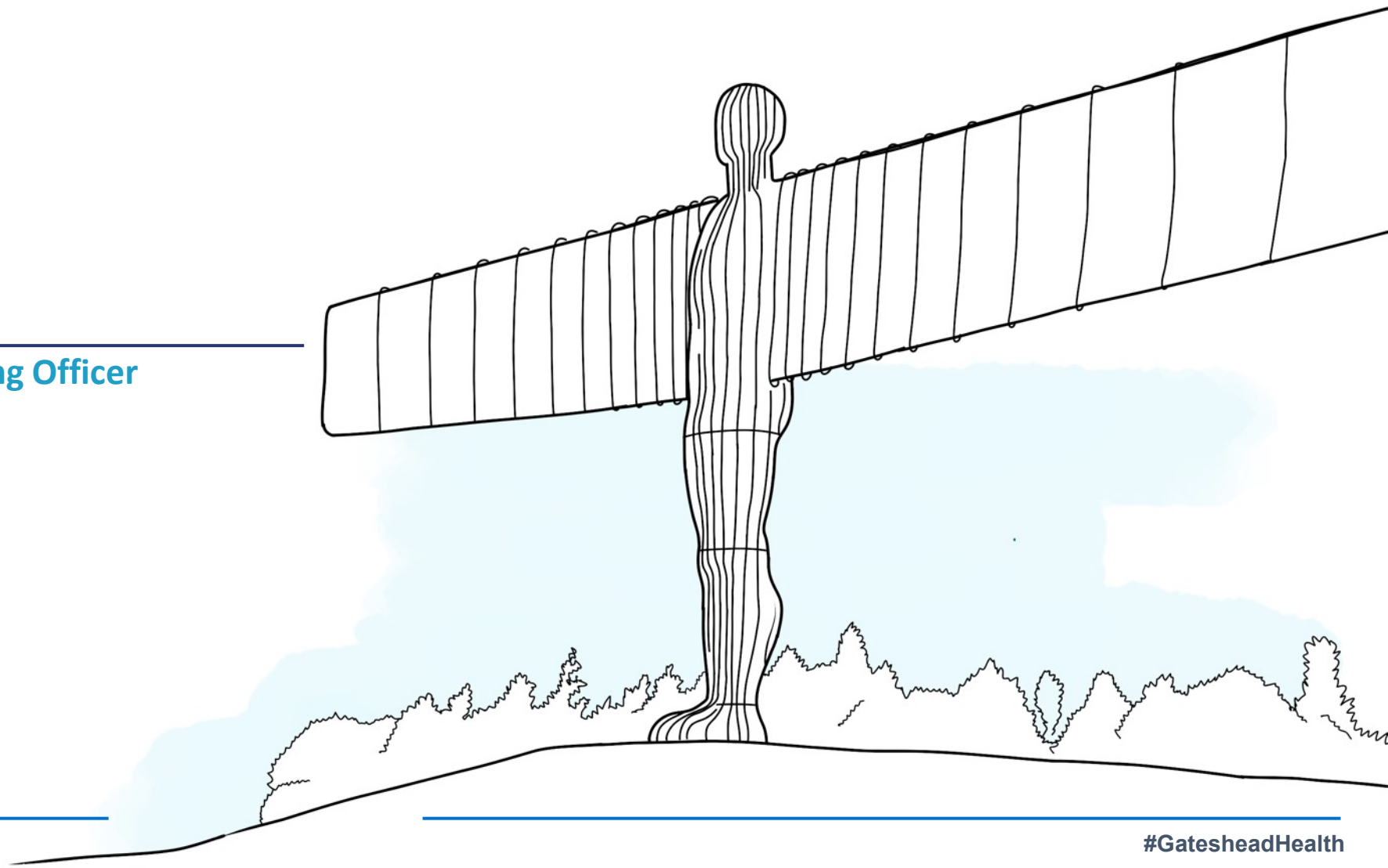
- Improving the productivity and efficiency of our operational services
- Improving the quality and safety of our services for our patients
- Being a great organisation with a highly engaged workforce
- Achieving financial sustainability

</td></tr>
<tr><td>Links to CQC KLOE</td><td>Caring
☒</td><td>Responsive
☒</td><td>Well-led
☒</td><td>Effective
☒</td><td>Safe
☒</td></tr>
<tr><td colspan="6">Risks / implications from this report (positive or negative):</td></tr>
<tr><td>Links to risks (identify significant risks and DATIX reference)</td><td colspan="5"></td></tr>
<tr><td>Has a Quality and Equality Impact Assessment (QEIA) been completed?</td><td colspan="2">Yes
☐</td><td colspan="2">No
☐</td><td>Not applicable
☒</td></tr>
</table>

2024-2025
Strategic Objectives Leading Indicators

Jo Halliwell – Group Chief Operating Officer

Final version



24 April 2024

#GatesheadHealth

Gateshead Health

Our patients Our people Our partners

Our vision captures what matters to us – delivering outstanding compassionate care.

Our five values can easily be remembered by the simple acronym ICORE

Innovation
We look for new ways to improve what we do and recognise that we all have a role to play in our continuous improvement.

Care
We care for our patients, communities, each other and ourselves with kindness and compassion.

Openness
We always act with integrity and transparency and are open and honest with ourselves and each other.

Respect
We treat everyone with respect and dignity, creating a sense of belonging and inclusion.

Engagement
We are inclusive and collaborative in our approach, working as a team and with our partners to deliver the best care possible.

Our Strategic aims:

1. We will continuously improve the quality and safety of our services for our patients.
2. We will be a great organisation with a highly engaged workforce.
3. We will enhance our productivity and efficiency to make the best use of our resources.
4. We will be an effective partner and be ambitious in our commitment to improving health outcomes.
5. We will develop and expand our services within and beyond Gateshead.

Our strategic intent:

- Northern Centre of Excellence for Women's Health
- Diagnostic centre of choice
- Outstanding District General Hospital

2024/25 Strategic objectives Final Proposal (1/5)

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

Objectives 24-25	Executive Lead	Tier 1 Committee
Evidence full compliance with the Maternity Incentive Scheme (MIS) and the Ockenden actions	Gill Findley	Quality Governance Committee
Full delivery of the actions within the Quality Improvement Plan leading to improved outcomes and patient experience with particular focus on improvements relating to mental health, learning disabilities and cancer.	Gill Findley	Quality Governance Committee
Evidence an agreed strategic approach to the development of an EPR supported by a documented and timed implementation plan.	Kris Mackenzie	Digital Committee
Development and implementation of an Estates strategy that provides a 3 year capital plan to address the key critical infrastructure and estates functional risks across the organisation by March 2025	Gavin Evans	Finance and Performance Committee

2024/25 Strategic objectives Final Proposal (2/5)

2) We will be a great organisation with a highly engaged workforce		
Objectives 24-25	**Executive Lead**	**Tier 1 Committee**
Caring for our people in order to achieve the sickness absence and turnover standards by March 2025	Amanda Venner	People and Organisational Development Committee
Growing and developing our people in order to improve patient outcomes, reduce reliance on temporary staff and deliver the 24-25 workforce plan	Amanda Venner	People and Organisational Development Committee
Evidence an improvement in the staff survey outcomes and increase staff engagement score to 7.3 in the 2025 survey	Amanda Venner	People and Organisational Development Committee

2024/25 Strategic objectives Final Proposal (3/5)

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

Objectives 24-25	Executive Lead	Tier 1 Committee
Improve the quality of care delivery and accessibility for patients by meeting the locally agreed stretch standards by March 2025.	Jo Halliwell	Finance and Performance Committee
Evidence of reduction in cost base and an increase in patient care related income by the end of March 2025 leading to a balanced financial plan for 2025-26.	Kris Mackenzie	Finance and Performance Committee
Review and revise the 22-25 Green Plan and align with the group structure by the end of Q2	Gavin Evans	Finance and Performance Committee

2024/25 Strategic objectives Final Proposal (4/5)

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

Objectives 24-25	Executive Lead	Tier 1 Committee
Work at place with public health, place partners and other providers to ensure that reductions in health inequalities are evidenced with a focus on women's health	Neil Halford	Quality Governance Committee
Work collaboratively as part of the Gateshead system to improve health and care outcomes to the Gateshead population	Neil Halford	Quality Governance Committee
Work collaboratively with partners in the Great North Healthcare Alliance to evidence an improvement in quality and access domains leading to an improvement in healthcare outcomes demonstrating 'better together'	Trudie Davies	Trust Board

2024/25 Strategic objectives Final Proposal (5/5)

5) We will look to utilise our skills and expertise beyond Gateshead

Objectives 24-25	Executive Lead	Tier 1 Committee
Contribute effectively as part of the Great North Healthcare Alliance to maximise the opportunities presented through the regional workforce programme	Amanda Venner	People and Organisational Development Committee
Evidenced business growth by March 2025 with a specific focus on Diagnostics, Women's health and commercial opportunities	Jo Halliwell Diagnostics and Women's Health Gavin Evans Commercial Opportunities	Finance and Performance Committee

2024/25 Leading indicators - Final

Strategic Aim	Lead Indicators	Breakthrough Indicators
We will continuously improve the quality and safety of our services for our patients	• Reduction in patient safety incidents linked to estate issues • Compliance with the Ockenden recommendations and Midwifery Incentive Scheme • Compliance with the quality improvement plan indicated by the % of actions on track	• *To be determined from the 12 patient safety indicators and 6 PSIRF strategic themes with a focus on Mental Health, Cancer and Learning Disabilities* • 25% reduction in critical infrastructure risk score • Achievement of a combined organisation PLACE score >95%
We will be a great organisation with a highly engaged workforce	• Improve the staff engagement score to 7.3 • Maintain the vacancy rate at <=2.5%	• Achievement of the internal turnover standard of 9.7% • Achievement of the internal sickness absence standard of 4.9% • Reduction in temporary staffing spend evidenced month on month
We will enhance our productivity and efficiency to make the best use of our resources	• Non elective length of stay <4 days • Achievement of the four hour trajectory to 78% by March 2025 • Achievement of the 0 x 52 week standard by end Q1 and delivery of the trajectory for 40 weeks by March 2025 • Evidence achievement of the 24-25 financial plan	• Achievement of the trajectory to reduce >12 hour total time in department • Achievement of the trajectory to achieve RTA to bed within 1 hour • Increase the proportion of new and follow up with procedure appointments from 28.5% to 33% • Reduce the number of patients with no criteria to reside to <10 (P2&3) • Forecast Outturn achievement of £12.647m • Reduction in run rate evidenced month on month • Recurrent CRP delivery forecast at minimum 60% • No less than £5m cash as per forecast at March 2025

2024/25 Leading indicators - Final

Strategic Aim	Lead Indicators	Breakthrough Indicators
We will be an effective partner and be ambitious in our commitment to improving health outcomes	• Evidence a reduction in the number of 'fragile' and 'vulnerable' services as a direct outcome of Alliance working • Evidence in an improvement in health inequalities in the key focus areas linked to the determinants of Health for Gateshead	• Smoking status to be recorded in the clinical record at the immediate time of admission in 98% of all inpatients by March 2025 • Reduction in the waiting times for paediatric autism pathway referrals from over 52 weeks to <30 by March 2025 • Reduction in the wait for gynaecology outpatients to no more than 26 weeks • Provide a minimum of 300 digital devices repurposed to the local community in 2024-25
We will develop and expand our services within and beyond Gateshead	• 0.5% increase in QEF externally generated turnover as a proportion of the turnover of QEF	

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 13i

Report Title:	**Maternity Integrated Oversight Report – April 2024**			
Name of Meeting:	Trust board			
Date of Meeting:	5th June 2024			
Author:	Ms Karen Parker, Lead Midwife for Risk and Patient Safety/Head of Midwifery			
Executive Sponsor:	Dr Gill Findley, Chief Nurse and Professional Lead for Midwifery and AHPs			
Report presented by:	Ms Karen Parker, Lead Midwife for Risk and Patient Safety/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 March 2024			
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*	Maternity Safecare 14/5/2024 Risk and Safety Council 21/5/2024			
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 April 2024, there were 162 births (11% increase on April 2023), 1 MNSI case and 0 perinatal losses. • Exceptions reported – positive outlier for SATOD (smoking at time of delivery) **Mortality and morbidity rates:** • 0 perinatal loss during April 2024 • 1 MNSI cases • 0 learning events **PMRT Q4 report** • 1 case reviewed by PMRT in Q4 • Appropriate care provided			
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** ☒	

NHS
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NHS Foundation Trust

Maternity
Integrated Oversight Report

Maternity data from April 2024

Maternity IOR contents

- Maternity Dashboard 2024/25:
  - April 2024 data

- Exception reports:
  - Maternity Incentive Scheme – year 5 confirmation & year 6 standards

- Items for information:
  - Perinatal Quality Surveillance minimum dataset
  - Incidents
    - 1 learning event reported in April 2024
    - 1 HSIB cases reported in April 2024
  - Perinatal Mortality and Morbidity
    - 0 perinatal losses in April 2024
  - Q4 Perinatal Mortality report summary

Maternity Oversight Report SPC Tool

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Total Births	Apr 24	162	-			155	113	197
Spontaneous vaginal deliveries	Apr 24	68	-			76	49	102
Assited births	Apr 24	94	-			80	54	105
Induction of Labour	Apr 24	65.00	-			63	43	83
Maternity Readmissions	Apr 24	1	-			3	-2	7
Neonatal Readmissions	Apr 24	5	-			5	-2	13
Smoking at time of booking	Apr 24	5.41%	15.00%			9.58%	3.75%	15.40%
Smoking at time of delivery	Apr 24	3.73%	6.00%			8.49%	1.22%	15.76%
In area CO at booking	Apr 24	93.83%	90.00%			87.64%	76.51%	98.78%
In area CO at 36 weeks	Apr 24	78.40%	80.00%			83.29%	72.17%	94.40%
Admitted directly to NNU (SCBU) (>37 weeks)	Apr 24	13	4			7	-2	17
Percentage Admitted directly to NNU (SCBU) (>37 we	Apr 24	8.50%	6.00%			5.14%	-1.59%	11.88%
Preterm birth rate <=36+6 weeks at birth	Apr 24	5.56%	6.00%			6.64%	2.47%	10.80%
Continuity of Carer: Percentage placed on pathway (2	Apr 24	16.57%	-			16.96%	7.90%	26.02%
Continuity of Carer: Percentage from BAME backgrou	Apr 24	16.13%	-			26.96%	0.69%	53.23%
Spontaneous Vaginal Births (%)	Apr 24	41.98%	-			48.80%	36.76%	60.84%
Induction Rate	Apr 24	40.37%	-			41.24%	31.41%	51.06%
Instrumental Delivery Rate	Apr 24	14.29%	-			12.65%	5.14%	20.17%
Elective C Section Rate	Apr 24	17.90%	-			18.99%	8.44%	29.53%
Emergency C Section Rate	Apr 24	25.93%	-			19.48%	7.65%	31.31%
C Section Rate	Apr 24	43.83%	-			38.46%	23.00%	53.93%
3rd or 4th degree tear (Total) Precentage	Apr 24	0.00%	3.00%			1.40%	-1.34%	4.15%
Massive PPH >=1.5L (All births)	Apr 24	9	2			10	1	18
Breastfeeding: Percentage of Initiated Breasfeeding	Apr 24	75.78%	66.20%			71.54%	56.20%	86.87%
Breastfeeding: Breasfeeding at Discharge (Transfer to	Apr 24	66.01%	56.20%			53.17%	37.26%	69.07%

Safe

Responsive

Maternity

Gateshead Health NHS Foundation Trust

Maternity Dashboard 2024/25

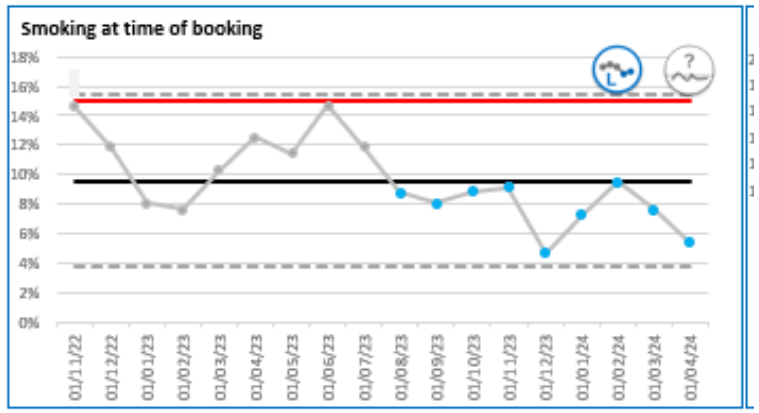
Maternity Dashboard 2024/25

Maternity

Gateshead Health NHS Foundation Trust

Responsive

Safe



Dashboard Narrative

- Only one measure outside SPC in April – Smoking at time of booking which is significantly below the expected level and therefore a positive outlier and follows a recent trend for this measure.
- Number of births is 11.5% higher than in April 2023
- Intervention rates are higher than in previous months with the lowest rate of spontaneous vaginal delivery noted on the dashboard

Exception report

Maternity

NHS

Gateshead Health

NHS Foundation Trust

InPhase report

- Meets criteria for MNSI referral – term pregnancy, in labour, therapeutic cooling – referred, DofC performed & letter sent, referred to MNISA (maternity independent advocacy) for support, rapid review completed

- MNSI triage decision is proceed to investigation, will be reported to NHS Resolution Early Notification Scheme (legal team)

- Learning;
  - rapid reviews and debriefs arranged and well attended by MDT and multiple specialities across the trust
  - proactive, forward thinking approach by emergency department when pregnancy and labour diagnosed – swift transfer to delivery suite
  - some additional equipment & process for checking/restocking added to dedicated maternity & neonatal cupboard in ED

Well Led

Safe

Maternity

NHS

Gateshead Health

NHS Foundation Trust

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 Q4 2024/25 100% compliance	**Maternity Incentive Scheme Final year 6**	
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:		

2024/25		April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
Number of perinatal losses		0											
Number of HSIB cases		1											
Number of incidents logged as moderate harm or above		1											
Minimum obstetric safe staffing on labour ward		100%											
Minimum midwifery safe staffing including labour ward (average fill rates)	Day shift	107.7											
	Night shift	105.2											
	CHP PD*	18.3											
Service user feedback	FFT "Overall how was your experience of our service" – total score for *very good* and *good* responses												
	Complaints	2											
HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust		0											
Coroner Reg 28 made directly to Trust		0											

*CHPPD overall care hours per patient per day

Exception reporting by schedule

Maternity NHS
Gateshead Health
NHS Foundation Trust

Caring
Responsive
Safe

Perinatal Mortality Review Tool (PMRT) – Q4 2023/24 reports

MBRRACE ID	Gestation & Outcome	DOB	Reported to MBRRACE within 7 working days (compliance required 100%)	Surveillance information completed within 1 month of death (compliance required 100%)	PMRT review started within 2 months of death (compliance required 95%)	PMRT review completed to draft stage within 4 months of death (compliance required 60%)	PMRT review published within 6 months of death (compliance required 60%)	Parental engagement (compliance required 100%)	External clinician (if appropriate)
Case 1 91610	Antenatal loss at 27+1	1/2024	Yes	Yes	Yes	Yes	Yes	Yes	Yes

NHS
Gateshead Health
NHS Foundation Trust

Report Cover Sheet Agenda Item: 13ii

Report Title:	**Birthrate+ 2024 Midwifery Workforce Assessment**			
Name of Meeting:	Board of Directors			
Date of Meeting:	5th June 2024			
Author:	Karen Parker Head of Midwifery			
Executive Sponsor:	Dr Gill Findley, Chief Nurse and Professional Lead for Midwifery and AHPs			
Report presented by:	Karen Parker			
Purpose of Report	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☐	**Information:** ☒
	The Trust has undertaken the required review of staffing in maternity to remain compliant with recommended safe staffing levels in the 2024 Birthrate+ midwifery workforce assessment. This paper presents the findings from the review and identifies the actions required to maintain compliance.			
Proposed level of assurance	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☒ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by:	No previous consideration			
Key issues:	**Maternity Incentive Scheme Year 6 (NHS Resolution, 2024)** *Requirements for safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?* *Required standard:* *a) A systematic, evidence-based process to calculate midwifery staffing establishment has been completed within the last three years.* *b) Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above.* **Three-year delivery plan for maternity and neonatal services (2023, NHS England)** *It is the responsibility of trusts to:* *• Undertake regular local workforce planning, following the principles outlined in NHS England's workforce*			

	planning guidance. Where trusts do not yet meet the staffing establishment levels set by Birthrate Plus or equivalent tools endorsed by NICE or NQB, to do so and achieve fill rates by 2027/28. *• Develop and implement a local plan to fill vacancies, which should include support for newly qualified staff and clinicians who wish to return to practice.* *• Provide administrative support to free up pressured clinical time.* **Birthrate+ 2024 workforce assessment recommendation is:** Total Clinical, Specialist and Management = 109.94WTE* Current budgeted establishment = 95.72 Current in post = 110.06 Variance: Baseline -14.22 In post +0.12 Additional support staff = 34.06WTE* Current budgeted establishment = 22.94 Current in post = 30.40 Variance: Baseline -11.12 In post -3.66 **Midwifery Continuity Of Carer impact** The service is not required to meet or report any targets for delivery of MCOC. In order to maintain safe staffing levels, the service has made the decision that full MCOC model is discontinued in favour of a hybrid enhanced model as described in this paper.	
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	The board is asked to note the withdrawal from a full midwifery continuity of carer model to maintain safe staffing with continued enhanced care for vulnerable families. The board is asked to accept and support the recommendations of the 2024 midwifery workforce for safe staffing in the maternity service, noting that the business unit will develop a suitable business case to address the shortfalls after full review of the current funding arrangements.	
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:	SA1 We will continuously improve the quality and safety for our patients SA2 We will be a great organisation with a highly engaged 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):	#2369 Approval of recommended safe staffing levels for support staff would close this risk to the service #2599 Approval of recommended safe staffing levels for midwifery staff would continue to provide mitigation to this risk until longer term solution to remove midwives providing scrub support in maternity theatre				
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☐		

2024 Birthrate+ Midwifery Workforce assessment

1. Executive Summary

1.1.
The purpose of this report is to provide the Board with a summary of the 2024 Birthrate+ (BR+) midwifery staffing assessment and a request for the Trust to support an increase workforce baseline establishment to comply with the recommendations.

1.2.
This report will in part fulfil the aims of the Maternity Incentive Scheme (Year 6) and the Three Year Delivery Plan for Maternity and Neonatal Services (2023).

1.3.
Significant work has been undertaken by the service supported by finance to understand current funded establishment. There is currently a significant overspend in the midwifery staffing budget lines due in part to Trust-wide non-establishment recruitment of Health Care Assistants during the Covid-19 pandemic and non-funded Midwifery Continuity of Carer (MCOC) midwifery posts.

1.4.
There have been a number of specialist midwifery roles funded with non-recurrent Local Maternity and Neonatal System (LMNS) funding. The LMNS has confirmed recurrent funding for specified posts from 2024/25 onwards. The expectation is that these will be included in the workforce establishment.

1.5.
NHSE issued a pause on targets for roll-out of MCOC teams in September 2022 following recommendations by the Ockenden report (2021) and requested Trusts review their own safe staffing position in relation to their ability to offer this model of care.

2. Introduction

2.1.
NHS Resolution operates the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) to continue to support the delivery of safer maternity care. The standards for Year 6 were released in April 2024.

2.2.
Gateshead Healthcare NHS Foundation Trust has submitted full compliance with all ten safety actions for the past three years.

2.3.
Safety action 5 requires Trusts to demonstrate an effective system of midwifery workforce planning to the required standard.

2.4.

- A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated.

