NHS
Gateshead Health
NHS Foundation Trust

Board of Directors (Part 1 – Public)

A meeting of the Board of Directors (Part 1 – Public) will be held at 09:30am on 31 July 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 5 June 2024	Decision	Chair	Paper
5.	09:40	Action log and matters arising	Assurance / decision	Chair	Paper
6.	09:45	Patient and Staff Story – A&E achievements	Assurance	Emergency Department	Presentation
ITEMS FOR DECISION					
7.	10:00	QE Facilities Articles of Association	Decision	QE Facilities Managing Director	Paper
8.	10:05	Finance and Performance Committee Terms of Reference	Decision	Company Secretary	Paper
9.	10:10	Organisational Structure Consultation Outcome	Decision	Chief Nurse	Paper
ITEMS FOR ASSURANCE					
10.	10:25	Chair's Report	Assurance	Chair	Paper
11.	10:35	Chief Executive's Report	Assurance	Chief Executive	Paper
12.	10:45	Great North Healthcare Alliance Progress Report	Assurance	Interim Director of Strategy, Planning and Partnerships	Paper
13.	10:55	Integrated Care Board Quality Strategy	Assurance	Chief Nurse	Paper
14.	11:05	Response to NHS England letter on maintaining quality in pressurised services	Assurance	Chief Nurse and Medical Director	Paper
15.	11:15	Paediatric Audiology Services – CQC assurance	Assurance	Chief Nurse	Paper
16.	11:25	Governance Reports:			
		i) Board Assurance Framework quarterly update	Assurance	Company Secretary	Paper
		ii) Organisational Risk Register	Assurance	Chief Nurse	Paper
17.	11:35	Assurance from Board Committees:			
		i) Finance and Performance Committee – June and July 2024	Assurance	Chair of the Committee	Paper
		ii) Quality Governance Committee – June 2024	Assurance	Chair of the Committee	Paper
		iii) Digital Committee – July 2024	Assurance	Chair of the Committee	Paper

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No	Start time	Item	Purpose	Lead	Paper / Verbal
		iv) People and Organisational Development Committee – July 2024	Assurance	Chair of the Committee	Paper
		v) Audit Committee – June 2024	Assurance	Chair of the Committee	Paper
18.	11:55	Board Walkabout Feedback	Assurance	Chief Nurse	Paper
19.	12:00	Finance Report	Assurance	Group Director of Finance and Digital	Paper
20.	12:10	Leading Indicators 2024/25 report	Assurance	Group Director of Finance and Digital	Paper
21.	12:20	Maternity Integrated Oversight Report	Assurance	Head of Midwifery	Paper
22.	12:30	Nurse Staffing Exception Report	Assurance	Chief Nurse	Paper
ITEMS FOR INFORMATION / MEETING GOVERNANCE					
23.	12:40	Cycle of Business	Information	Company Secretary	Paper
24.	12:45	Questions from Governors in Attendance	Discussion	Chair	Verbal
25.	12:55	Any Other Business	Discussion	Chair	Verbal
26.	1:00	Date and Time of Next Meeting – 09:30am on Tuesday 24th September 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					

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Board of Directors (Part 1 – Public)

Minutes of a meeting of the Board of Directors (Part 1) held at 9.30am on Wednesday 5th June 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
Mrs Hilary Parker	Non-Executive Director
Mrs Maggie Pavlou	Non-Executive Director
Mr Mike Robson	Vice Chair / Non-Executive Director
Mrs Amanda Venner	Group Director of People & Organisational Development
Attendees present	
Mrs Jennifer Boyle	Company Secretary
Mrs Karen Parker	Head of Midwifery (24/06/13)
Ms Diane Waites	Corporate Services Assistant
Governors and Observers	
Ms Helen Adams	Staff Governor
Mr Steve Connolly	Lead Governor/Public Governor – Central Gateshead
Mrs Karen Tanriverdi	Public Governor – Central Gateshead
Mrs Brenda Webb	Public Governor – Central Gateshead
Apologies	
Mr Andrew Moffat	Non-Executive Director
Mrs Anna Stabler	Non-Executive Director

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24/06/01	**Chair's Business:** The meeting being quorate, Mrs A Marshall, Chair, declared the meeting open at 9.30 am and confirmed that the meeting had been convened in accordance with the Trust's Constitution and Standing Orders. She welcomed those present including the Trust's Governors. Mrs Marshall explained that this is the first meeting since the end of the financial year therefore agenda items will include a look forward to 2024/25. Due to the pre-election rules some papers have been removed and will be deferred until the next meeting.	

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24/06/02	**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.	
24/06/03	**Apologies for Absence:** Apologies were received from Mr A Moffat and Mrs A Stabler.	
24/06/04	**Minutes of the Previous Meeting:** The minutes of the meeting of the Board of Directors held on Wednesday 27th March 2024 were approved as a correct record subject to the following minor amendments: 24/03/20 Leading Indicators (page 17): "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". Should read "*following a query from Mrs A Stabler, Non-Executive Director, Dr G Findley, Deputy Chief Executive and Chief Nurse, reported that whilst we will continue to monitor the absolute number of C.Difficile cases and report as required, it is not planned to include this as a leading indicator going forward. Our preferred measure is the rates of infection expressed by bed days as this is more meaningful clinically".*	
24/06/05	**Matters Arising from the Minutes:** The Board reviewed the action tracker as below: • Action 24/03/07 re. Corporate Governance Manual and ensuring that a review is included on the Internal Audit Plan 2024/25. Internal Audit have an audit in plan to review compliance with the Standing Financial Instructions (SFIs) therefore this action was agreed for closure. • Action 24/03/07 re. to undertake a review of the Articles of Association in line with the approved QE Facilities SFIs. A review has taken place and will be presented at the next QE Facilities Board prior to ratification at the next Trust Board meeting. Action deadline to be amended accordingly. • Action 24/03/09 re. strategic objectives and leading indicators 2024/25 to be discussed and Board comments to be incorporated and presented back at the Extraordinary Board meeting on 24	

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	April 2024. This has been completed and the new leading indicator report is on today's agenda. Action therefore agreed for closure. • Action 24/03/21 re. Freedom to Speak Up (FTSU) Guardian Report and consideration around including information relating to referrals received from FTSU champions as well as linking with other key indicators ie. sickness absence. It was confirmed that this be included in reports going forward therefore action agreed for closure. • Action 24/03/24 re. updating the cycle of business to reflect the items discussed as part of the meeting: Green Plan, maternity staffing report, Deputy