• In line with midwifery staffing recommendations from Ockenden, Trust Boards must provide evidence (documented in Board minutes) of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations. • Where Trusts are not compliant with a funded establishment based on BirthRate+ or equivalent calculations, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls. • The plan to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent undertaken, where deficits in staffing levels have been identified must be shared with the local commissioners.

Table 1 *Minimum evidence requirement for Trust boards to demonstrate compliance with Safety Action 5 (NHS Resolution, April 2024)*

2.5
The NHSE three-year delivery plan for maternity and neonatal services (2024) Theme 2 (Growing, retaining and supporting our workforce); Objective 4 (Grow our workforce)

2.6 It is the responsibility of trusts to: • Undertake regular local workforce planning, following the principles outlined in NHS England's workforce planning guidance. Where trusts do not yet meet the staffing establishment levels set by Birthrate Plus or equivalent tools endorsed by NICE or NQB, to do so and achieve fill rates by 2027/28. • Develop and implement a local plan to fill vacancies, which should include support for newly qualified staff and clinicians who wish to return to practice. • Provide administrative support to free up pressured clinical time.

3. Key issues / findings

3.1.
The previous BR+ was completed in 2021 and the Trust agreed to support the recommendations for safe staffing levels in that report.

3.2.
The service commissioned BR+ to perform a midwifery workforce assessment in 2023. The final report was received by the service in April 2024 (Appendix 1)

3.3.
The 2024 report includes recommendations for three different models of community care;

A. A full "traditional" community midwife model with 1:96 caseload.
B. The current model of Horizon team (fully MCOC, 1:36 caseload including intrapartum care for 240 pregnant people), Harbour team (enhanced care, caseload 1:66, not including intrapartum care for 240 pregnant people) & traditional community care for the remaining pregnant people.
C. Hybrid model – enhanced care (1:66, not intrapartum) for 240 pregnant people with traditional community care for the remaining pregnant people.

3.4.
The midwifery safe staffing recommendations for the acute unit are not altered by differing community models and include safe staffing to be able to provide the model of triage care in the Pregnancy Assessment Unit as recommended by the Care Quality Commission.

3.5.
The total clinical care requirement for the acute unit = 69.28wte, this includes a contribution of 2.70wte from the specialist midwifery roles.

3.6.
Specialist midwives - BR+ recommends 12% additional non-clinical specialist roles

Birthrate+ total wte	11.78wte	
		Variance
Current funded establishment	2.28wte	-9.5
Current in post	12.53	+0.75
Excluding SIFT funded post	1.00wte	
Temporary funded posts – PPF, bereavement, digital leadership backfill	1.60wte	
Current in post exc above	9.93	-1.85

3.7.
The 2024 report recommends the following midwifery safe staffing establishments:

Total Clinical, Specialist and Management wte	**Recommended WTE**		
	Traditional community model	Core with MCOC and enhanced teams	Core with enhanced teams
Current total wte baseline establishment	95.72		
Current total wte in post	110.06		
Birthrate Plus wte	110.61	116.49	109.94
Variance wte establishment	-14.89	-20.77	-14.22
Variance wte in post	-0.55	-6.43	+0.12

Table 3 *2024 BirthRate+ recommendations*

2024 Birth Rate BR Recommended wte	**98.16**
Specialist roles	**11.78**
Total wte (21% uplift)	**109.94**
Total wte (23% uplift)*	**112.24**

Table 4 *2024 BirthRate+ recommendations*

3.8.
In addition to the midwifery staffing, there is a clinical need to have support staff working on delivery suite, maternity ward, in outpatient clinics and in community. To calculate the requirement for these support staff, professional judgement of the numbers per shift is used rather than a clinical dependency method.

Table 5 has the additional support staff required who contribute to care of women and babies in the acute unit but are not included in the BR+ clinical total wte.

Delivery Suite and Theatres	10.84wte
Maternity Ward	10.84wte
PAU	1.81wte
Antenatal Clinics	4.07wte
Community	3.5wte
Labour/SCBU ward housekeeper	1.0wte
Total	**34.06wte**

Table 5 *Additional Support Staff wte*

4. Solutions / recommendations

4.1.
The service recommends the hybrid model for community midwifery care recognising the challenges of providing a resilient full midwifery continuity of care team and the significant uplift in midwifery workforce required to provide this model of care.

4.2.
A hybrid model will enable to service to provide an enhanced level of targeted community antenatal and postnatal care to families most in need. The previous MCOC was modelled on GP surgeries located in areas of highest deprivation. The new model of enhanced care will be assessed on well described individual risk factors including deprivation, ethnicity, language and learning difficulties.

4.3.
In response to the Ockenden recommendations, NHS England wrote to all Trusts in September 2022 removing the previous targets for implementing full MCOC models of care and supporting Trusts to “develop local plans that work for them…….taking into account local populations and more specialised models of care required for some women”.

4.4.
The recommendations within this paper are based on the current 21% uplift provided for sickness, training and annual leave. There is a recognition within national and local teams that there is an increased requirement for training for specialist services such as maternity in order to achieve compliance with recommended mandatory safety training. BR+ has also provided recommendations for the service based on a 23% uplift (Table 4 above) The service recognises the regional and national challenges with midwifery recruitment (North East and North Cumbria current midwifery vacancies equate to around 80wte midwives across the LMNS) and therefore does not intend to ask the

Trust to support this increased uplift at present. The service was able to meet the Year 5 MIS requirements for training and feels confident that it will be able to continue to meet the Year 6 requirements in line with the modified NENC LMNS training faculty recommendations for 2024/25 training year.

4.5.
The service currently has staff in posts which are not included in the baseline establishment – this is in part due to over-recruitment during the Covid-19 pandemic, non-established funding for the Horizon team and permanent maternity leave posts.

The service requires the addition of the following to the current funded establishment to be compliant with year 6 MIS requirements for safe midwifery staffing:

+14.22 wte to baseline establishment to remain BR+ for midwifery workforce, this is a saving of 0.12wte on current midwives in post.

+11.12 wte to baseline to ensure safe staffing for support staff (Healthcare Assistant and Maternity Support Worker) workforce, this is an addition of +3.66 wte to current workforce in post.

Once current baseline establishment meets BR+ requirements, it would be anticipated that recruitment would only become necessary following leavers or temporary leave cover (maternity, career break, secondments etc).

4.6.
The maternity service supported by the POD team are actively managing all long term sickness to ensure that staff are supported back to work where applicable. The service is also reviewing current secondments, temporary roles and career breaks to maximise staff available to provide frontline clinical midwifery care.

4.7.
This BR+ report is reflective of the increase in birthing numbers at the QE (overall 9% increase in 2023/24, monthly increase of 11-13% compared with same month in 2023) coupled with an increase in the acuity of pregnant people accessing the maternity service. This increase in both activity and acuity are currently absorbed by the service but gradual increased in red flag events, inability to meet safe staffing acuity and complaints are starting to become visible within the service.

4.8.
The Year 5 MIS rebate will not be utilised for theatre assistant practitioners (TAPS) as per the 2020 business case as there have been new challenges identified with this plan to support the removal of midwives from theatre scrub role, therefore the midwives will continue to provide this role with the safe staffing support from maternity HCAs until an alternative future theatre plan has been developed. Therefore, there may be a proportion of MIS funding that can be allocated to support the safe recommendations for the HCA workforce. This funding is non-recurrent and dependant on achieving full compliance with the MIS safety actions and therefore the Trust is asked to underwrite this workforce cost to protect the establishment should MIS not be achieved.

4.9.
Non-compliance with BR+ recommendations would result in inability to demonstrate full compliance with the ten safety actions (specifically, safety action 5 – midwifery workforce) of the Maternity Incentive Scheme which in turn would result in the loss of the financial rebate of at least 10% of CNST contribution (approximately £245k in

2023). Non-compliance with BR+ would also mean the service would be unable to meet the requirements of the three-year delivery plan around safe staffing.

4.10.
Confirmation of non-recurrent funding has been received from the LMNS for previously-temporary posts such as bereavement and retention and recruitment.

Conclusion

The board is asked to accept and support the recommendations of the 2024 midwifery workforce for safe staffing in the maternity service.

The service will continue to ensure that all available clinical staff are working in appropriate areas and absences are actively managed utilising Trust policies and with POD support.

The service will work with the Surgical Business Unit to explore the workforce establishment further and develop an appropriate business case to ensure that the funded establishment meets with the BR+ safe staffing recommendations.

References

B1915-three-year-delivery-plan-for-maternity-and-neonatal-services-march-2023.pdf

MIS-Year-6-guidance.pdf

https://www.ockendenmaternityreview.org.uk/wp-content/uploads/2022/03/FINAL_INDEPENDENT_MATERNITY_REVIEW_OF_MATERNITY_SERVICES_REPORT.pdf

Glossary

Midwifery Continuity of Carer (MCOC) - the continuity of carer model is a way of delivering maternity care so that women receive dedicated support from the same midwifery team throughout their pregnancy. This encompasses antenatal, intrapartum and postnatal care.

Birthrate Plus® (BR+) is a framework for workforce planning and strategic decision-making and has been in variable use in UK maternity units since 1988, with periodic revisions as national maternity policies and guidance are published. It is based upon an understanding of the total midwifery time required to care for women and on a minimum standard of providing one-to-one midwifery care throughout established labour. The principles underpinning the BR+ methodology are consistent with the recommendations in the NICE safe staffing guideline for midwives in maternity settings and have been endorsed by the RCM and RCOG.

Local Maternity and Neonatal System (LMNS) – a partnership of NHS organisations who work with women, their families and healthcare staff to improve maternity and neonatal services. We are part of the North East and North Cumbria LMNS.

BSOTS (Birmingham Symptom Specific Obstetric Triage System) - BSOTS is a maternity triage system, which improves the safety of mothers, babies, and the

management of the department. It consists of a prompt and brief assessment (triage) of women when they present with unexpected problems or concerns, and then a standardised way of determining the clinical urgency in which they need to be seen. Implementation is supported by the Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives and is now the model recommended by CQC.

BIRTHRATE PLUS® ASSOCIATES LIMITED

MIDWIFERY WORKFORCE REPORT

GATESHEAD HEALTH
NHS FOUNDATION TRUST

APRIL 2024

Contents

Birthrate Plus®: THE SYSTEM

Birthrate Plus® (BR+) is a framework for workforce planning and strategic decision-making and has been in variable use in UK maternity units since 1988, with periodic revisions as national maternity policies and guidance are published.

It is based upon an understanding of the total midwifery time required to care for women and on a minimum standard of providing one-to-one midwifery care throughout established labour. The principles underpinning the BR+ methodology are consistent with the recommendations in the NICE safe staffing guideline for midwives in maternity settings and have been endorsed by the RCM and RCOG.

The RCM recommends using Birthrate Plus® (BR+) to undertake a systematic assessment of workforce requirements, since BR+ is the only recognised national tool for calculating midwifery staffing levels. Whilst birth outcomes are not influenced by staff numbers alone, applying a recognised and well-used tool is crucial for determining the number of midwives and support staff required to ensure each woman receives one-to-one care in labour (as per recommendation 1.1.3).

Birthrate Plus® has been used in maternity units ranging from stand-alone community/midwife units through to regional referral centres, and from units that undertake 10 births p.a. through to those that have in excess of 8000 births. In addition, it caters for the various models of providing care, such as traditional, community-based teams and continuity caseload teams. It is responsive to local factors such as demographics of the population; socio-economic needs; rurality issues; complexity of associated neo-natal services, etc. The methodology remains responsive to changes in government policies on maternity services and clinical practices. Birthrate Plus® is the most widely used system for classifying women and babies according to their needs and using clinical outcome data to calculate the numbers of midwives required to provide intrapartum and postpartum care.

An individual service will produce a casemix based on clinical indicators of the wellbeing of the mother and infant throughout labour and delivery. Each of the indicators has a weighted score designed to reflect the different processes of labour and delivery and the degree to deviations from obstetric normality. Five different categories are created - the lower the score the more normal are the processes of labour and delivery.

Other categories classify women admitted to the delivery suite for other reasons than for labour and delivery.

Together with the casemix, the number of midwife hours per patient/client category based upon the well-established standard of one midwife to one woman throughout labour, plus extra midwife time needed for complicated Categories III, IV & V, calculates the clinical staffing for the annual number of women delivered.

Included in the workforce assessment is the staffing required for antenatal inpatient and outpatient services, ante and postnatal care of women and babies in community birthing in either the local hospital or neighbouring ones.

The method works out the clinical establishment based on agreed standards of care and specialist needs and then includes the midwifery management and specialist roles required to manage maternity services. Adjustment of clinical staffing between midwives and competent & qualified support staff is included.

The recommendation is to provide total care to women and their babies throughout the 24 hours 7 days a week inclusive of the local % for annual, sick & study leave allowance and for travel in community**.**

Factors affecting Maternity Services

The Governance agenda, which includes evidence-based guidelines, on-going monitoring, audit of clinical practices and clinical training programmes, will have an impact upon the required midwifery input; plus, other key health policies. Birthrate Plus® allows for inclusion of the requisite resources to undertake such activities.

Increasingly, with having alongside midwife units where women remain for a short postnatal stay before being transferred home, the maternity wards provide care to postnatal women and/or babies who are more complex cases. Transitional care is often given on the ward rather than in neonatal units, safeguarding needs require significant input which put higher demand on the workload.

Shorter postnatal stays before transfer home requires sufficient midwifery input in order to ensure that the mothers are prepared for coping at home. It is well known that if adequate skilled resources are provided during this postnatal period, then such problems as postnatal depression or inability to breast-feed can be reduced or avoided.

Community based care is expanding with the emphasis being placed on ‘normal/low risk/need care being provided in community by midwives and midwifery support roles. Women and babies are often being seen more in a clinic environment with less contacts at home. However, reduced antenatal admissions and shorter postnatal stays result in an increase in community

care. Midwives undertake the Newborn and Physical Examination (NIPE) instead of paediatricians, either in hospital or at home.

Cross border activity can have an impact on community resources in two ways. Some women may receive antenatal and/or postnatal care from community staff in the local area but give birth in another Trust. This activity counts as extra to the workload as not in the birth numbers. They have been termed as "imported" cross border cases. Equally, there ae women who birth in a particular hospital but from out of area so are ‘exported’ to their local community service. Adjustments are made to midwifery establishments to accommodate the community flows. Should more local women choose to birth at the local hospital in the future adjustments will need to be made to workforce to provide the ante natal and intrapartum care.

The NICE guideline on Antenatal Care recommends that all women be ‘booked’ by 10 weeks’ gestation, consequently more women are meeting their midwife earlier than previously happened. This early visit requires midwifery assessment/advice, but the pregnancy may end as a fetal loss, so the total number of postnatal women is less than antenatal women.

Discussion of Data

1. The midwifery workforce report is for maternity services in Queen Elizabeth Hospital Gateshead (QEH) and local community.

2. An allowance of 21% uplift have been calculated for all staff, with 12.5% community travel included in the staffing figures. As with many Trusts, due to the increasing need for training and updating, some of which has arisen out of the Ockendon Report, an adequate allowance is required to fulfil the training requirements for midwives. At the request of the Head of Midwifery, staffing is shown with 23% uplift (Table 12).

3. Annual birth activity is shown in Table 1.

	Annual Total
Hospital	1836
Home	20
Total Births	**1856**

Table 1: Annual Activity

4. The decision was made to collect new casemix. The casemix has the major impact on the midwifery establishment especially for intrapartum care as the additional time applied to Categories III to V results in an increase from the one midwife to one woman ratio. A 3 months' sample for September, October and December 2023 was obtained by the midwifery team and additional scrutiny provided by the Birthrate Plus consultant (Table 2).

Casemix	**%Cat I**	**%Cat II**	**%Cat III**	**%Cat IV**	**%Cat V**
	2.0	8.0	18.0	28.5	43.5
	28.0%			*72.0%*	
2020/21 Casemix	23.0%			77.0%	

Table 2: Casemix

5. Table 2 shows there has been a decrease in the acuity of women with 5% of women in the 3 lower categories. However, the % in categories IV and V is similar to most maternity units with Category V having the highest. The casemix is unique to each service as reflects the clinical and social needs of women, local demographics, clinical decision making and adherence to national guidelines. Appendix 1 provides a description of the 5 categories.

6. Table 3 shows the additional intrapartum activity in the delivery suite.

	Annual Total
Antenatal cases needing 1 to 1 care	350
Medical Inductions of Labour	1500
Postnatal readmissions	13
Escorted transfers OUT	35
Non-viable pregnancies	25

Table 3: Additional Intrapartum Activity

7. All delivery suites have antenatal cases (350) where women require monitoring and often treatment for obstetric or medical problems such as antepartum haemorrhage, preterm labour, reduced fetal movements, etc. Postnatal readmissions may require a theatre procedure or enhanced midwifery care for conditions such as sepsis.

8. Medical inductions of labour are seen on Delivery Suite. The annual total of 1500 are actual insertions but may be less women as some may have multiple insertions.

9. The Pregnancy Assessment Unit (PAU) sees scheduled and unscheduled women with labour queries and for other reasons throughout the 24 hours and 7 days a week. There are annually 6787 episodes and it is usual to have more activity than births. The staffing provides 3 midwives at all times.

10. Table 4 shows the annual activity on the Maternity Ward.

	Annual Total
Antenatal admissions	275
Postnatal women	1836
P/N readmissions	98
Extra care babies	373
NIPEs by midwives	1000

Table 4: Maternity Ward Activity

11. Of the 275 antenatal admissions to the ward, 33% have an overnight stay or shorter with 67% requiring a longer stay and/or increased clinical needs.

12. The ‘extra care babies’ of 373 are those that have a postnatal stay longer than 72hrs for either clinical or social reasons. The increase in babies that require frequent monitoring is also covered in the casemix as more hours are allocated to women in the higher categories IV and V.

13. There is some readmission activity to the ward accounting for 98 cases with some women first being seen on delivery suite.

14. Staffing is included for NIPEs by ward midwives completing the majority. NIPE for home births is routinely included.

15. Outpatient Clinic services are based on the average hours of each session time and numbers of staff to cover these, rather than on the number of women attending and a dependency classification. Professional judgement is used to assess the numbers of midwives and support staff required to 'staff' the clinics/sessions. The outpatients' profile is unique to each maternity service.

16. Table 5 provides a summary of the community population receiving maternity care.

	Annual Total
Home Births	20
Community Exports (Out of Area births)	*427*
Imports – AN and PN care	761
Imports – AN Care only	430
Imports – PN care only	14
Total Community Cases (AN &/or PN care excluding attrition)	2634
Attrition Cases *(pregnancy loss or move out of area)*	224
Significant Safeguarding cases	245

Table 5: Community Activity

17. The community exports of 427 are women who birth in QEH but live outside of the geographical area and therefore receive community care in their local trust.

18. The community annual total includes 761 women who birth in neighbouring units and receive ante and postnatal care from the Trust midwives (community imports). The birth episodes are provided by neighbouring units.

19. There are 430 women receiving antenatal care only – birth and postnatal care are provided by a neighbouring Trust and just 14 women receiving postnatal care only.

20. The total community cases are 2634 including all imports and home births which is 778 more than actual births. Community cases are often different to the total birth numbers and this should be considered when understanding the wte required for each area.

21. The 224 attrition cases are women who may book and/or see a midwife in early pregnancy but either move out of area or have a pregnancy loss.

22. There are 245 women with safeguarding needs that may not reach the threshold for formal intervention but require significant input from the community midwives, such as increased surveillance, support and signposting to other services.

Discussion of Workforce Results

23. The Birthrate Plus staffing is primarily based on the activity and methodology rather than on where women may be seen and/or which midwives provide the care.

24. The staffing for delivery suite is based on 5 midwives per shift as core and applies to the 3 community models (see point 26).

25. Additional time is included for midwives to 'scrub' for the 3 elective lists per week. The additional weighting of 40% for emergency theatre cases will provide a 2nd midwife should they be required to scrub.

26. The staffing is shown with 21% and 23% uplift and based on 3 community models, namely:

    a. Traditional community service where midwives provide the intrapartum care to home births, ante and postnatal care of hospital births so no caseload teams
    b. Inclusion of one midwifery caseload team (MCoC) providing ante, intra and postnatal care to 240 women per annum, together with an enhanced team for an annual caseload of 240 vulnerable women providing community based ante and postnatal care.
    c. A model with just the enhanced teams and an annual caseload of 480 women.

27. The establishment for scanning by midwives is 5.08wte which is excluded from the Birthrate Plus staffing and subsequent comparison as the midwives are not undertaking any clinical assessments of women working purely in a scanning role.

28. Day to day management by ward and department managers, community team leaders and coordination of intrapartum services are included in the clinical establishments.

29. The total clinical wte will contain the contribution from appropriately trained Band 3 MSWs in community postnatal services.

30. Most maternity units apply a skill mix of 90/10 so that 10% of the clinical wte are suitably qualified MSWs (Band 3s) working in postnatal services in the ward and on community. It is a local decision by the senior midwifery management team as to an appropriate skill mix, using professional judgement along with their local knowledge and expertise of the service. However, for maternity units with births around and under 2000, the skill mix is usually less at 95/5 or thereabouts and the decision to only have support staff in the community. To have MSWs instead of midwives on the postnatal ward will reduce the availability of midwives during periods of escalation.

31. **Breakdown of Birthrate Plus® Staffing (21%)**

	Recommended WTE		
	Traditional community model	Core with MCOC and enhanced teams	Core with enhanced teams
Intrapartum Services • Births • Antenatal Cases • Inductions of Labour • P/N Readmissions • In-utero transfers out • Non-viable cases	27.10wte RMs	27.10wte RMs	27.10wte RMs
PAU	16.42wte RMs	16.42wte RMs	16.42wte RMs
Maternity Ward • Antenatal admissions • Postnatal women • Readmissions • Extra care babies • NIPEs	22.90wte RMs	22.90wte RMs	22.90wte RMs
Outpatient Services • Booking and Follow up Clinics • Obstetric Clinics • Specialist Clinics	2.86wte RMs	2.86wte RMs	2.86wte RMs
Community Services: • Home Births • Community Cases • Attrition Cases • Additional Safeguarding	28.91wte RMs and PN MSWs	23.86wte RMs and PN MSWs	21.04wte RMs and PN MSWs
MCoC	n/a	6.67wte RMs	n/a
Enhanced Teams	n/a	3.64wte RMs	7.27wte RMs
Total Clinical WTE	**98.76wte RMs and PN MSWs**	**104.01wte RMs and PN MSWs**	**98.16wte RMs and PN MSWs**

Table 6: Birthrate Plus® Clinical Staffing 21% uplift

Clinical Specialist Midwives

32. The clinical specialist midwives have both a clinical and non-clinical role. It is a local decision of senior midwifery management as to the % contribution to the clinical staffing. The remaining % is included in the non-clinical roles. Currently there are 10.54wte Specialist Midwives in substantive funded posts of which 2.70wte (25.6%) is allocated to the clinical total. The remaining 7.84wte (74.4%) are included in the additional wte plus the 4.00wte senior midwifery managers.

Current Clinical Funded Bands 3 – 7

33. Comparisons are made with the current funded establishment as per table 7 below.

WTE RMs Bands 5 – 7	Specialist Midwives contribution	PN MSWs	Current Total Clinical wte
89.46	2.70	3.30	95.46

Table 7: Current Funded Establishment

Comparison of Clinical Staffing

	Recommended WTE		
	Traditional community model	Core with MCOC and enhanced teams	Core with enhanced teams
Current Clinical wte	95.46	95.46	95.46
Birthrate Plus wte	98.76	104.01	98.16
Variance wte	-3.30	-8.55	-2.70

Table 8: Comparison of Clinical Staffing 21% uplift

34. Table 8 indicates the shortfall in clinical staffing with the current skill mix 96.5% as registered staff and 3.5% as MSWs.

Non-Clinical Midwifery Roles

35. The total clinical establishment as produced from Birthrate Plus® excludes the management and the non-clinical element of the specialist midwifery roles needed to provide maternity services, as summarised below.
    - Head of Midwifery, Matrons, Lead Risk and Safety Midwife
    - Specialist Midwives with responsibility for:
        - Antenatal and Newborn Screening
        - Public Health
        - Diabetes
        - Fetal wellbeing
        - Practice development
        - Safeguarding
        - Risk management
        - Retention and recruitment
        - Bereavement
        - Preterm birth
        - Digital

    In addition to these posts, consideration should also be given to recommendations from national reports such as Ockendon 2022 with regards to new roles

    Applying 12% to the Birthrate Plus clinical wte provides additional staff for the above roles with it being a local decision as to which posts are required and appropriate hours allocated (Table 9). *Note: To apply a % to the clinical total ensures there is no duplication of midwifery roles.*

	Recommended WTE		
	Traditional community model	Core with MCOC and enhanced teams	Core with enhanced teams
Current Clinical wte	14.04	14.04	14.04
Birthrate Plus wte	11.85	12.48	11.78
Variance wte	2.19	1.56	2.26

Table 9: Comparison of additional specialist and management wte

36. Table 9 shows the current funded establishment is slightly more than recommended for the non-clinical roles as usually required in all maternity services. This offsets the shortfall in the clinical establishment.

Summary of Workforce

Total Clinical, Specialist and Management wte	**Recommended WTE**		
	Traditional community model	Core with MCOC and enhanced teams	Core with enhanced teams
Current Total wte	109.50	109.50	109.50
Birthrate Plus wte	110.61	116.49	109.94
Variance wte	-1.11	-6.99	-0.44

Table 10: Total Clinical, Specialist and Management wte

37. The results indicate that the funded establishment has a small deficit of registered midwives.

38. The establishment for scanning by midwives is 5.08wte which is excluded from the Birthrate Plus staffing and subsequent comparison in Table 10.

39. In addition to the midwifery staffing, there is a need to have support staff working on delivery suite, maternity ward, in outpatient clinics and in community. To calculate the requirement for these support staff, professional judgement of the numbers per shift is used rather than a clinical dependency method.

40. Table 11 has the additional support staff required who contribute to care of women and babies but are not included in the Birthrate Plus clinical total wte. 21% uplift has been applied.

Delivery Suite and Theatres	10.84wte
Maternity Ward	10.84wte
PAU	1.81wte
Antenatal Clinics	4.07wte
Total	29.56wte

Table 11: Additional Support Staff wte

41. **Breakdown of Birthrate Plus® Staffing (23%)**

Clinical, Specialist and Management wte	**Recommended WTE**		
	Traditional community model	Core with MCOC and enhanced teams	Core with enhanced teams
Intrapartum Services	27.55wte RMs	27.55wte RMs	27.55wte RMs
PAU	16.53wte RMs	16.53wte RMs	16.53wte RMs
Maternity Ward	23.49wte RMs	23.49wte RMs	23.49wte RMs
Outpatient Services	2.90wte RMs	2.90wte RMs	2.90wte RMs
Community Services:	29.66wte RMs and PN MSWs	24.48wte RMs and PN MSWs	21.59wte RMs and PN MSWs
MCoC	n/a	6.80wte RMs	n/a
Enhanced Teams	n/a	3.71wte RMs	7.42wte RMs
Total Clinical WTE	**100.87wte RMs and PN MSWs**	**106.20wte RMs and PN MSWs**	**100.22wte RMs and PN MSWs**
Additional Specialist and Management wte	**12.10wte**	**12.74wte**	**12.03wte**
TOTAL RECOMMENDED WTE	**112.97wte**	**118.94wte**	**112.24wte**
Variance +/-	-3.47wte	-9.44wte	-2.74

Table 12: Birthrate Plus® Staffing 23% uplift

Appendix 1

Method for Classifying Birthrate Plus® Categories by Scoring Clinical Factors in the Process and Outcome of Labour and Delivery

There are five [5] categories for mothers who have given birth during their time in the delivery suite [Categories I – V)

CATEGORY I **Score = 6**

This is the most normal and healthy outcome possible. A woman is defined as Category I [*lowest level of dependency*] if:
The woman's pregnancy is of 37 weeks' gestation or more, she is in labour for 8 hours or less; she achieves a normal delivery with an intact perineum; her baby has an Apgar score of 8+; and weighs more than 2.5kg; and she does not require or receive any further treatment and/or monitoring.

CATEGORY II **Score = 7 – 9**

This is also a normal outcome, very similar to Category I, but usually with the perineal tear [score 2], or a length of labour of more than 8 hours [score 2]. IV Infusion [score 2] may also fall into this category if no other intervention. However, if more than one of these events happens, then the mother and baby outcome would be in Category III.

CATEGORY III **Score = 10 – 13**

Moderate risk/need such as Induction of Labour with syntocinon, instrumental deliveries will fall into this category, as may continuous fetal monitoring. Women having an instrumental delivery with an epidural, and/or syntocinon may become a Category IV.

CATEGORY IV **Score = 14 –18**

More complicated cases affecting mother and/or baby will be in this category, such as elective caesarean section; pre-term births; low Apgar and birth weight. Women having epidural for pain relief and a normal delivery will also be Category IV, as will those having a straightforward instrumental delivery.

CATEGORY V **Score = 19 *or more***

This score is reached when the mother and/or baby require a very high degree of support or intervention, such as, emergency section, associated medical problem such as diabetes, stillbirth, or multiple pregnancy, as well as unexpected intensive care needs post-delivery. Some women who require emergency anaesthetic for retained placenta or suture of third-degree tear may be in this category.

NHS
Gateshead Health
NHS Foundation Trust

Report Cover Sheet Agenda Item: 14i

Report Title:	**Nursing Staffing Exception Report**			
Name of Meeting:	Board of Directors			
Date of Meeting:	5th June 2024			
Author:	Laura Edgar, Head of Nursing Workforce Helen Larkin, Clinical Lead E-rostering			
Executive Sponsor:	Gillian Findley, Chief Nurse and Professional Lead for Midwifery and AHPs, Deputy Chief Executive			
Report presented by:	Gillian Findley, Chief Nurse and Professional Lead for Midwifery and AHPs, Deputy Chief Executive			
Purpose of Report	**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 to provide adequate staffing levels.			
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:	Nursing and midwifery forum			
Key issues:	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 April 2024. April has demonstrated some areas with staffing challenges relating to sickness absence and enhanced care requirements. During April, we continued to experience periods of increased patient activity with surge pressure resulting in escalation areas. This has impacted on staffing resource. There is continued focused work around the recruitment and retention of staff and managing staff attendance. Wards where staffing fell below 75% of the funded establishment are shown within the paper. Detailed context and actions taken to mitigate risk are documented. A staffing escalation protocol is now in operation across all areas within the organisation and			

<table>
<tr><td></td><td colspan="5">assurance of this operating as expected, is provided by the number of staffing incident reports raised through the incident reporting system.</td></tr>
<tr><td>Recommended actions for this meeting:</td><td colspan="5">The Board of Directors is 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 was one staffing incident raised via InPhase during the month of April, of which there was no harm 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
April 2024

1. Introduction

This report details the staffing exceptions for Gateshead Health NHS Foundation Trust during the month of April 2024. The staffing establishments are set by use of the Safer Nursing Care staffing tool (SNCT). This is a recognised, nationally used evidence-based tool that matches the acuity of patients with the staffing requirements for acute medical and surgical wards. Mental health Services use the Mental Health Optimal Staffing Tool (MHOST) and Maternity use the Birth Rate Plus tool. These are reported to Quality Governance Committee and the Trust Board separately.

2. Staffing

The actual ward staffing against the budgeted establishments from April 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 April 2024

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 (%)**
102.0%	**107.6%**	**98.6%**	**104.9%**

The Trust is required to present information on funded establishments (planned) against actual nurses on duty. The above figures are average fill rates and thus do not reflect the daily challenges experienced during Covid-19 and operational pressures to maintain adequate staffing levels.

Exceptions:

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

Safer Nursing Care Tool (SNCT) data collection is completed bi-annually in January and July each year. Patient acuity and dependency data is triangulated with key performance indicators and professional judgement templates in line with the Developing Workforce Safeguards and Safe Staffing Recommendations (NHSi 2018). A revised SNCT tool has been introduced, which incorporates 1-1 enhanced care requirements along with considerations for single side room environments to support establishment reviews. Data collection commenced at the beginning of April with a further data collection planned for August.

Contextual information and actions taken

SCBU report 3 qualified WTE vacancies and 1 WTE on Maternity leave, additionally there has been continued long term sickness in the unit. SCBU are expecting 3 qualified nurses to come into post in the next 2 months

Paediatric services had higher levels of sickness absence during the month of April, which has demonstrated reduced levels of Healthcare assistant fill rates.

Ward 28 report Lower elective orthopaedic inpatient numbers on a Monday/ Friday and over weekends.
One HCA rostered nights all of April supernumerary due to occupational health recommendations.
HCAs regularly redeployed on nights to support other areas.

Ward 25 had high levels of HCA sickness during the month of April with five separate episodes, one member of staff left with immediate effect and one staff member on maternity leave. In addition to this ward, 25 had multiple closed beds for a significant period due to IPC reasons.

The exceptions to report for April are as below:

April 2024	
Registered Nurse Days	**%**
SCBU	74.3%
Registered Nurse Nights	**%**
Healthcare Support Worker Days	**%**
Paediatric services	64.1%
Healthcare Support Worker Nights	**%**
Ward 28 Ortho elective ward	60.3%
Ward 25	74.4%

In April, 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 April, 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 April, the Trust total CHPPD was 8.6. This compares well when benchmarked with other peer-reviewed hospitals.

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 was one staffing incident raised via the incident reporting system. This was in SDEC.

Nursing Red Flags

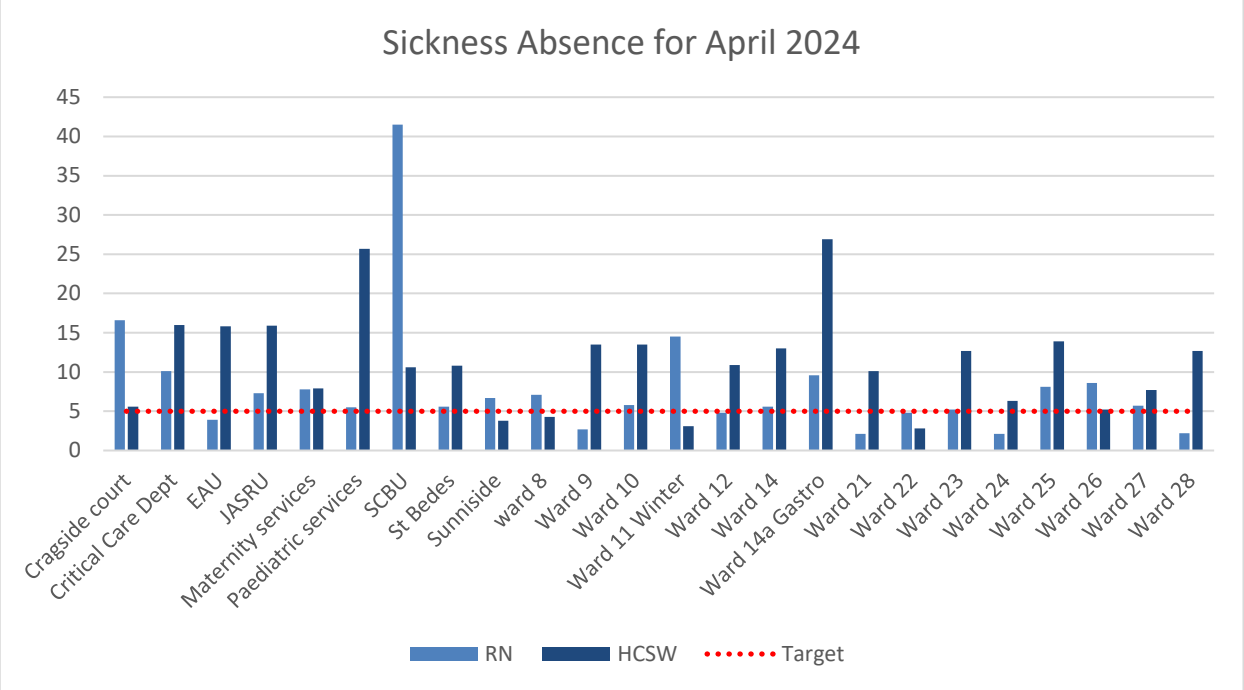
The National Institute for Health and Care Excellence (NICE) guideline for Safe Staffing for nursing in adult inpatient wards in acute hospitals (2014) recommend the use of nursing Red Flag reporting. A Nursing red flag can be raised directly as a result of rostering practice/shortfall in staffing or 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 April there were 14 nursing red flags reported. This is compared to 19 red flags reported in March. Of those 14 Red flags raised, ten of those were raised for paediatric services. One was raised for ward 25 These are outlined below.

Date	Shift type	Ward	Flag Type	Narrative
02/04/2024	Day	Paediatric Services	Shortfall in RN time	Only 3 Qualified RNs on Peapod due to sickness and unable to cover with Bank
03/04/2024	Day	Paediatric Services	Shortfall in RN time	Only 3 Qualified RNs due to taking staff from dayshift to cover nightshift
09/04/2024	Day	Paediatric Services	Less than 2 RNs on shift	Only 3 Qualified to support triage, resus and peapod
12/04/2024	Day	Paediatric Services	Less than 2 RNs on shift	Only 3 on Long day, 4th long day had to cover night shift due to long term sickness
13/04/2024	Day	Paediatric Services	Shortfall in RN time	Only 3 long days on duty, 4th nurse had to be taken off to cover night shift

19/04/2024	Day	Paediatric Services	Less than 2 RNs on shift	Only 3 Qualified today, below safe staffing numbers.
21/04/2024	Day	Paediatric Services	Shortfall in RN time	Only three staff nurses on duty (early shift) safe staffing deemed to be four
22/04/2024	Day	Paediatric Services	Less than 2 RNs on shift	No TW tonight, message gone out to staff to request
24/04/2024	Day	Paediatric Services	Temporary Staffing	No HCA on peapod today due to sickness, Day Unit HCA covered with Bank
26/04/2024	Day	Paediatric Services	Less than 2 RNs on shift	Staffing reduced to 3 Q on late shift. Shift out to bank and remains uncovered. To review activity in day unit for potential to redeploy Q from here if needed.
17/04/2024	Day	Ward 25	Missed 'intentional rounding'	Multiple areas of enhanced care. Unable to cohort all

5. Attendance of Nursing workforce

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



6. Governance

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

7. Conclusion

This paper provides an exception report for nursing and midwifery staffing in April 2024 and provides assurance of ongoing work to triangulate workforce metrics against staffing and care hours.

8. Recommendations

The Board of Directors is asked to receive this report for assurance.

Dr Gill Findley
Chief Nurse and Professional Lead for Midwifery and AHPs

Appendix 1- Table 3: Ward by Ward staffing April 2024

	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	87.7%	108.7%	84.5%	150.0%	221	8.2	11.0	19.2
Critical Care Dept	79.0%	123.1%	95.5%	97.1%	235	31.6	6.6	38.3
Emergency Care Centre - EAU	84.3%	103.4%	93.3%	117.1%	1353	6.5	4.0	10.5
JASRU	96.8%	88.2%	100.8%	92.9%	589	3.7	4.1	7.8
Maternity Unit	107.7%	125.5%	105.2%	96.7%	649	13.4	4.9	18.3
Paediatrics	111.2%	64.1%	107.6%	N/A	47	49.8	8.5	58.3
Special Care Baby Unit	74.3%	88.8%	117.3%	80.4%	168	9.8	3.2	13.0
St. Bedes	112.4%	108.5%	101.5%	93.0%	259	6.7	4.9	11.6
Sunniside Unit	75.9%	163.7%	118.6%	102.1%	225	6.7	6.5	13.2
Ward 08	135.5%	126.8%	92.5%	111.0%	621	4.2	3.6	7.8
Ward 09	129.6%	109.8%	84.6%	101.7%	826	3.0	2.4	5.4
Ward 10	135.5%	126.8%	92.5%	111.0%	621	4.2	3.6	7.8
Ward 11 Winter Escalation	0.0%	0.0%	0.0%	0.0%	N/A	-	-	-

	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 12	80.2%	109.1%	104.1%	104.6%	744	2.6	3.1	5.7
Ward 14 Medicine	92.6%	103.5%	134.6%	99.5%	752	3.1	2.7	5.8
Ward 14a Gastro	85.9%	102.7%	125.9%	126.2%	768	2.8	3.0	5.8
Ward 21 T&O	121.7%	110.6%	107.0%	147.2%	791	3.3	3.6	7.0
Ward 22	118.7%	103.4%	84.8%	96.4%	908	2.8	3.1	5.9
Ward 23	126.7%	97.0%	101.8%	94.8%	696	3.4	3.3	6.8
Ward 24	147.4%	97.9%	84.7%	97.5%	911	3.3	3.1	6.3
Ward 25	151.4%	88.6%	93.9%	74.4%	803	3.9	2.9	6.8
Ward 26	95.6%	119.5%	103.7%	123.6%	834	2.9	3.5	6.4
Ward 27	133.9%	125.7%	99.0%	102.4%	854	3.5	3.4	6.9
Ward 28	88.8%	89.4%	104.1%	60.3%	159	9.6	6.2	15.8
QUEEN ELIZABETH HOSPITAL - RR7EN	**102.0%**	**107.6%**	**98.6%**	**104.9%**	**14136**	5.0	3.7	8.6

Report Cover Sheet Agenda Item: 14ii

Report Title:	**Inpatient Safer Nursing Care Staffing Bi-Annual Report**			
Name of Meeting:	Board of Directors			
Date of Meeting:	5th June 2024			
Author:	Laura Edgar, Head of Nursing Workforce			
Executive Sponsor:	Dr Gillian Findley, Chief Nurse			
Report presented by:	Dr Gillian Findley, 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 January 2024. 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	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☒ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by:	Quality Governance Committee 30.6.24			
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.			

<table>
<tr><td></td><td colspan="5">Individual ward areas have been reviewed using a triangulated approach to safer staffing.

There is a revised Adult In-patient SNCT that the Trust will be using in the future within safer staffing reviews.</td></tr>
<tr><td>Recommended actions for this meeting:</td><td colspan="5">Recommendations:

Board of Directors 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 there is an updated SNCT tool that the Organisation will be utilising moving forwards.</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">Supports the majority of objectives</td></tr>
<tr><td>Links to CQC KLOE</td><td>Caring
☒</td><td>Responsive
☒</td><td>Well-led
☒</td><td>Effective
☒</td><td>Safe
☒</td></tr>
<tr><td colspan="6">Risks / implications from this report (positive or negative):</td></tr>
<tr><td>Links to risks (identify significant risks and DATIX reference)</td><td colspan="5">No risks link directly to this paper.</td></tr>
<tr><td>Has a Quality and Equality Impact Assessment (QEIA) been completed?</td><td colspan="2">Yes
☐</td><td colspan="2">No
☐</td><td>Not applicable
☒</td></tr>
</table>

Safe Staffing – Bi Annual

Inpatient Safer Nursing Care Staffing Report

April 2024

Contents

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 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 January 2024. Key observations, mitigations, and where appropriate establishment recommendations are also highlighted.

National context

Nursing continues to face ongoing challenges with recruiting and retaining nurses, with a reported 46,000 vacant nursing posts in England in November 2023 with a record high of 11.8% vacancy rate within NHS nursing roles.

The Government 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. There has been a significant increase in nursing professionals both nationally and locally, through the international recruitment programme, with internationally educated professionals accounting for one in five of the professionals on our register. Our workforce is becoming more ethnically diverse, making a vital and welcome contribution to health and wellbeing.

We must continue to ensure 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.

Analysis of Gateshead Health Safer Staffing Nursing Review January 2024

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.

A refreshed SNCT tool was launched in December 2023, including additional levels of acuity and dependency to support the identification of enhanced care needs in adult in patient wards. Staff at the organisation were not trained to use the revised tool ready for data collection in January 2024, therefore the decision was taken to use the previous tool to mitigate misinterpretation of the new descriptors. The licence agreement for this tool remained valid. Nursing establishment review meetings were not

undertaken at this point, given the requirement to move to analysing data under the revised tool for future collections. Time was therefore utilised to roll out training to clinical leaders in preparation for further data collection.

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 propose recommendations. Further recommendations for the ED department will be presented in a separate report once the model has been agreed by the Business unit.

SNCT Audit – The SNCT audit is required to be presented Bi – annually to board. The report presented in October can be found here
Gateshead Health - SNCT report October 23- final draft.docx

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) was 8.5 in January 2024 compared with 8.2 in January 2023. Although reduced Gateshead health benchmarks well with other regional trusts with NUTH (8.3) CDDFT (7.7) and NSECH (7.4).

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 January 23 and January 24, Gateshead health has averaged 89% fill rate for registered nursing and 124% fill rate for care staff. The increased fill rate for care staff is largely attributable 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.

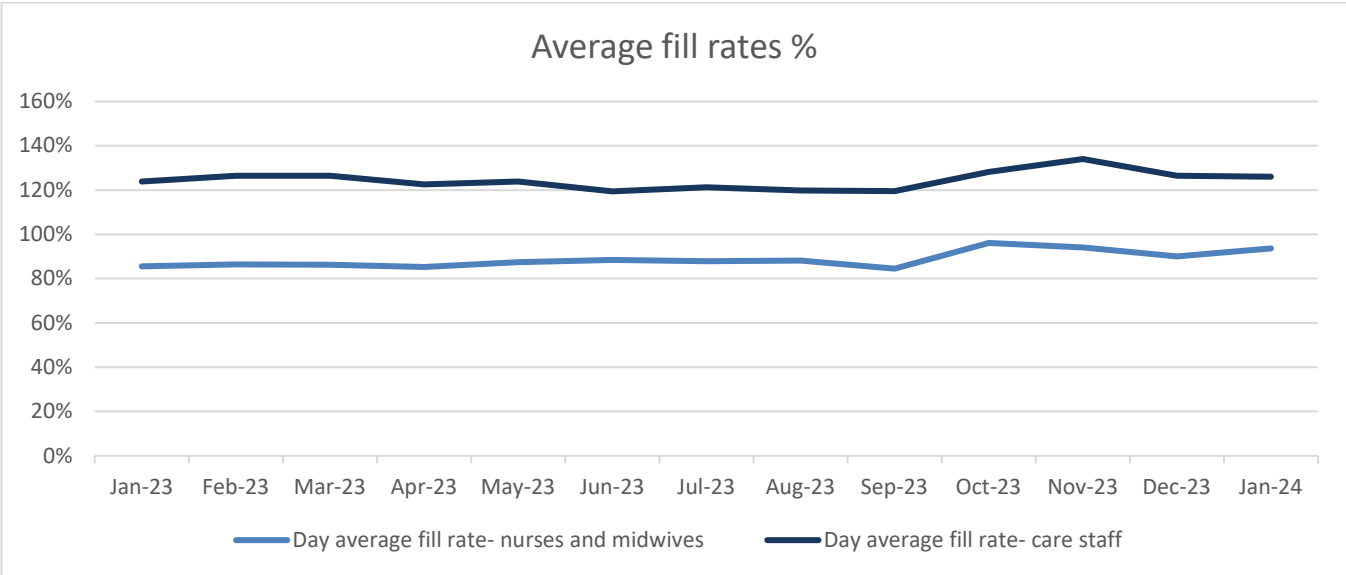


Figure 2: monthly fill rate

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. During January- March 24 the main key themes recorded are:

- Shortfall in Registered Nurse time (15)
- Missed ‘intentional’ rounding (29)
- Temporary Staffing (6)

It is important to note that whilst red flag reporting is evident, continued work with the ward teams to empower usage, low reporting is likely linked to staff being too busy to raise a red flag. Matrons continue to support red flag reporting to ensure accurate documentation.

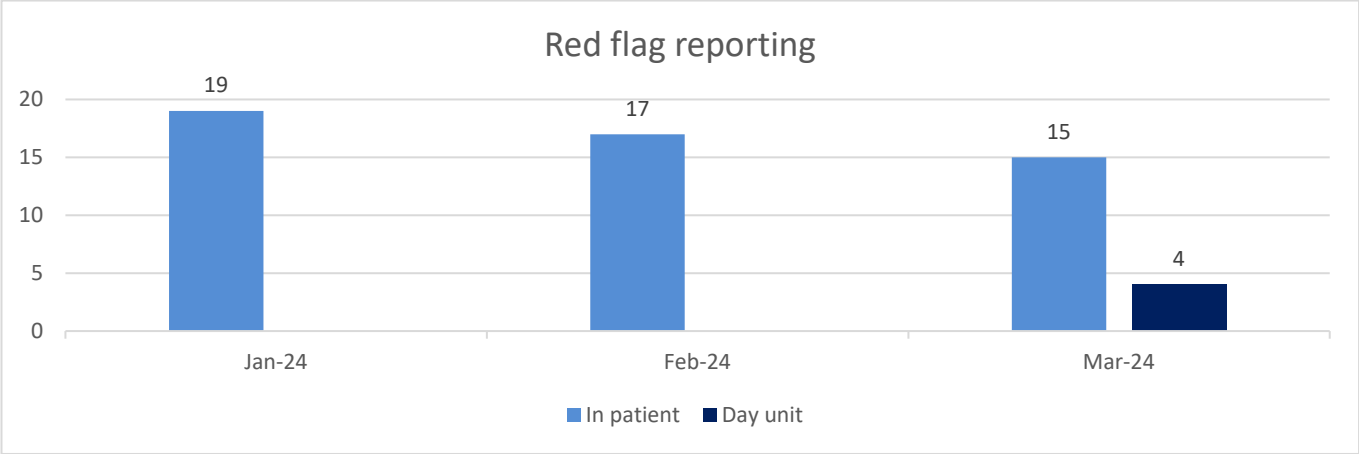


Figure 3: Red Flags

Right staff

Recruitment and retention
Recruitment and retention remain a key priority for Gateshead Health, with a current vacancy rate of +1.6% for nursing against the Trust target of 8%. This position of over recruitment within the nursing workforce is largely attributable to the successful international recruitment programme. Recruitment into specialist areas such as Paediatrics remains an ongoing focus for the Trust.

International recruitment
Gateshead has successfully recruited 176 internationally educated nurses, of which 150 have passed their Objective Structured Clinical Examination (OSCE) since January 2023. 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 experienced nurses with a variation of skills and knowledge, over coming months following consolidation we will continue work within the Practice Development team to support career progression discussions and further recognition of their skills and experience.

Gateshead Health agreed to be part of cohort 6 supporting NHS England's Refugee programme, and welcomed 5 nurses in January. The nurses are working clinically 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 reduced nursing turnover rate and now demonstrate in the lowest quartile, with this at 9.2% for January 24, comparative to the provider mean at 11%. This has reduced since the previous staffing review (12.5% in March 2023).

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 6.76% combined in January. Work continues with POD to review sickness and absence reasons and work with staff to support them to return to work safely.

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 86.09% in April 24. 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 all ward leaders are not budgeted for allocated management time or clinical supervisory time to support ward staff. The trust completed a pilot for full time supervisory management time last year and was 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. Although this is not fully implemented across all ward areas, it is noted that ward managers are allocating some supervisory time to undertake management duties when safe staffing levels permit.

Healthcare support workers (HCSW): National guidance around the differentiation between band 2 and 3 HCSW and skills has required Gateshead Health to review this role and each clinical area requirement, which will require re-banding of many posts in the coming months. This work has now been actioned and the Trust are in the implementation phase of the project. The Trust has previously supported over establishment of HCSW due to the increased vacancies within the registered nursing workforce. As the RN gap reduced, work to reduce the over established HCSW workforce mirrored. As of January 24, it is reported a vacancy rate of 1% in this workforce group.

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. Notably, redeployment from staff from 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.

To note, in the revised Adult inpatient SNCT tool, headroom is set at 22% therefore we will be required to use this as a baseline moving forwards.

Bank/agency use:

There has been concentrated work since the previous review to reduce the utilisation of bank and agency, which has significantly reduced the reliance on off framework agency.

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.

Gateshead health spent £4,307,923 on bank staffing expenditure between Apr 23 and Mar 24, and £1,853,800 on agency staff.

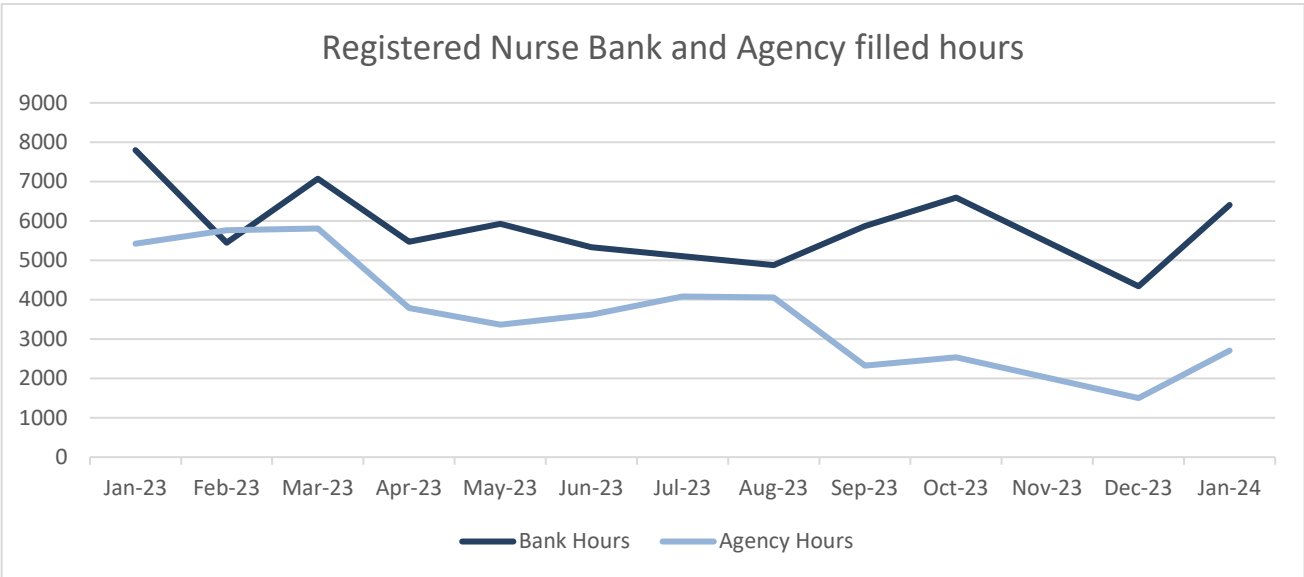


Figure 8 Registered Nurse Bank and Agency Filled hours 23/24

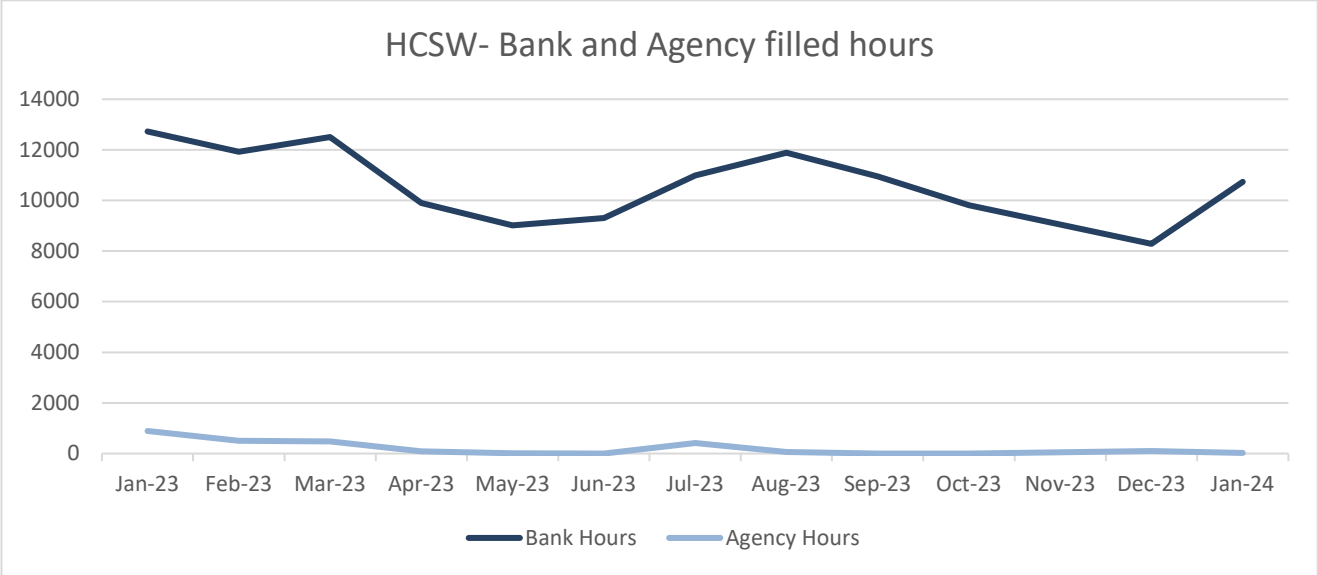


Figure 9 HCSW Bank and Agency filled hours in 23/24.

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 10 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 at night. 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 present ongoing challenges with regards to ensuring safe staffing across all areas. Consideration should be given to the reduced external supply of the professional 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. Recruitment and retention practices require consistent and concerted effort across all areas of pay, training, retention, and job security.

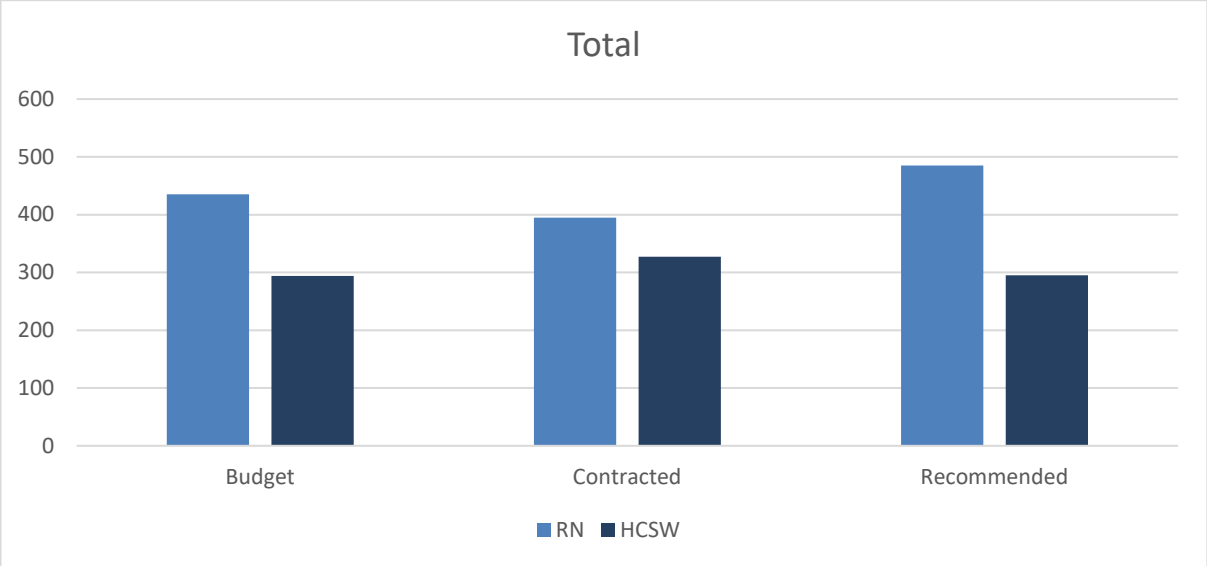
Recommendations:

- Recommendation to recognise the paper for assurance regarding the safer staffing review process. It is recognised there is now a revised SNCT tool, to encapsulate the recognition of enhanced care,

therefore it is recommended a safer staffing review utilising the refreshed tool will take place during April.

- Recommendation to note the change to standard headroom of 22% in the revised SNCT tool, therefore we will be required to adjust this moving forwards.

- Recommendation for presentation of report for ED staffing outside of this report when model agreed by Medical Business unit.



Actions:

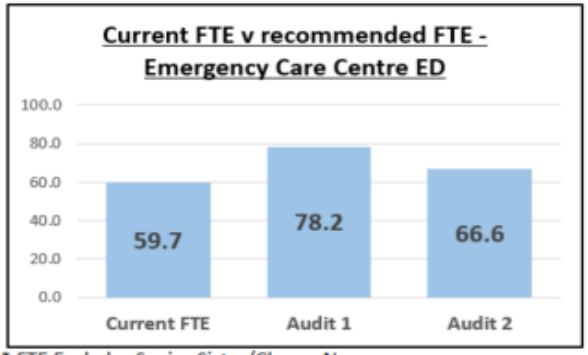
- Ongoing monitoring of acuity and occupancy over next 6 months to determine whether establishment modifications are required in line with the current increasing acuity using the revised Adult Inpatient SNCT.

References

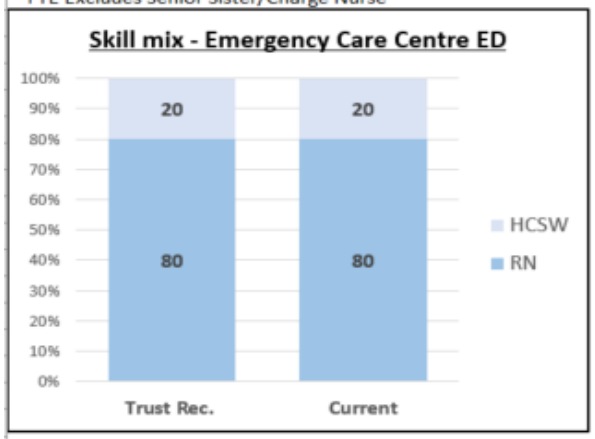
NHSI: (2018) Developing workforce safeguards.
NQB: (2016) Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time.
The Kings Fund (2022) The NHS nursing workforce – have the flood guards opened.
Shelford Group: (2014) Safer Nursing Care Too

Appendix 1: SNCT Data Analysis:

Medical Service Line 1 Emergency Department



* FTE Excludes Senior Sister/Charge Nurse



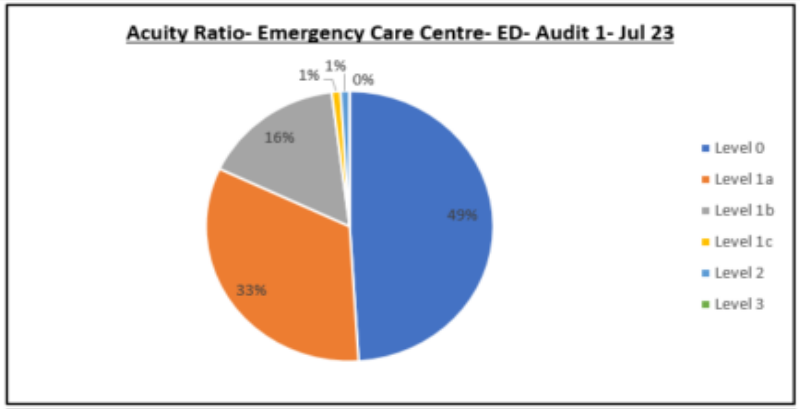
Emergency Care Centre ED SNCT results 2024

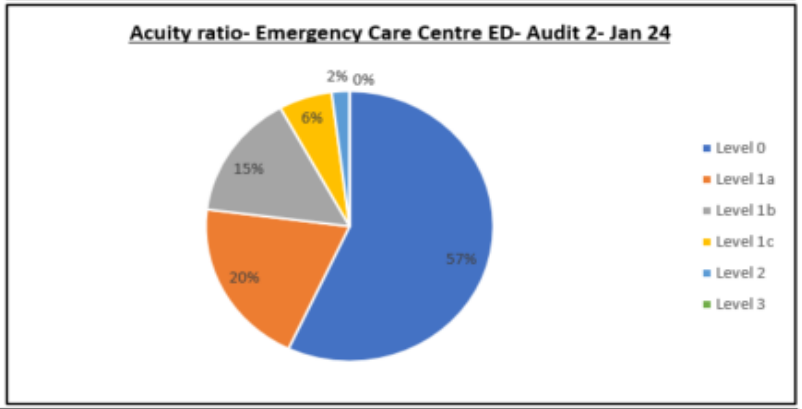
Top Graph on the left:
Demonstrates the comparison between the budgeted staffing, the recommended staffing according to the SNCT in Audit 1 and Audit 2.

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, 1c= 1-1 enhanced care, 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.

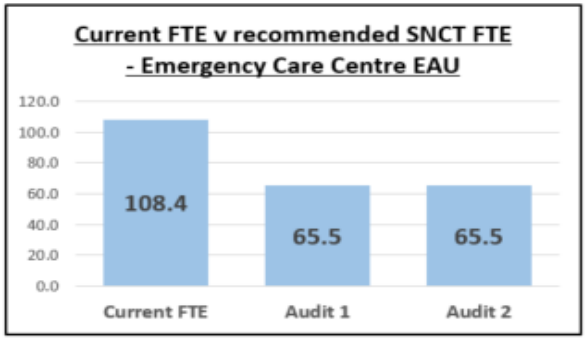




Nursing & Midwifery Care Quality Indicators

			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%	100.00%		6	0	42	80.70%	0	21.56	12.70%	5.00%		
		Audit 2	100.00%	83.30%		12	0	26	80.20%	0	28.9	11.40%	6.10%		

EAU



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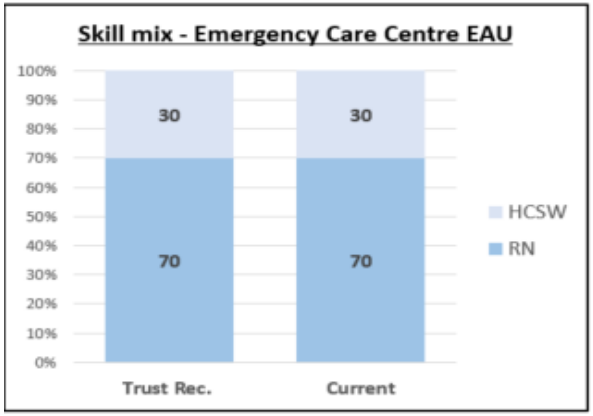

Emergency Care Centre EAU SNCT results 2024

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:
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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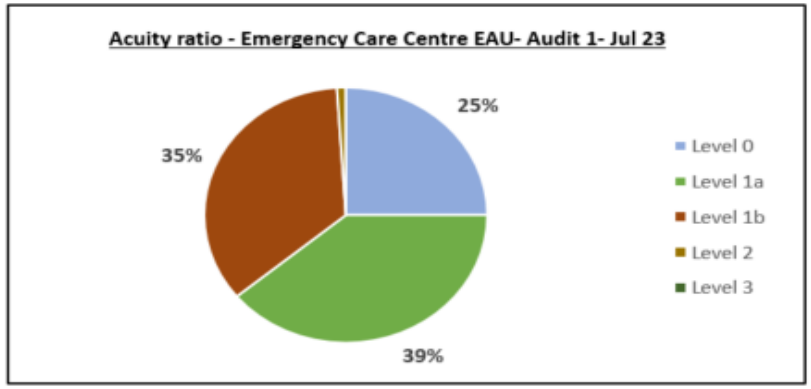
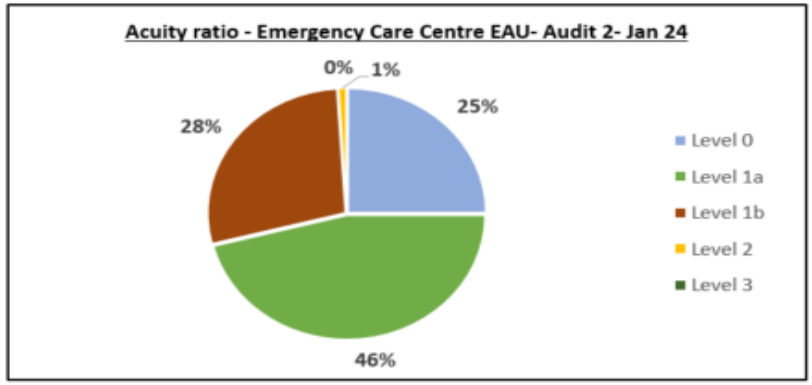
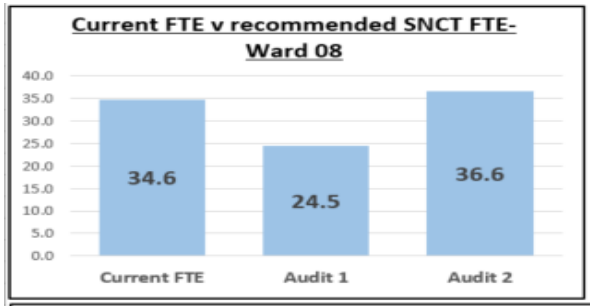


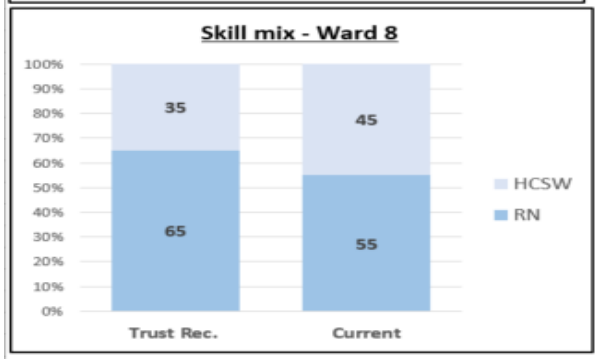


Nursing & Midwifery Care Quality Indicators

			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%	100.00%	74.50%	2	0	0	88.80%	1	1.7	14.00%	5.52%	10.7	
		Audit 2	100.00%	98.60%	74.50%	23	5	30	91.10%	1	1.70	13.20%	6.80%	10.45	7.38

Medicine Service Line 2- Ward 8





Ward 8 SNCT results 2024

Top Graph on the left:
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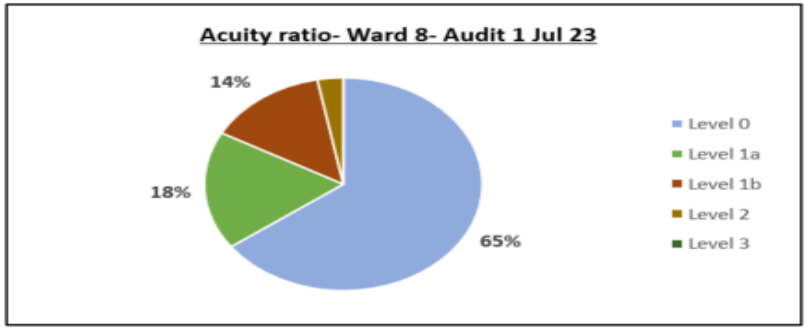

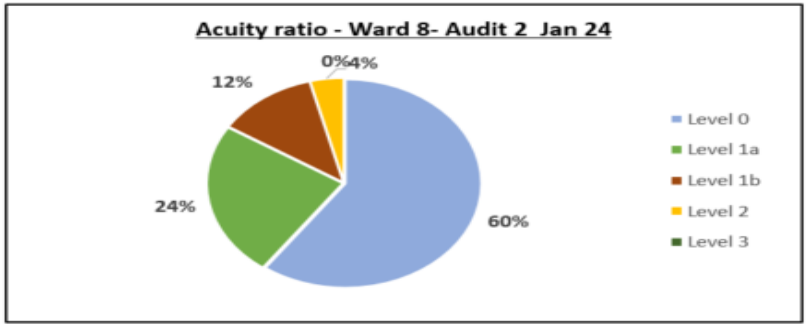

Nursing & Midwifery Care Quality Indicators

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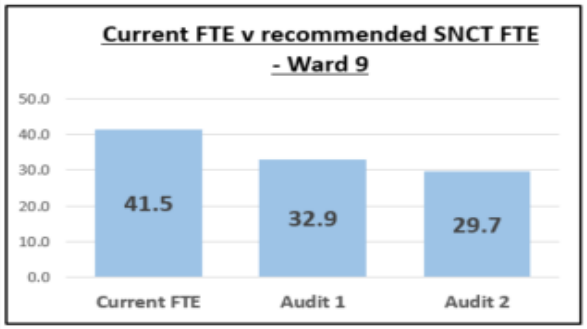
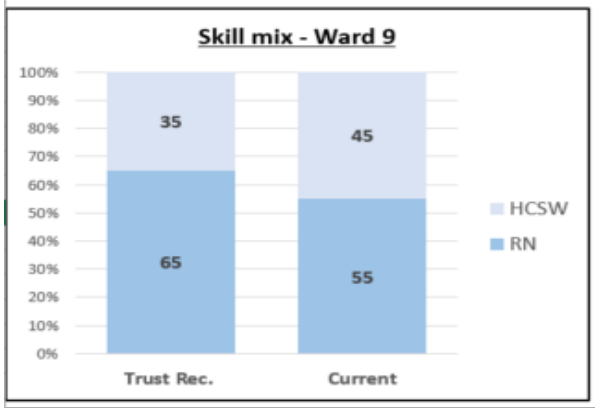
Ward	Division	Audit	data compliance	Hand Hygiene	Observations on time	inpatient falls with harm	Hosp. acquired pressure ulcers	Reportable Medication errors	Friends and family test	Safer Staffing red flags	No. vacancies	% AL used	% sickness	CHPPD	Peer CHPPD
Ward 8	Medicine	Audit 1	100.00%	98.90%	75.20%	1	2	12	99.70%	0	5.25	13.90%	13.47%	7.6	
		Audit 2	100.00%	97.00%	72.30%	8	3	5	98.60%	1	1.3	13.20%	14.40%	6.8	7.27

ard 9





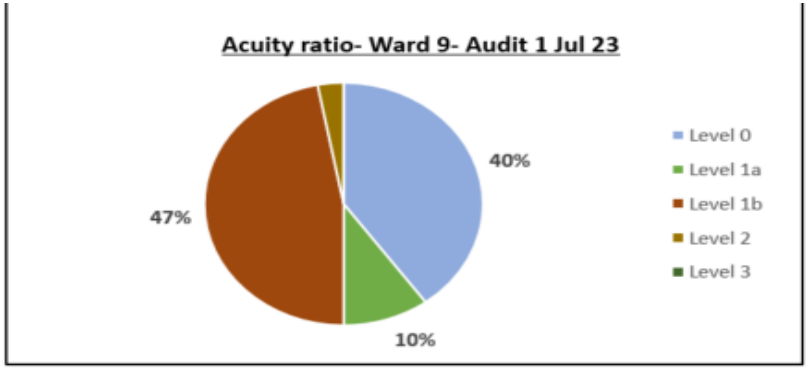
Ward 9 SNCT results 2024

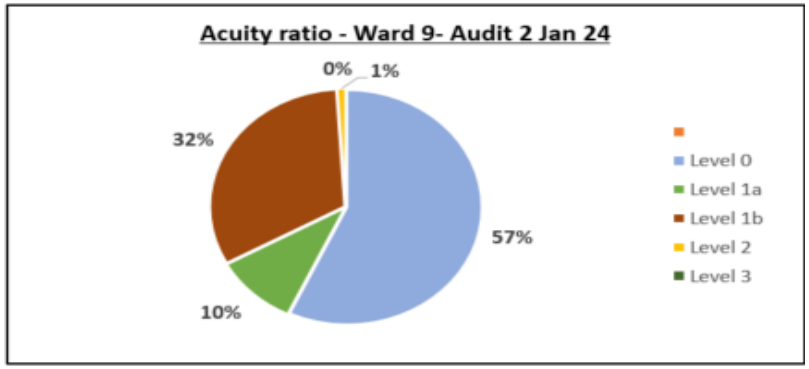
Top Graph on the left:
Demonstrates the comparison between the budgeted staffing, the recommended staffing according to the SNCT in Audit 1 and Audit 2.

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.

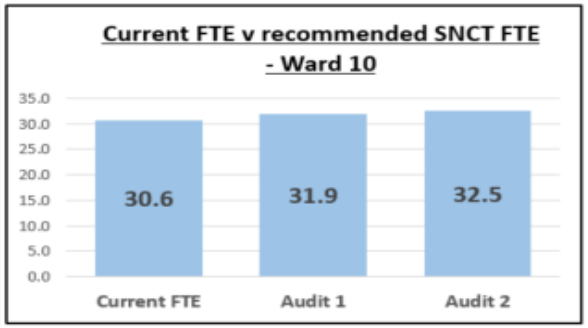
Table below:
Shows the data compliance, variance between the current funded establishment and the recommended establishment alongside the patient outcomes, patient experience and staff outcomes.

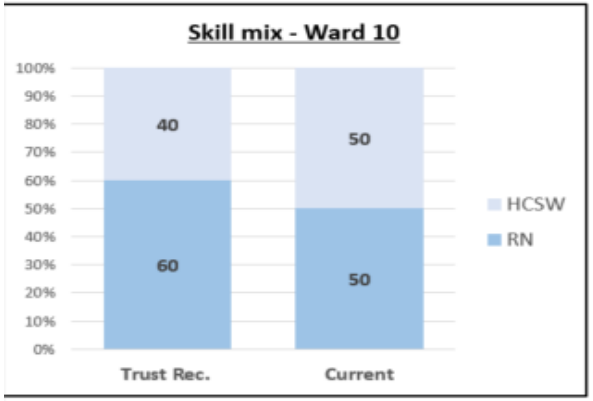




Nursing & Midwifery Care Quality Indicators														
			input staffing	Input - process of care		Outcome - Incidence of harm			Outcome - Patient Experience	Outcome-Staff Experience				
Ward	Division	Audit	data compliance	Hand Hygiene	Observations on time	inpatient falls with harm	Hosp. acquired pressure ulcers	Reportable Medication errors	Friends and family test	Safer Staffing red flags	No. vacancies	% AL used	% sickness	CHPPD	Peer CHPPD
Ward 9	Medicine	Audit 1	100.00%	100.00%	91.00%	11	14	5	98.90%	0	8.5	9.80%	6.80%	6.1	
		Audit 2	100.00%	77.50%	90.00%	14	10	8	96.30%	5	1.4	12.70%	5.90%	5.4	6.6

Ward 10





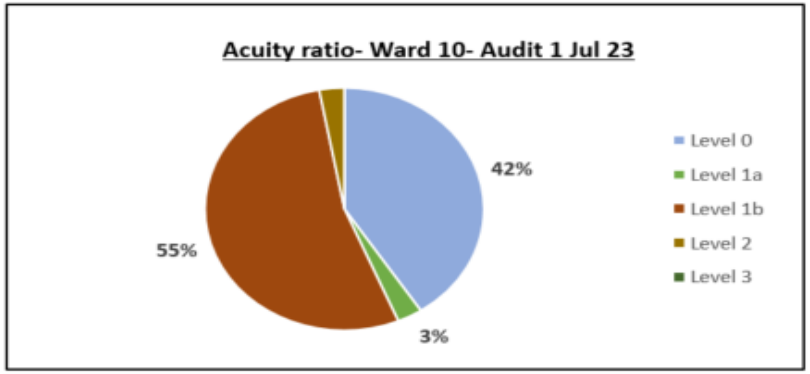
Ward 10 SNCT results 2024

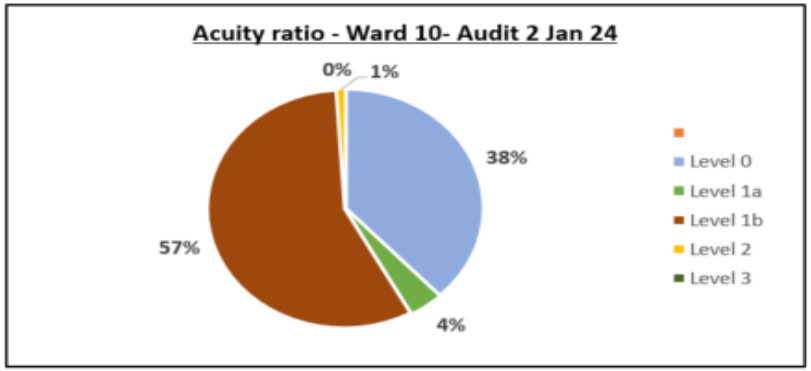
Top Graph on the left:
Demonstrates the comparison between the budgeted staffing, the recommended staffing according to the SNCT in Audit 1 and Audit 2.

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.

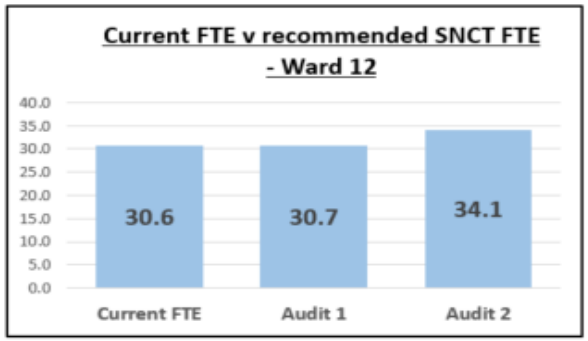


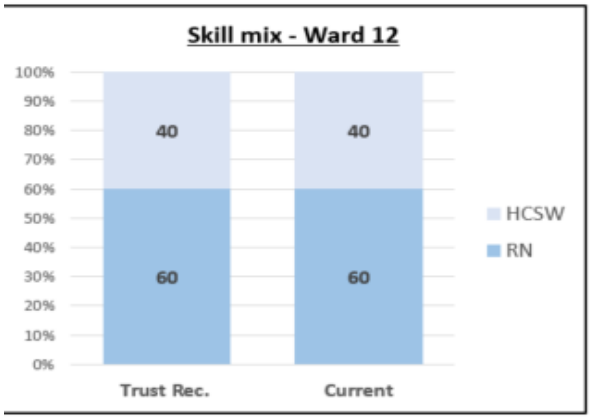


Nursing & Midwifery Care Quality Indicators

			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
Ward 10	Medicine	Audit 1	100.00%	97.20%	86.40%	10	3	4	66.70%	4	5.06	13.00%	7.20%	6.9	
		Audit 2	100.00%	87.50%	87.40%	11	7	5	98.80%	7	4.3	12.20%	10.20%	6	6.9

Ward 12





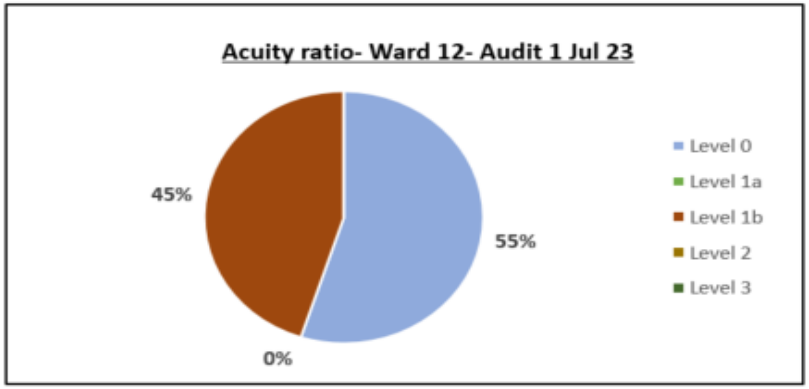
Ward 12 SNCT results 2024

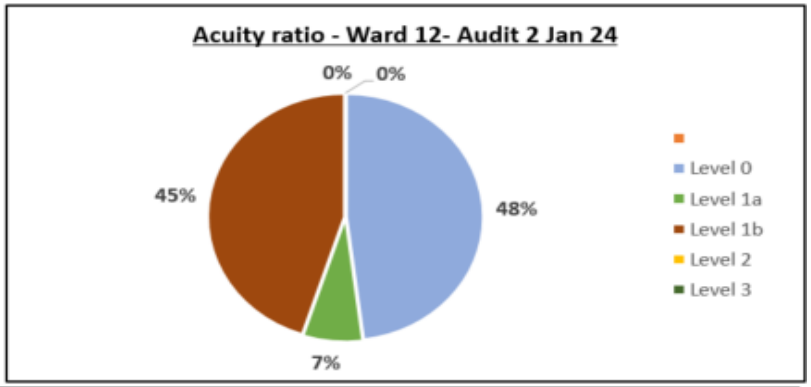
Top Graph on the left:
Demonstrates the comparison between the budgeted staffing, the recommended staffing according to the SNCT in Audit 1 and Audit 2.

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.

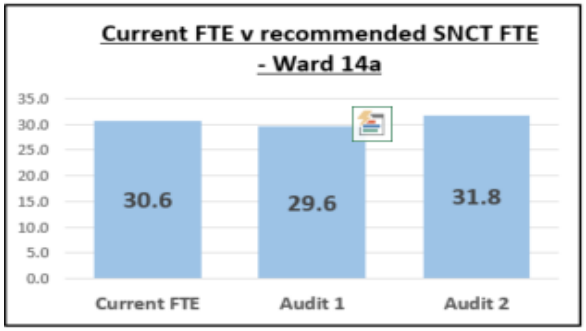


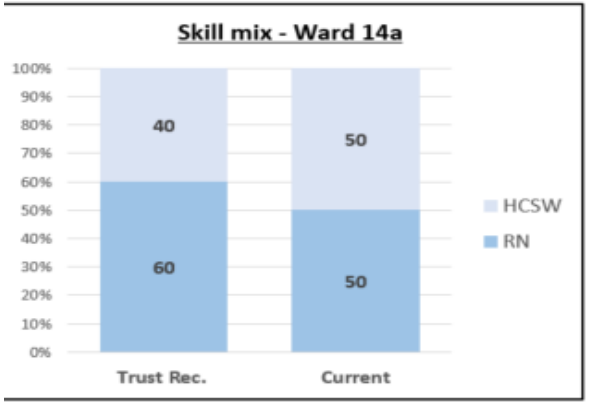


Nursing & Midwifery Care Quality Indicators

			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%	100.00%	88.90%	2	0	0	72.70%	5	2.67	15.40%	11.10%	5.7	
		Audit 2	100.00%		74.30%	19	4	11	100.00%	8	1.7	13.20%	9.90%	5.4	7

Ward 14





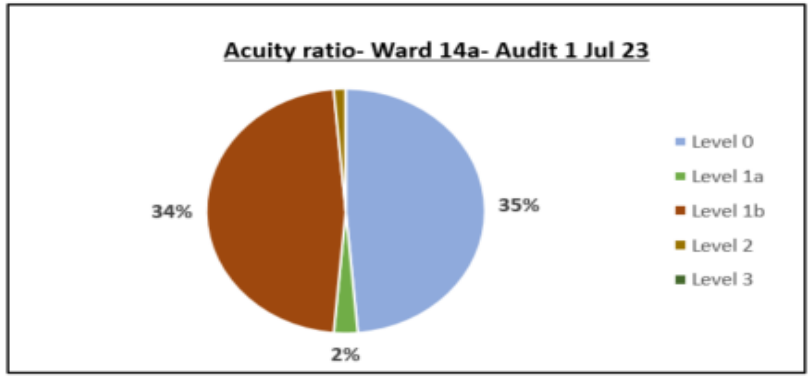
Ward 14a SNCT results 2024

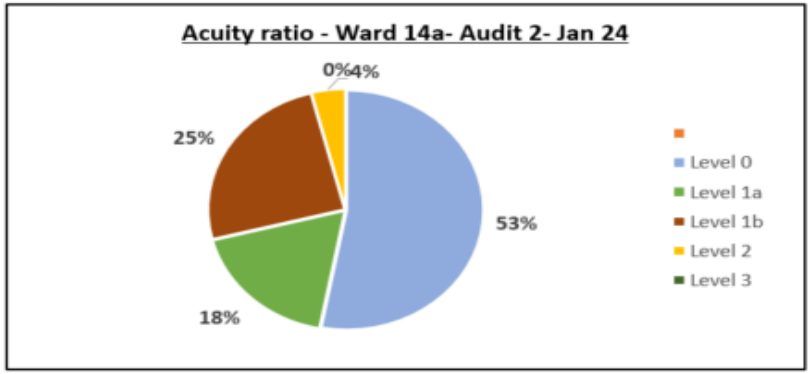
Top Graph on the left:
Demonstrates the comparison between the budgeted staffing, the recommended staffing according to the SNCT in Audit 1 and Audit 2.

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.

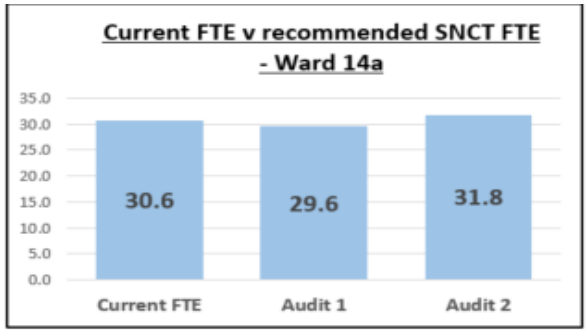


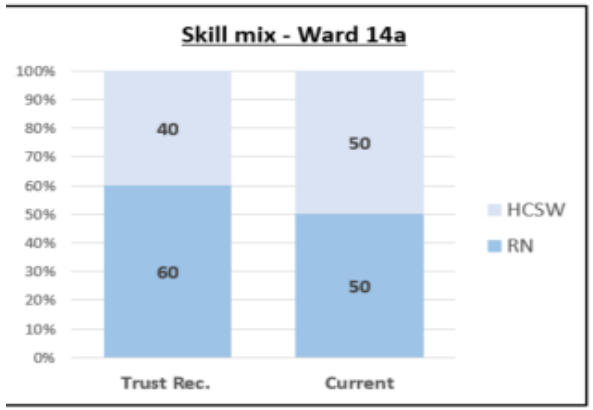


Nursing & Midwifery Care Quality Indicators

			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 14a	Medicine	Audit 1	100.00%	100.00%	88.90%	2	0	0	72.70%	1	7.3	11.30%	2.80%	11.4	
		Audit 2	100.00%	97.90%	84.60%	4	7	5	87.90%	3	0.1	13.40%	6.40%	5.9	6

Ward 14a





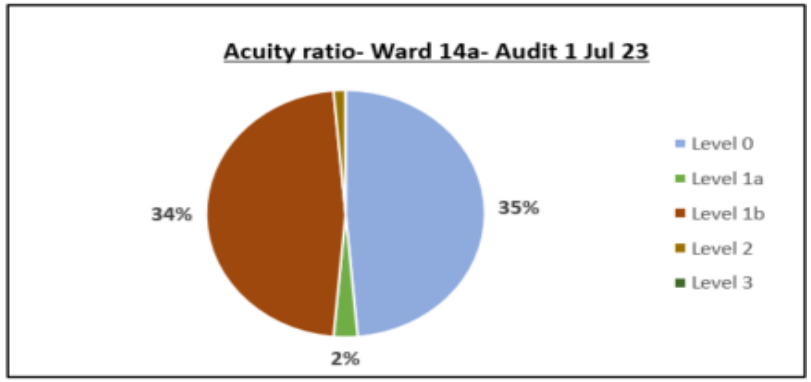
Ward 14a SNCT results 2024

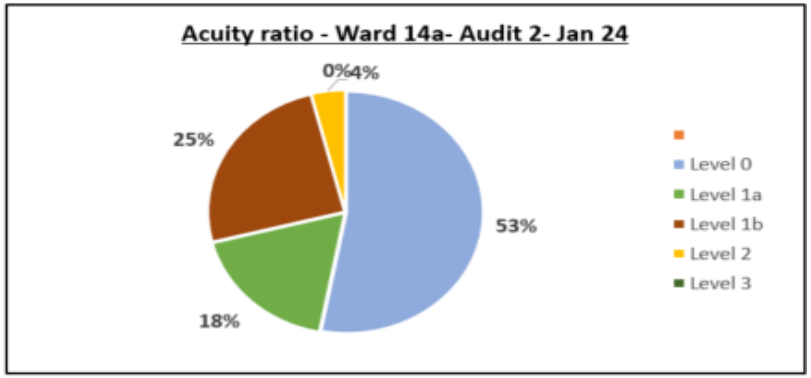
Top Graph on the left:
Demonstrates the comparison between the budgeted staffing, the recommended staffing according to the SNCT in Audit 1 and Audit 2.

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.

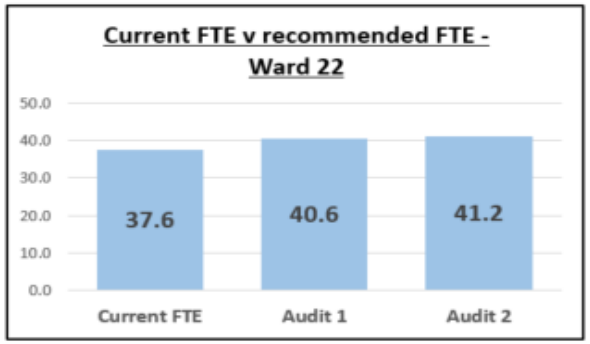


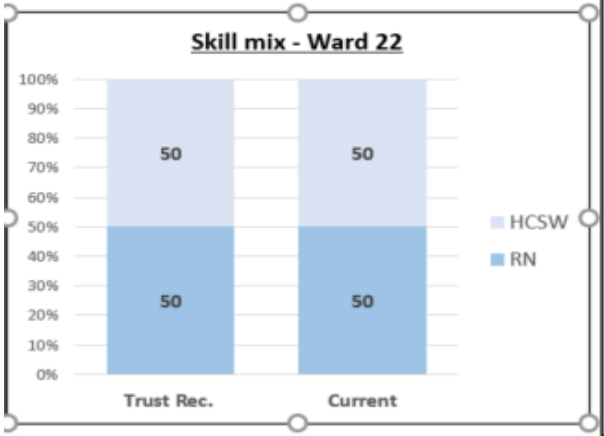


Nursing & Midwifery Care Quality Indicators

			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 14a	Medicine	Audit 1	100.00%	100.00%	88.90%	2	0	0	72.70%	1	7.3	11.30%	2.80%	11.4	
		Audit 2	100.00%	97.90%	84.60%	4	7	5	87.90%	3	0.1	13.40%	6.40%	5.9	6

Medicine Service Line 3- Ward 22





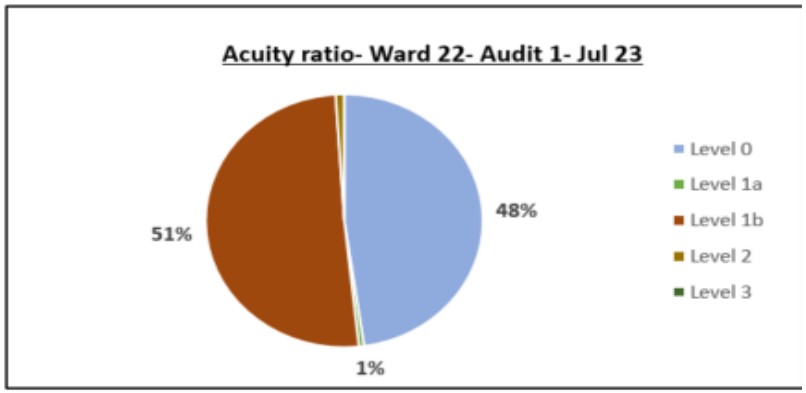
Ward 22 SNCT results 2024

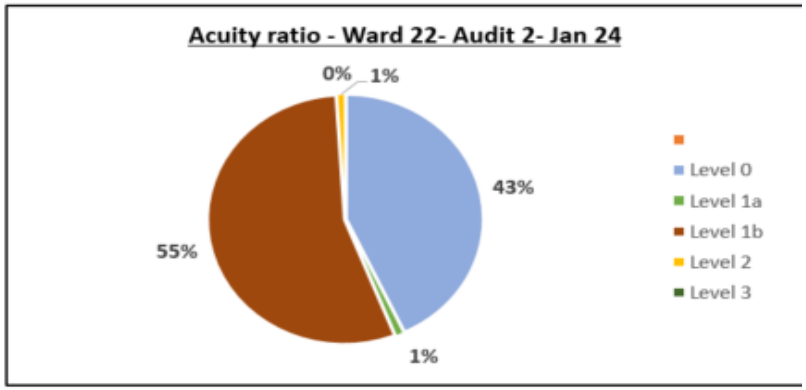
Top Graph on the left:
Demonstrates the comparison between the budgeted staffing, the recommended staffing according to the SNCT in Audit 1 and Audit 2.

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.

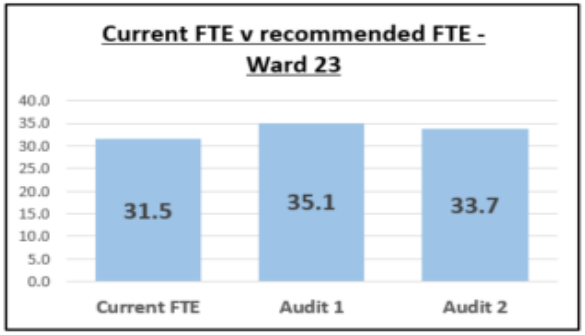


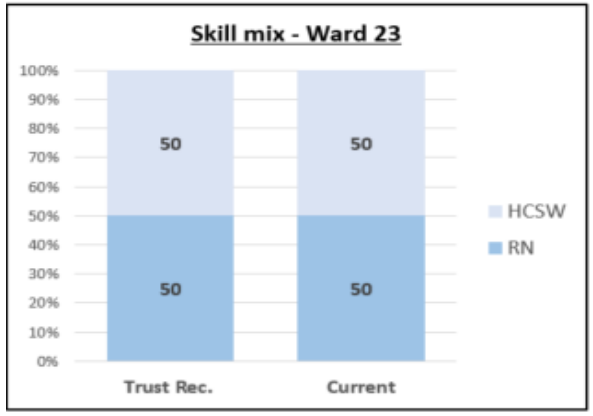


Nursing & Midwifery Care Quality Indicators

			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%	89.30%	13	7	8	91.70%	1	0.33	13.50%	7.50%	5.6	
		Audit 2	100.00%	100.00%	88.30%	12	4	7	99.40%	5	0.3	12.70%	5.40%	5.8	7.1

Ward 23





Ward 23 SNCT results 2024

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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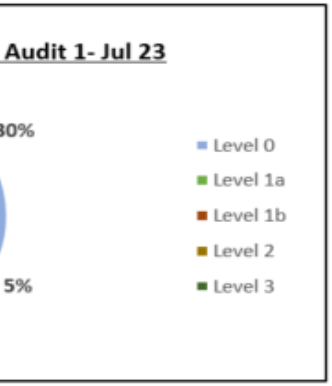
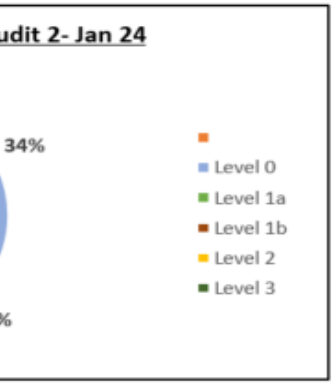
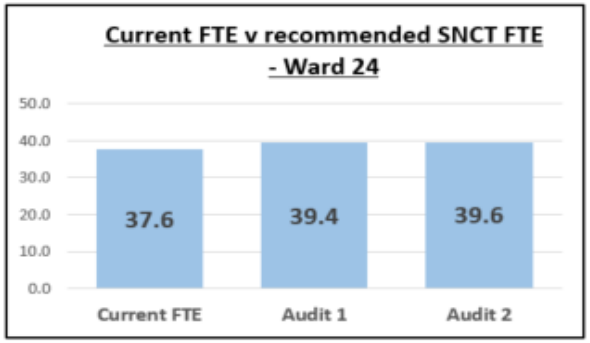


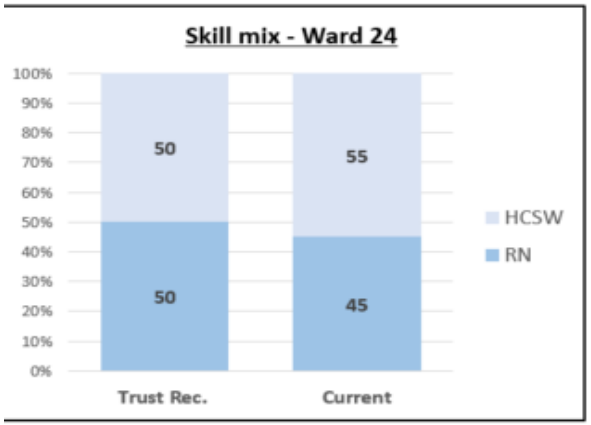


Nursing & Midwifery Care Quality Indicators

			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 23	Medicine	Audit 1	100.00%	100.00%	85.40%	10	3	5	66.70%	1	0.84	12.00%	5.60%	6.8	
		Audit 2	100.00%	100.00%	88.60%	10	4	4	100.00%	4	5.5	11.70%	12.40%	6.9	7.1

Ward 24





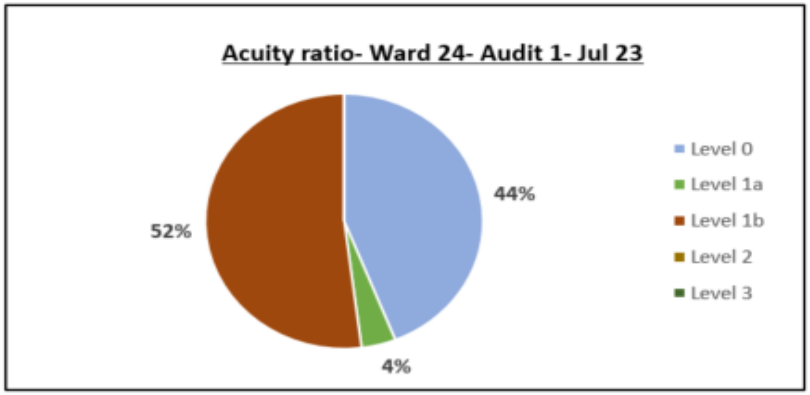
Ward 24 SNCT results 2024

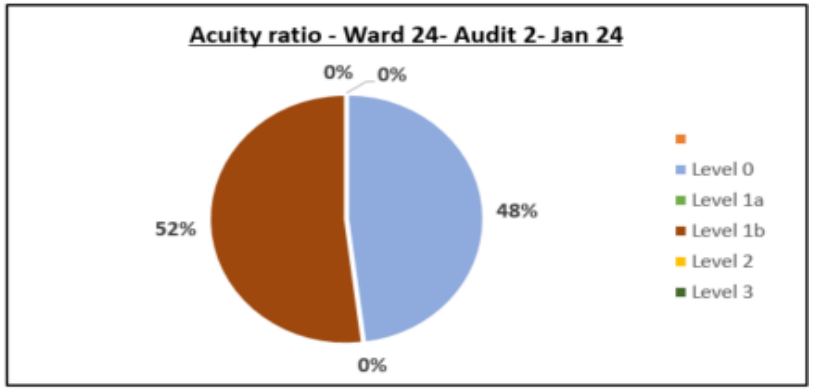
Top Graph on the left:
Demonstrates the comparison between the budgeted staffing, the recommended staffing according to the SNCT in Audit 1 and Audit 2.

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.

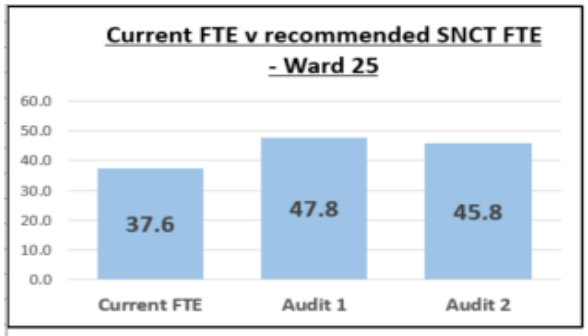
Table below:
Shows the data compliance, variance between the current funded establishment and the recommended establishment alongside the patient outcomes, patient experience and staff outcomes.

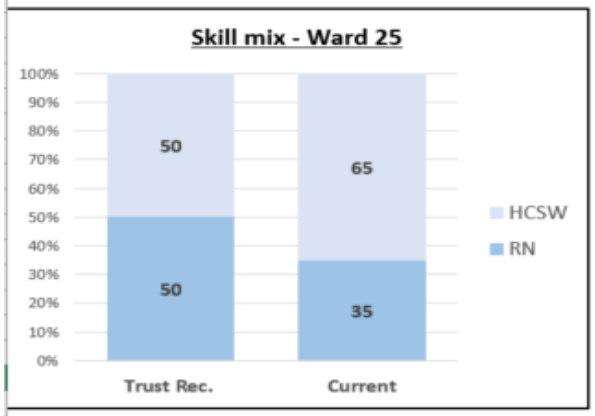




Nursing & Midwifery Care Quality Indicators														
			input staffing	Input - process of care		Outcome - Incidence of harm			Outcome - Patient Experience	Outcome-Staff Experience				
Ward	Division	Audit	data compliance	Hand Hygiene	Observations on time	inpatient falls with harm	Hosp. acquired pressure ulcers	Reportable Medication errors	Friends and family test	Safer Staffing red flags	No. vacancies	% AL used	% sickness	CHPPD	Peer median CHPPD
Ward 24	Medicine	Audit 1	100.00%	97.20%	93.90%	11	3	5	96.70%	1	4.21	13.20%	9.10%	5.3	
		Audit 2	100.00%	100.00%	100.00%	21	7	9	97.40%	5	0.6	12.60%	6.80%	5.8	7.1

Ward 25





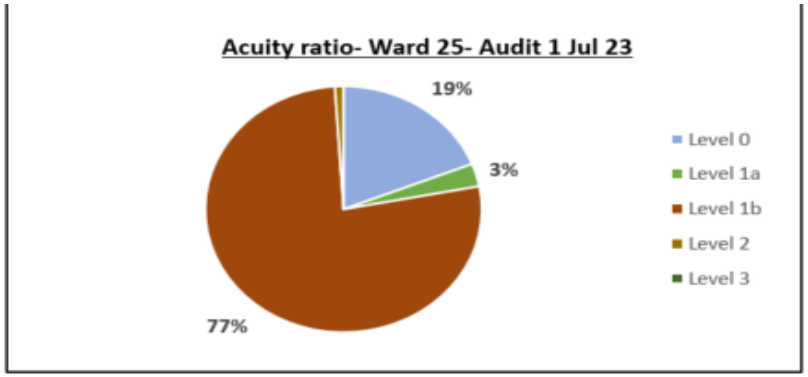
Ward 25 SNCT results 2024

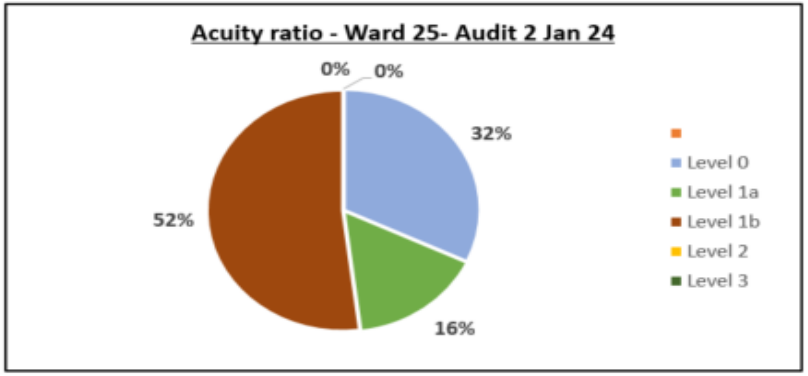
Top Graph on the left:
Demonstrates the comparison between the budgeted staffing, the recommended staffing according to the SNCT in Audit 1 and Audit 2.

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.

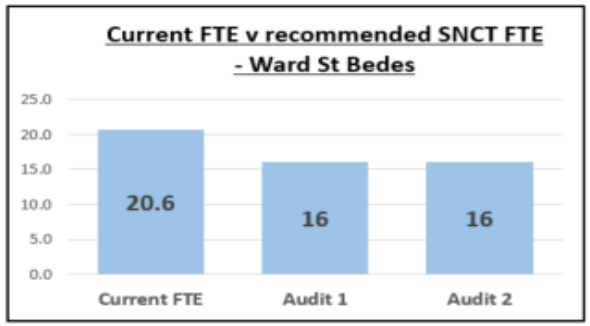


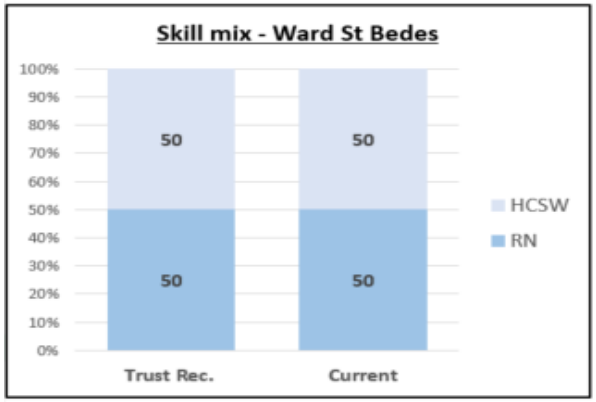


Nursing & Midwifery Care Quality Indicators

			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 25	Medicine	Audit 1	100.00%	67.80%	83.40%	17	11	10	98.10%	10	0.37	13.20%	8.90%	5.7	
		Audit 2	100.00%	69.70%	79.20%	16	8	13	100.00%	20	1.2	11.60%	11.30%	5.8	7.1

St bedes





Ward St Bedes SNCT results 2024

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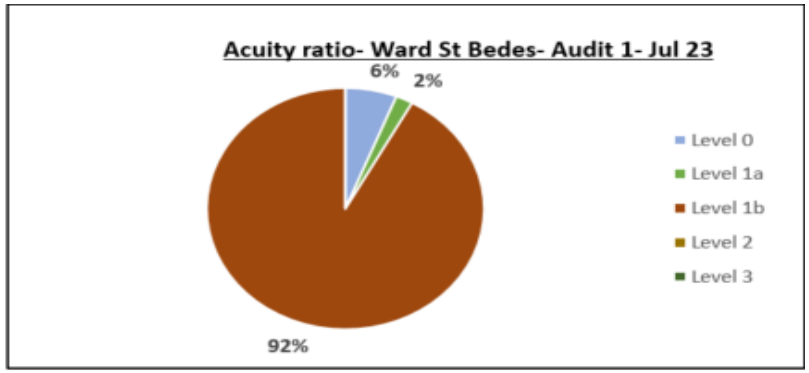
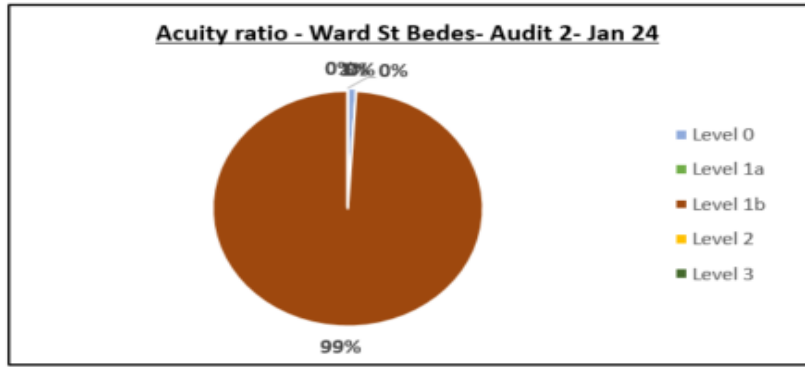
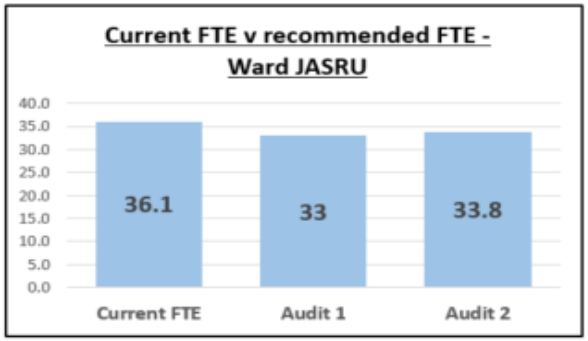
Shows the data compliance, variance between the current funded establishment and the recommended establishment alongside the patient outcomes, patient experience and staff outcomes.

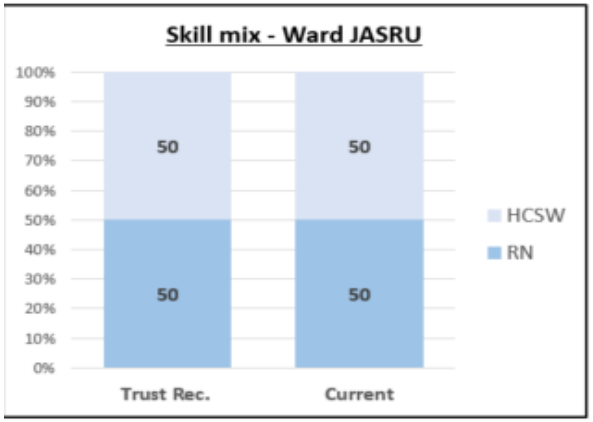




Nursing & Midwifery Care Quality Indicators														
			input staffing	Input - process of care		Outcome - Incidence of harm			Outcome - Patient Experience	Outcome-Staff Experience				
Ward	Division	Audit	data compliance	Hand Hygiene	Observations on time	inpatient falls with harm	Hosp. acquired pressure ulcers	Reportable Medication errors	Friends and family test	Safer Staffing red flags	No. vacancies	% AL used	% sickness	CHPPD	Peer median CHPPD
Ward St Bedes	Medicine	Audit 1	100.00%	100.00%	82.10%	2	3	4		0	1.92	15.10%	9.00%	11.7	
		Audit 2	100.00%	100.00%	86.60%	1	8	9		0	0.2	15.90%	5.60%	9.09	8.05

JASRU





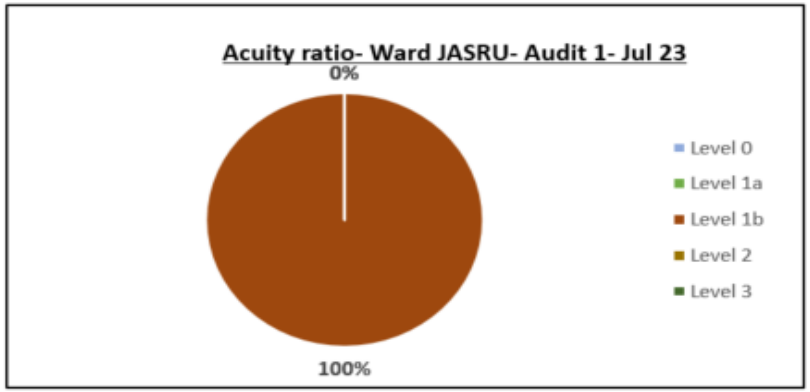
Ward JASRU SNCT results 2024

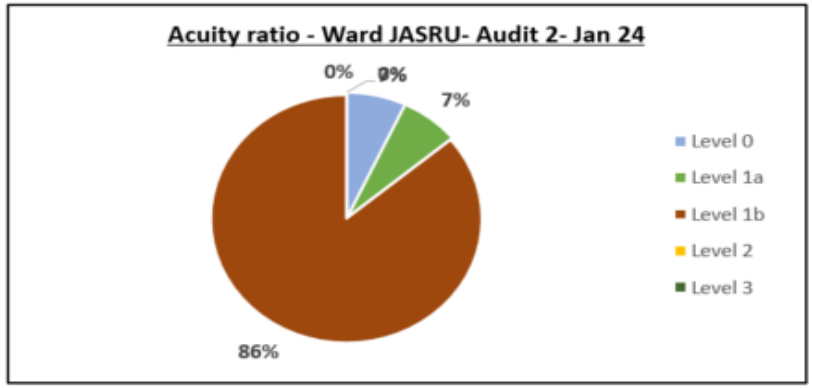
Top Graph on the left:
Demonstrates the comparison between the budgeted staffing, the recommended staffing according to the SNCT in Audit 1 and Audit 2.

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.

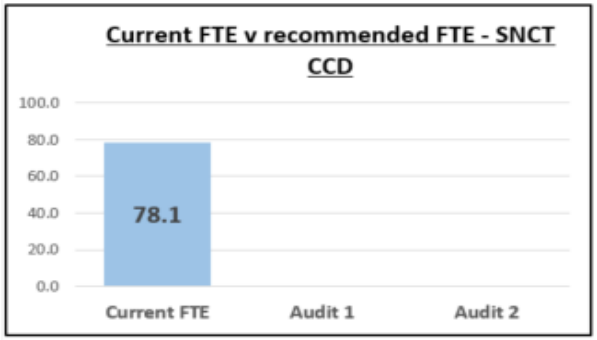
Table below:
Shows the data compliance, variance between the current funded establishment and the recommended establishment alongside the patient outcomes, patient experience and staff outcomes.

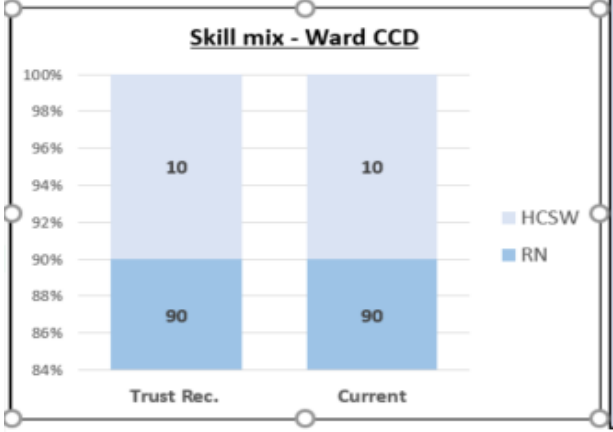




Nursing & Midwifery Care Quality Indicators														
			input staffing	Input - process of care		Outcome - Incidence of harm			Outcome - Patient Experience	Outcome-Staff Experience				
Ward	Division	Audit	data compliance	Hand Hygiene	Observations on time	inpatient falls with harm	Hosp. acquired pressure ulcers	Reportable Medication errors	Friends and family test	Safer Staffing red flags	No. vacancies	% AL used	% sickness	CHPPD	Peer median CHPPD
Ward JASRU	Medicine	Audit 1	100.00%	97.50%	84.90%	6	4	3	93.30%	2	0.84	13.00%	18.10%	7.6	
		Audit 2	100.00%	100.00%	85.00%	6	5	3	100.00%	1	1.4	12.10%	17.30%	7.8	6.79

Surgery Service Line 1- Critical Care Department





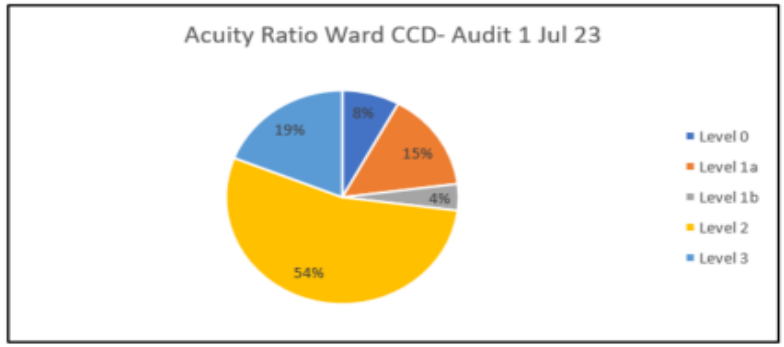
Ward CCD SNCT results 2024

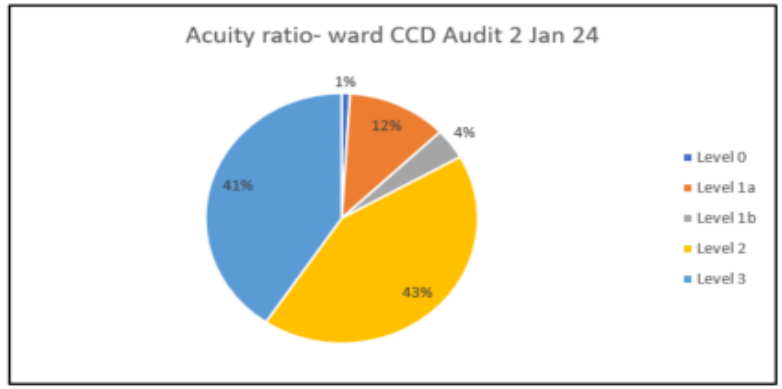
Top Graph on the left:
Demonstrates the comparison between the budgeted staffing, the recommended staffing according to the SNCT in Audit 1 and Audit 2.

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+

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.

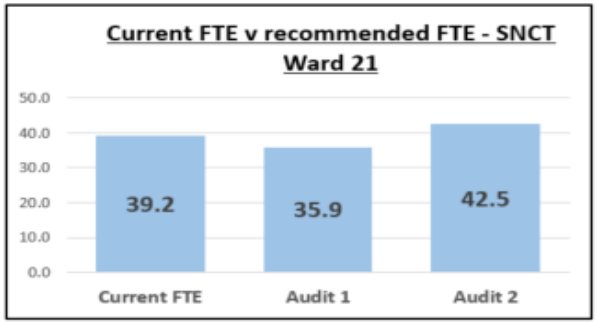


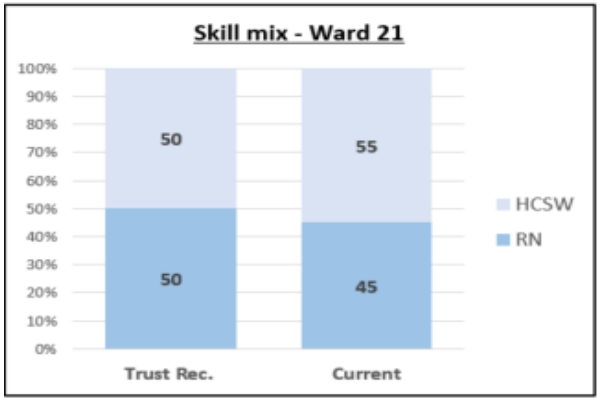


Nursing & Midwifery Care Quality Indicators

			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 CCD	Surgery	Audit 1	100.00%	100.00%	n/a	0	9	12	100.00%	0	8.76	15.60%	8.00%	48.7	
		Audit 2	100.00%	99.70%	n/a	3	10	14	100.00%	0	3.1	13.20%	9.30%	36.7	27.9

Ward 21





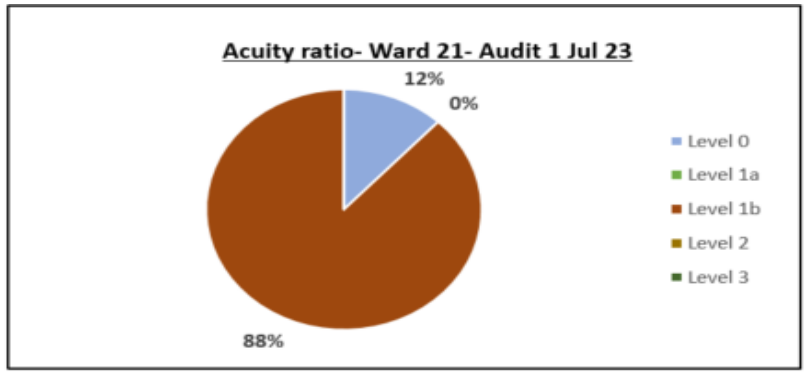
Ward 21 SNCT results 2024

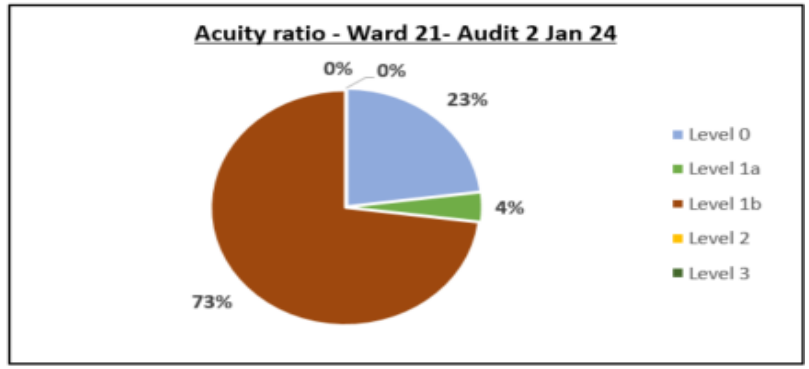
Top Graph on the left:
Demonstrates the comparison between the budgeted staffing, the recommended staffing according to the SNCT in Audit 1 and Audit 2.

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.

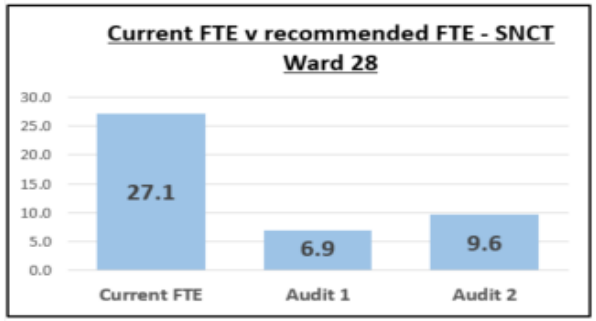
Table below:
Shows the data compliance, variance between the current funded establishment and the recommended establishment alongside the patient outcomes, patient experience and staff outcomes.

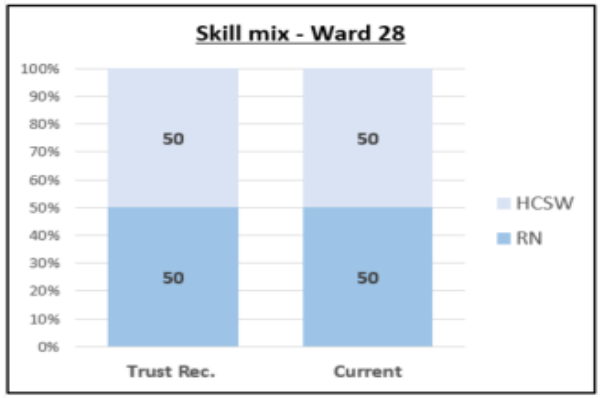




Nursing & Midwifery Care Quality Indicators														
			input staffing	Input - process of care		Outcome - Incidence of harm			Outcome - Patient Experience	Outcome-Staff Experience				
Ward	Division	Audit	data compliance	Hand Hygiene	Observations on time	inpatient falls with harm	Hosp. acquired pressure ulcers	Reportable Medication errors	Friends and family test	Safer Staffing red flags	No. vacancies	% AL used	% sickness	CHPPD	Peer median CHPPD
Ward 21	Surgery	Audit 1	100.00%	94.10%	71.80%	2	10	7	97.00%	0	3.16	13.60%	6.50%	7.9	
		Audit 2	100.00%	98.00%	68.80%	2	10	4	79.20%	0	4.3	11.30%	5.10%	7.2	7.6

Ward 28





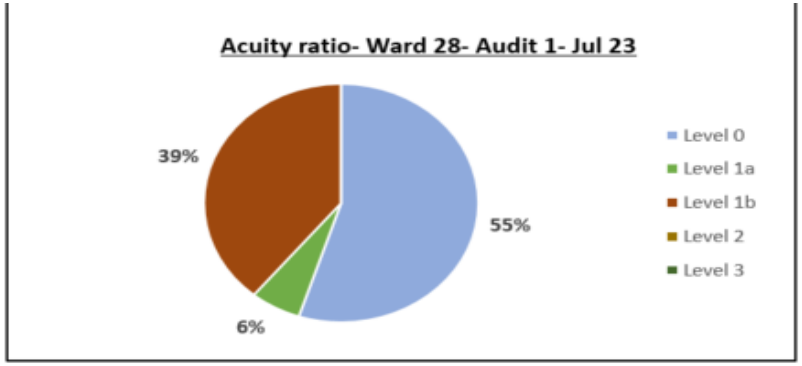
Ward 28 SNCT results 2024

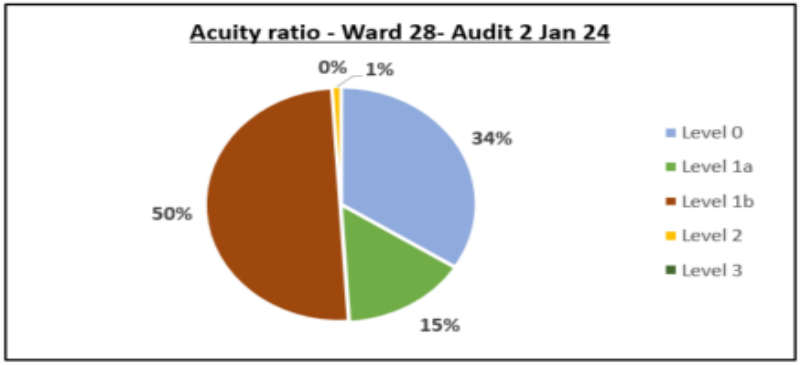
Top Graph on the left:
Demonstrates the comparison between the budgeted staffing, the recommended staffing according to the SNCT in Audit 1 and Audit 2.

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.

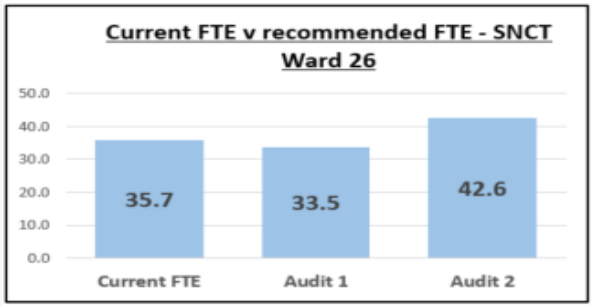
Table below:
Shows the data compliance, variance between the current funded establishment and the recommended establishment alongside the patient outcomes, patient experience and staff outcomes.

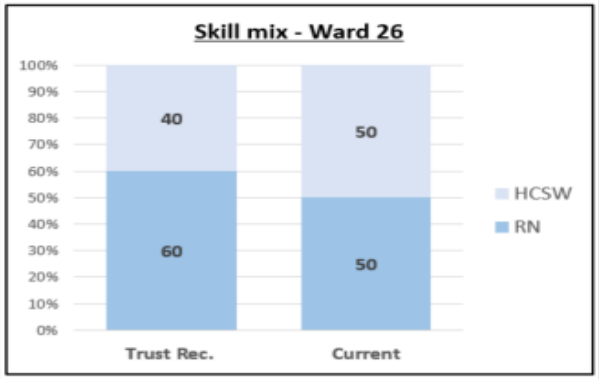




Nursing & Midwifery Care Quality Indicators														
			input staffing	Input - process of care		Outcome - Incidence of harm			Outcome - Patient Experience	Outcome-Staff Experience				
Ward	Division	Audit	data compliance	Hand Hygiene	Observations on time	inpatient falls with harm	Hosp. acquired pressure ulcers	Reportable Medication errors	Friends and family test	Safer Staffing red flags	No. vacancies	% AL used	% sickness	CHPPD	Peer median CHPPD
Ward 28	Surgery	Audit 1	100.00%	100.00%	88.40%	0	1	0	100.00%	0	7.51	15.40%	5.50%	9.6	
		Audit 2	100.00%	100.00%	91.20%	6	0	0	100.00%	0	5.8	1240.00%	5.80%	12.9	8.2

Surgery Service Line 3- Ward 26





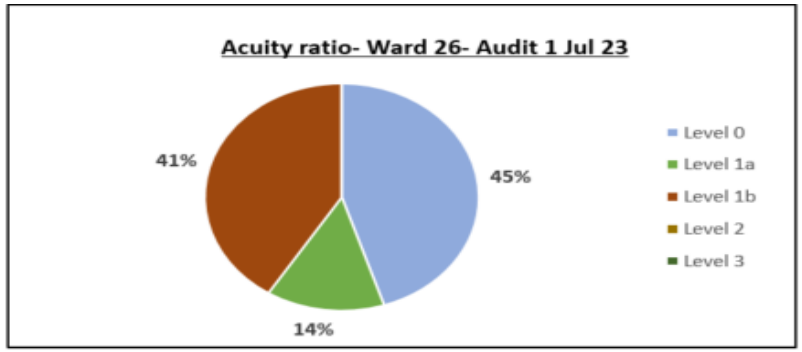
Ward 26 SNCT results 2024

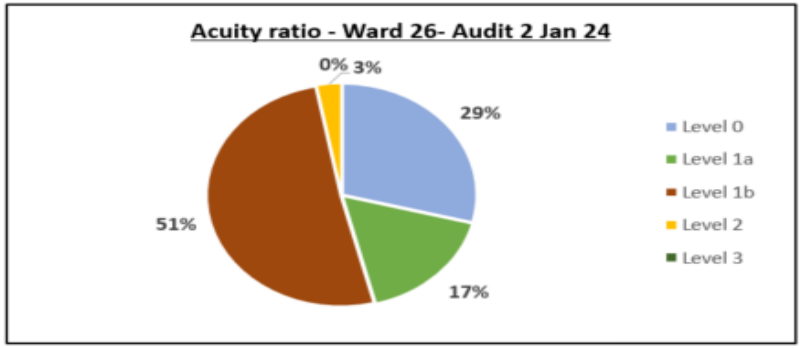
Top Graph on the left:
Demonstrates the comparison between the budgeted staffing, the recommended staffing according to the SNCT in Audit 1 and Audit 2.

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.

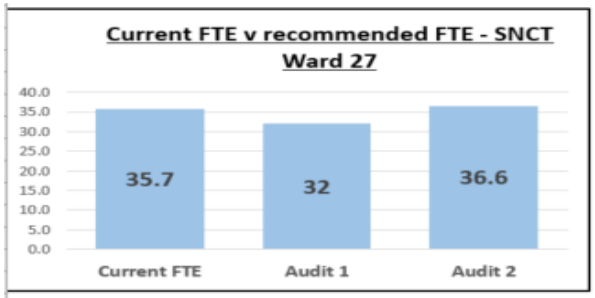


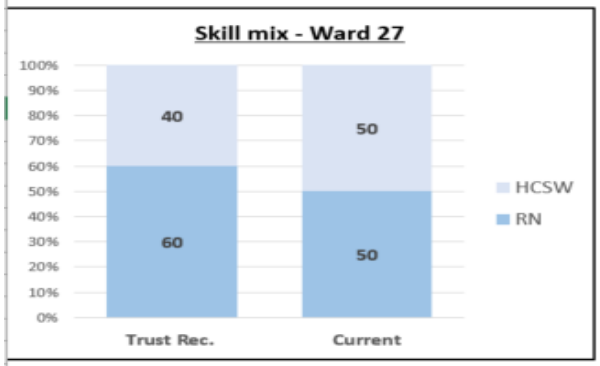


Nursing & Midwifery Care Quality Indicators

			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 26	Surgery	Audit 1	100.00%	96.40%	68.70%	3	8	10	93.90%	0	3.2	14.40%	7.00%	7.7	
		Audit 2	100.00%	100.00%	72.70%	7	8	10	96.00%	1	5.8	13.00%	5.40%	7.5	9.4

Ward 27





Ward 27 SNCT results 2024

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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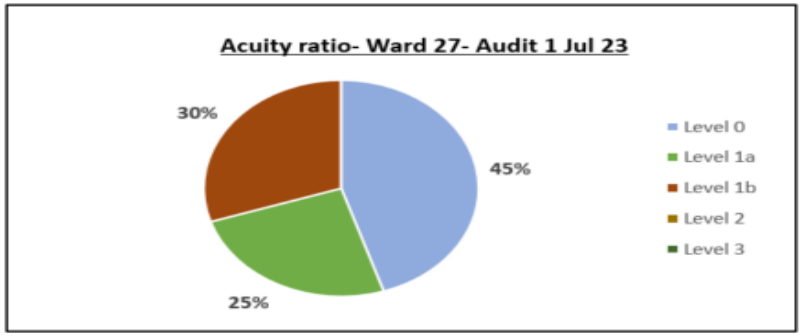

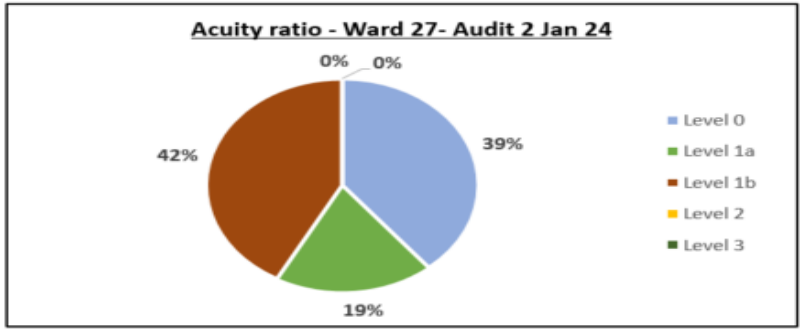

Nursing & Midwifery Care Quality Indicators

			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 27	Surgery	Audit 1	100.00%	83.40%	78.60%	6	0	9	89.10%	0	0.17	13.50%	8.40%	7.4	
		Audit 2	100.00%	70.50%	77.30%	7	6	15	93.70%	0	5.5	12.80%	5.30%	6.6	6.98

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:	5th June 2024			
Author:	Andy Ward – Senior Information Analyst – Quality & Patient Safety Wendy McFadden – Strategic Lead Clinical Effectiveness			
Executive Sponsor:	Neil Halford – Medical Director			
Report presented by:	Neil Halford – 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. • 21 cases were not scrutinised by the Medical Examiner's; 14 released by Lead Medical Examiner Officer (due to Christmas pressure), 5 referred directly to coroner, 2 neonatal deaths. 10 cases were scrutinised but unable to be scored and reviewed to the Mortality Council. • 99.6% of cases reviewed are identified as being definitely not preventable; 97.2% of cases reviewed were identified as good practice; No potentially preventable deaths were identified during the period. • 133 cases still require a Mortality Council review. • 37 cases still require a ward level review.			

<table>
<tr><td>Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper</td><td colspan="5">To receive the paper for assurance</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:</td><td>Aim 1
☒</td><td colspan="4">We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>Aim 2
☐</td><td colspan="4">We will be a great organisation with a highly engaged workforce</td></tr>
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☐</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">List corporate objective reference and headline – e.g., 1.4 Maximise the use of Nervecentre to improve patient care</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">NA</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>

Mortality Report

Executive Summary

The latest SHMI was published on 11th April 2024 covering the period from December 2022 to November 2023. The Trust has a SHMI Banding of ‘As Expected’ with a score of 0.96.

The HSMR for the period February 2023 to January 2024 is 110.6 giving a banding of 'Higher than Expected’.

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

99.6% of cases are identified as being definitely not preventable.
97.2% 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.

Medical Examiner regulations have now been laid before parliament, which will reform death certification in England and Wales. Under these reforms all deaths will legally become subject to either a medical examiner’s scrutiny or a coroner’s investigation. The changes coming into force on 9 September 2024 will put all the medical examiner system’s obligations, duties and responsibilities on a statutory footing, and ensure they are recognised by law.

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.

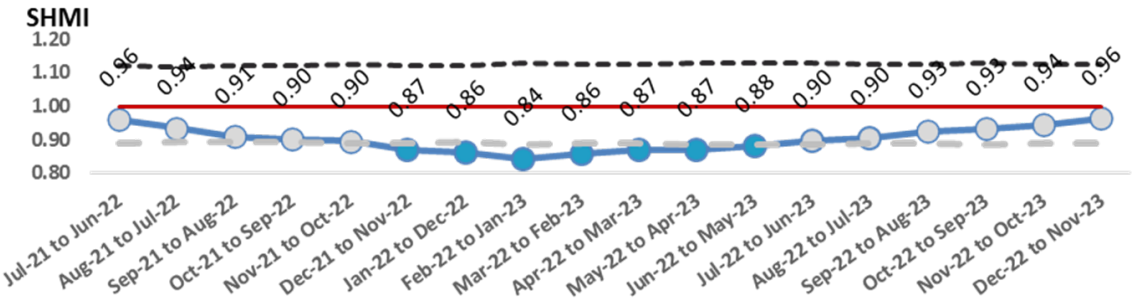
The SHMI compares the actual number of patients who die following hospitalisation (both in- hospital deaths and deaths within 30 days of discharge) at a trust with the number that would be expected to die based on average England figures, given the characteristics of the patients treated there.

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 December 2022 to November 2023

The latest SHMI published for Gateshead Trust on 11th April 2024 covering the period from December 2022 to November 2023. The Trust has a SHMI Banding of ‘As expected’ with a score of 0.96. The Trust remains with a SHMI under the England average of 1.00. However, an increasing trend continues to be observed.



There are some forthcoming changes to the SHMI methodology from the May 2024 publication onwards as detailed below.

- COVID-19 activity will be included if the discharge date is on or after 1 September 2021
- Hospice sites within non-specialist acute trusts will be excluded (St Benedict’s Hospice -South Tyneside and Sunderland)
- In the site level breakdown of the data, a SHMI value will only be calculated for a subset of sites
- The methodology for identifying the primary and secondary diagnoses for spells consisting of multiple episodes will be updated.
- Activity with an invalid primary diagnosis will be moved to a separate diagnosis group.

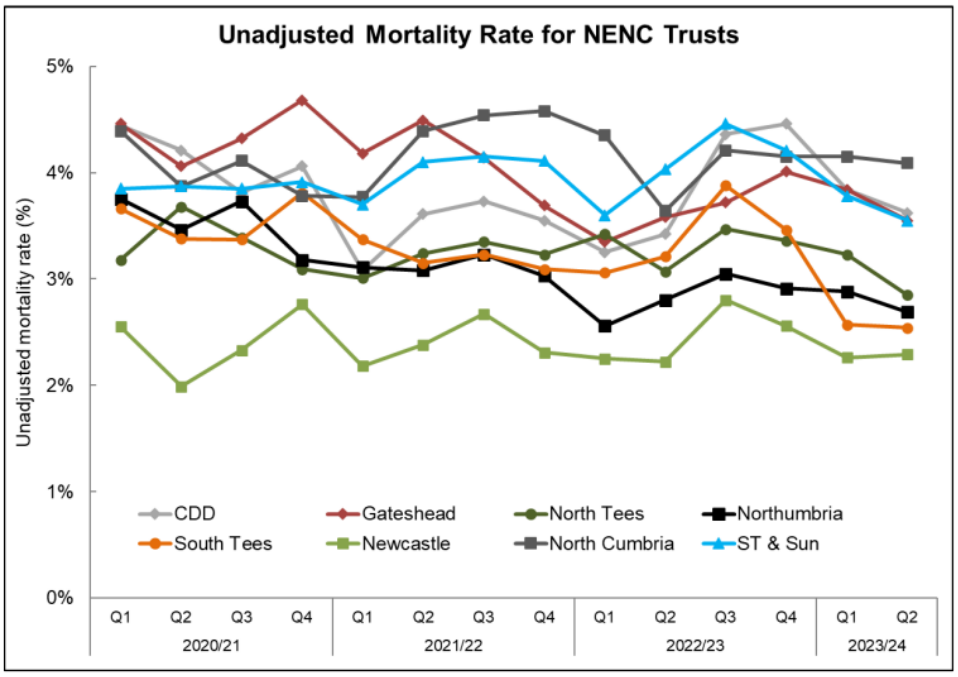
In addition to these changes. From May onwards the Trust will move from recording Same Day Emergency Care (SDEC) activity from its Admitted Patient Care dataset (APC) to the Emergency Care Data Set (ECDS) as Type 5 A&E activity.

A number of trusts are now submitting Same Day Emergency Care (SDEC) data to the Emergency Care Data Set (ECDS) rather than the Admitted Patient Care (APC) dataset.

The SHMI is calculated using APC data. Removal of SDEC activity from the APC data may impact a Trust’s SHMI value and may increase it.

The SHMI trusts in the region typically mirrors unadjusted mortality which varies between trusts from approximately 2% to 5%. For 5 of the NENC trusts SHMIs are ‘as expected’;

County Durham and Darlington, South Tees and South Tyneside & Sunderland are ‘Higher than expected’



3. Trust based data analysis:

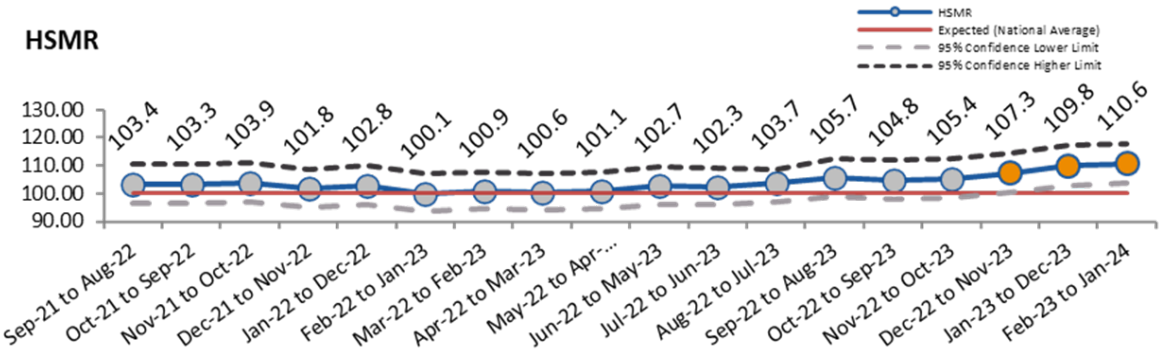
The Hospital Standardised Mortality Ratio (HSMR) is a risk-based assessment using a basket of 56 primary diagnosis groups which account for approximately 80% of hospital mortality.

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 February 2023 to January 2024

The HSMR for the period February 2023 to January 2024 is 110.6 showing giving a banding of 'Higher than Expected’. The HSMR has been higher than expected for the most recent three consecutive periods and a general upward trend is observed.



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
	HSMR	Congestive heart failure, non-hypertensive	Feb-23 to Jan-24	66	39.8	26.2	165.98	**86.2%**	100%	**98.2%**
	SHMI	Cancer of the prostrate, testis, other male genital organs	Jan-23 to Dec-23	14 (11 in hospital)	5.7	8.3	245.95	100%	100%	100%
	HSMR CUSUM*	Septicaemia	Jan-24	21	13.4	7.6	7.09	**65.0%**	100%	100%
	HSMR CUSUM*	Cancer of the colon	Jan-24	10	4.8	5.2	7.62	**80%**	100%	100%
	HSMR CUSUM*	Congestive heart failure	Jan-24	19	9.0	10	10.42	100.%	100%	**88.9%**
	HSMR CUSUM	Cancer of the bronchus; lung	Jan-24	17	12.5	4.5	3.45	100%	100%	100%
	HSMR CUSUM*	Chronic obstructive pulmonary disease and bronchiectasis	Jan-24	14	10.3	3.7	3.47	100%	100%	100%
	HSMR CUSUM*	Cancer of prostate	Dec-23	4	2.1	1.9	3.49	**75%**	100%	100%
	HSMR CUSUM*	Respiratory failure	Nov-23	3	1.3	1.7	3.48	100%	100%	100%
	HSMR CUSUM*	Acute and unspecified renal failure	Nov-23	10	7.2	2.8	3.08	**90%**	100%	100%

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

Congestive Heart Failure

56/65 cases (one patient died at Newcastle) have reviewed. Six cases have been referred to Mortality Council and are awaiting review. A further three cases identified by the Medical Examiner as room for improvement need reviewing by the ward team or Mortality Council.

All cases that have been reviewed were scored as Hogan 1 Definitely not preventable. All but one case scored as good practice. This case scored NCEPOD 3 Room for improvement in organisational care following an incorrect dosing of Midazolam.

For all other clinical classification groups all cases, where scored were scored as definitely not preventable and good practice. However, a number of cases are awaiting further review, and a small number were not scored by the Medical Examiner over the Christmas period and were released by the Lead Medical Examiner Officer.

Septicaemia: Four cases referred to mortality council, two cases require review at either ward level or mortality council. One case scored over the Christmas period. This case was overseen by the Medical Examiner Officer.

Cancer of the Colon: One case not scored by the Medical Examiner over the Christmas period; the other case is an Autism / Severe Mental Illness patient requiring a specific review.

Cancer or Prostate: One case not scored by the Medical Examiner over the Christmas period.

Acute and unspecified renal failure: Once case awaiting review by the ward team.

Proposal to focus on one mortality Indicator.

It was observed in recently the North-East Quality Observatory Service (NEQOS) had taken the decision to omit HSMR figures from the quarterly reports it provides to subscriber Trusts.

On asking for the rational for the removal of HSMR Tony Roberts of NEQOS advised that Boards have limited time to talk about mortality, and if there's a difference between HSMR and SHMI that can use up all the available time as you try to impact the cause of the difference and so at NEQOS we were pleased to move away from HSMR. It became possible when CQC stopped using the HSMR-based mortality-alert system which Dr Foster previously provided to them.'

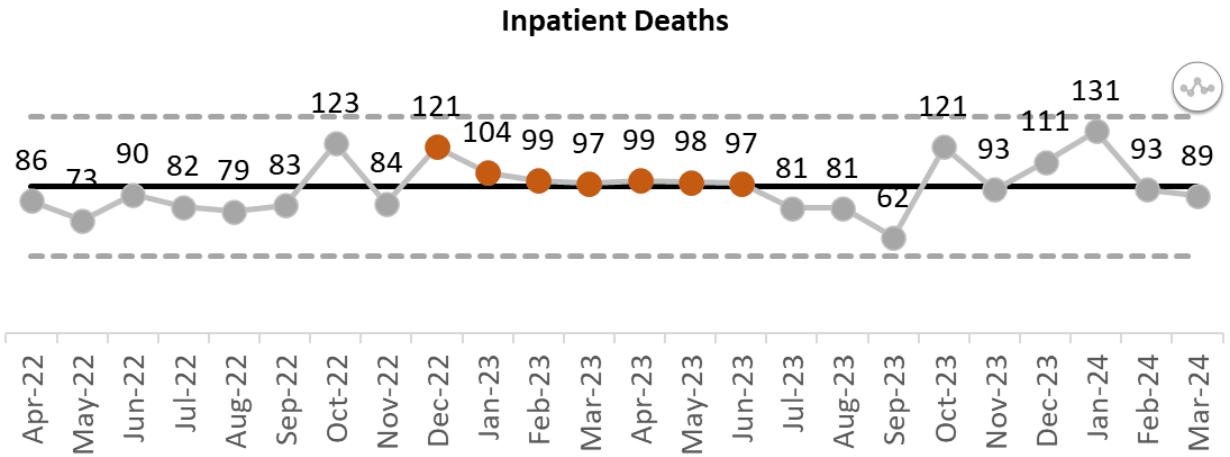
Given the current changes to the NHS England SHMI Indictor and the cessation of use the HSMR by the CQC, it may be timely to reflect on whether the Trust would prefer to continue to monitor both indicators or solely monitor the SHMI indicator.

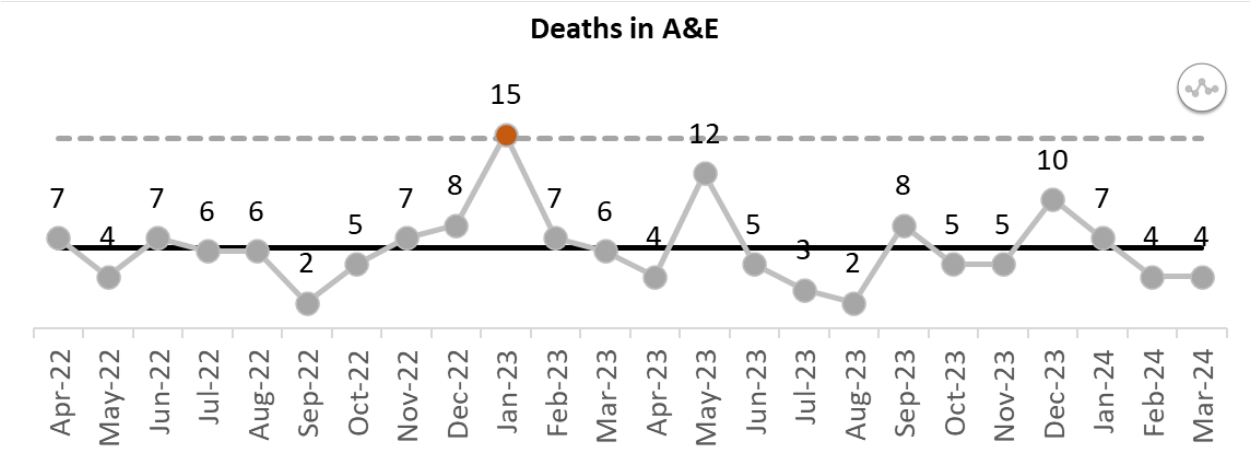
Inpatient mortality and deaths in A&E

The chart below provides the figures for the Trust inpatient deaths and deaths in the A&E department.

Inpatient mortality has been more varied in recent months; figures for February and March are typical for those months. Common cause variation observed for the last 8 months following a period of deaths above the 2-year average.

Deaths in the A&E department fluctuate around the 2-year average.





4. Learning from Deaths and Mortality Review

Mortality Review Reporting March 2023 to February 2024

Mortality Review **Data Extracted** **15/04/2024**
Deaths **01/03/2023** **to** **29/02/2024**

Deaths in period	Deaths reviewed by Medical Examiner and scored	Learning Disability Deaths reviewed at Mortality Council	Severe Mental Illness deaths reviewed at Mortality Council	Number awaiting scoring Mortality Council / further scoring	Cases referred to Ward Team by ME reviewed	Number awaiting Ward Level review following referral by ME	There has been one death of a patient sectioned under the Mental Health Act. This was reported to the CQC appropriately
1237	* 1206	3	2	133	18	37	
Denominators	1237	12	11		55		
	97.5%	25.0%	18.2%		32.7%		

* 14 cases released by the Lead ME Officer.
5 cases referred directly to the coroner.
10 cases unable to score - referred to Mortality Council
2 neonatal deaths not reviewed by the ME as previously not included for ME review.

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 superceds the ME scrutiny.
The figures below represent the outcomes of 1087 cases fully reviewed and scored.

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)	Ward Team Reviews	
99.6%	0.3%	0.1%	0.0%	0.0%	0.0%	0.0%	243	19.6%

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	No Score Allocated
97.2%	0.3%	2.1%	0.2%	0.0%	0.2%	0.0%

Figures based on the following priority order of scoring: Mortality Council > Ward Based Team Review > ME Scrutiny.

97.5% of deaths have been reviewed by the medical examiner in the latest reporting period. Fourteen cases were released by the Lead Medical Examiner Officer, Five cases were referred directly to the corner. Ten cases were unable to be scored and referred to the Mortality Council. Two cases relate to neonatal deaths that occurred prior to these cases being added to the remit of the scrutiny by the Medical Examiner.

25% (3/12) of learning disasblity deaths and 18.2% (2/11) of deaths from patients with severe mental ilnness (SMI) have been reviewed. The Learning Disability service comprises of one member of staff, who has unfortunately been absent from work since December 2023, plans are in place to recruit an additional member of staff to the team. The Learning Disability death reviews are specialised and are not able to be completed by any other staff members.

A total of 1087 cases have been fully reviewed (this includes scoring by the medical examiner medical examiner, ward level reviews and / or Mortality Council reviews where required). The outcomes from those reviews are:

- 99.6% of cases are identified as being definitely not preventable.
- 97.2% of cases reviewed were identified as good practice.
- 2.6% of cases identified room for improvement.
- 0 deaths identified as potentially avoidable (Hogan score >=4)

There are 133 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, Councils have been stood down due to the impact of industrial action. An advert to promote attendance by medical staff at the Mortality Council featured in the staff

newsletter and also the MD bulletin, with an aim to decrease the occasions when the meeting cannot go ahead due to lack of representation. Clinicians are also now invited to the Mortality Council to present their cases if they so wish.

Learning from Mortality Council

For the period October 2023 to March 2024, 66 cases were reviewed by the Mortality Council. The scores of the review are detailed in the table below:

Hogan 1 – Definitely not preventable	58
Hogan 2 – Slight evidence of prevention	6
Hogan 3 – Possibly preventable less than 50:50	1

NCEPOD 1 – Good practice	26
NCEPOD 2 – Room for improvement clinical care	4
NCEPOD 3 – Room to improve organisation of care	32
NCEPOD 4 – Room to improve clinical and organisational	2
NCEPOD 6 – Insufficient information	1

1 case that was reviewed is to return with further information before a final score can be determined.

Good practice

- Learning disability nurse involved in patient's care early in their journey, really good implementation of reasonable adjustments
- Excellent care, evident from very comprehensive documentation
- Family involvement in end of life discussions

Learning

Ward moves & transfers

Ward moves should be recorded on Careflow as timely as possible.
Multiple ward moves contributing to communication issues and deterioration of patients.
Consultant cover on wards 3 and 4 – patient stepped down and did not have a senior review.

Support for relatives

Guidance required when supporting relatives when they are present at a cardiac arrest.

Emergency Health Care Plans (EHCPs)

Family expressed concern around ECHP not being followed. This was not within the patient's notes. Can be issues around the visibility of this document due to multiple sources of information. A pilot of the implementation of Treatment Escalation Plans had been carried out and these are now to be implemented across the organisation. Comms around this will be disseminated. This would assist with the prevention of patient's receiving treatment they do not necessary need or want.

Clinical Pathways

Urgent Trauma

Pathway for urgent trauma and their prioritisation of admission needs to be developed.

Alcohol withdrawal
Clarification is required around the process to follow when patients are at risk of alcohol withdrawal.

Neurological observations
Guideline required for the management of neuro observations.

Deprivation of Liberty (DoLs)
Polite reminder that a separate DoLs application should be completed for each separate admission

Quarterly learning bulletins are shared at the Business Unit SafeCare meetings, in the staff newsletter and available on the learning library.

5. Medical Examiner

Medical Examiner regulations have now been laid before parliament, which will reform death certification in England and Wales. Under these reforms all deaths will legally become subject to either a medical examiner's scrutiny or a coroner's investigation. The changes coming into force on 9 September 2024 will put all the medical examiner system's obligations, duties and responsibilities on a statutory footing, and ensure they are recognised by law.

20 of the 28 GPs in Gateshead are regularly referring deaths into the Medical Examiner's office. Engagement and communication has taken place with all practice and systems and processes set up in readiness for the commencement of the statutory phase.

6. 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.

7. Recommendation

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

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 16

Report Title:	QE Facilities Business Review May 2024			
Name of Meeting:	Trust Board			
Date of Meeting:	5 June 2023			
Author:	QEF Senior Leadership Team			
Sponsor:	Mr G Evans, QE Facilities Managing Director			
Report presented by:	Mr G Evans, QE Facilities Managing Director			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
	To receive the six month update for assurance and 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*				
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: *Outline what the meeting is expected to do with this paper*	The Board is requested to receive the update setting out business growth by March 2025 with a specific focus on Diagnostics, Women's Health and commercial opportunities.			

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** ☒

BUSINESS REVIEW

May 24

CONTENTS

QEF HIGHLIGHTS

- £4.6m Outturn profit delivered to the Group in 2023/24
- Increased Staff Survey Response Rate (59%) with higher than Sector results in 6 areas.
- Business Efficiency Programme Success - £3.8m Savings Against a Target of £2.3m in 2023 – 24.
- Continued Progress of the Community Diagnostic Centre.
- Governance Review

QEF FINANCE

Internal Reporting Metrics	YTD Mar-24 £000s	YTD Budget Mar-24 £000s	Variance Mar-24 £000s Positive/(Negative)
Income	76,339	75,000	1,339
Staff Costs	(22,949)	(23,148)	199
Other expenses	(46,028)	(45,474)	(554)
Corporate Overhead Charge	(2,757)	(1,843)	(914)
Profit/(Loss) After Tax	4,605	4,535	70

Profit of £4.605m achieved against budget of £4.535m during 2023-24.

Non consolidated pay pressure of over £1m was absorbed with savings supporting the delivery of the Group profit target.

Budget target for 2024-25 set at £5.475m to support delivery of Group CRP targets.

Business Efficiency plan of £2.5m underpins the assumptions within the budget.

QEF Budget Summary

	FY24 - Budget	FY25 - Budget - proposed 1st Draft	Movement v Prior Year
Income	75,002	79,959	4,957
Staff Costs	(23,148)	(24,609)	(1,461)
Other Expenses	(45,477)	(48,071)	(2,594)
Corporate Overhead	(1,839)	(1,804)	35
Profit Before Tax	4,538	5,475	937

QEF FINANCE - BUSINESS EFFICIENCIES

Target	Achieved to Date	Forecast
£2.31m	£1.30 m	£2.63 m

QEF People – Engagement

- 2023 survey response rate 59%
- Organisational Engagement score of 6.9%
- Six departments reporting higher engagement scores than sector average.
- Departmental Actions Plans in place with localised actions identified and regularly reviewed.
- Organisational Action Plan with strategic actions created.
- Programme of organisational communications agreed for local and strategic actions in response to staff survey results
- Focus on 2023 staff survey and improved response rate.

QEF PEOPLE – Development Highlights

Successful recruitment process complete providing additional organisational POD resource → Focus on alignment with Group policies and processes → Improved focus and support for ER case work → Review of Appraisal documentation and refresher training → Full adoption of TRAC recruitment system followed by a review of internal and external recruitment process

Identification of internal development and secondment opportunities → Improved POD KPI's for Board, SLT and SMT oversight → Engagement with the Group F2SUG and ongoing recruitment of F2SU Champions → Engagement with Health and Wellbeing to recruit departmental Mental Health Advocates. → Zero tolerance to poor behaviours

Focus on supporting Core Skills compliance → SMT and SLT accessible training and development. → Focus on Apprenticeship recruitment and accessibility for all → Focus on EDI and engagement with the Group EDI Lead to promote Equality, Inclusivity and Diversity in all practice and process. → Focus on succession planning and personal development

QEF ESTATES AND FACILITIES

- Estates Reactive repairs: 18,632 activities complete (23/24)
- Estates Planned Maintenance: 7,862 activities complete (23/24)
  - Replacement of Primary Mains Water Supply.
  - AECOM External Assurance Review.

CSSD invested in state of the art laser engraving technology which will allow instruments reprocessed through the department to be fully traceable

QEF ESTATES AND FACILITIES

- Domestic services have invested in MyAudit and MyDomestic to fully digitise the environmental monitoring and job allocation systems
- 5* Hygiene rating maintained for Catering Services
- 255,500 patient meals served last year with 89% patient satisfaction.
- New Vending range launched
- Exciting new menus, meal deals and theme days
- New sustainability concepts which include locally sourced suppliers

Medical Engineering: Three winners in the Group 2024 apprentice of the year awards

QEF TRANSPORT, PORTERING & SECURITY

- **890** Security patrols
- **86,610** patient moves by the Portering team

Numbers have doubled due to demand especially through the busy winter pressure period

- **2,696** patients transported
- PMVA Training Level 2 = **228** and level 3 = **77**

PMVA department attained Bild certification

First Acute Hospital

Bild Association of Certified Training

QEF PHARMACY SERVICES

- 87,400 medication items dispensed and supplied to patients last year* in Gateshead Health and other regional NHS Trusts.
- Implemented a SACT or Systemic Anti-Cancer Therapy Homecare service to allow patients to receive cancer service treatment at home.
- Partnership with Gateshead Council to support a Stop Smoking service for patients in our community. Responsible for over half of all stop smoking quit attempts in the Gateshead area.
- Partnership with the North-East Ambulance Service to support medicines management for emergency care services.
- Supporting the wholesale medicines supply chain to private Healthcare providers across the North-East and Cumbria.

*2023/2024

QEF BUSINESS DEVELOPMENT

“We will develop and expand our services within and beyond Gateshead”

Bids

- NUTH Inter-Trust Courier Services.
- Medicines Manufacturing Centre Support Services Agreement

Pipeline

- Group Training Academy based out of Spire House, in partnership with Learning and Development.
- Northeast Ambulance Services Estates Planned and Reactive Maintenance, 3rd Party Transport and Warehousing services.
- Northeast Ambulance Services 3rd Party Transport Framework, further expansion of Transport Services.

QEF CHALLENGES

- Changing Regulatory Frameworks
- ICB/NHSE influences
- NHS funding
- HMRC policy changes
- Leadership Team in Transition
- Financial constraints
  - GHNT sustainability
  - SOF 3 status
- Stakeholder relations e.g. Trust, NEAS
- Rising cost base
- Staff expectations
- Resource/skills constraints

QEF OPPORTUNITIES

- Partnerships
  - Regional & National Collaborations
  - Joint Ventures
  - Shared services
- Growing healthcare market
- Enhanced profile/visibility
- Improvements in internal services
    - Improved productivity
    - Use of technology/innovation
    - Reviewed scope of services

Meeting:	Trust Board
Chair:	Alison Marshall
Financial year:	2024/25

	Lead	Type of item	Public/Private	Jul-24	Sep-24	Nov-24	Jan-25	Mar-26
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	Director of Strategy and Planning	Item for Decision	Part 1					√
Board Assurance Framework - approval of opening position	Company Secretary	Item for Decision	Part 1					
Board Assurance Framework - approval of closing 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					√
SID and Deputy Chair Appointment	Company Secretary	Item for Decision	Part 1 & Part 2	√				
Items for Assurance			Part 1 & Part 2					
Board Committee Assurance Reports	Committee Chairs	Item for Assurance	Part 1	√	√	√	√	√
Trust Strategic Objectives - updates	Director of Strategy and Planning	Item for Assurance	Part 1	√		√	√	√
Board Assurance Framework - 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 & Part 2				√	√
Finance Report	Group Director of Finance	Item for Assurance	Part 1	√	√	√	√	√
Leading Indicator Report	Group Director of Finance	Item for Assurance	Part 1	√	√	√	√	√
Maternity Integrated Oversight Report	Chief Nurse	Item for Assurance	Part 1	√	√	√	√	√
Maternity Staffing Report	Chief Nurse	Item for Assurance	Part 1					
Nurse Staffing Exception Report	Chief Nurse	Item for Assurance	Part 1	√	√	√	√	√
Bi-annual Inpatient Safer Nursing Care Staffing Report	Chief Nurse	Item for Assurance	Part 1			√		
Learning from Deaths (6 monthly report)	Medical Director	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		√			√
Green Plan	QEF Managing Director	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					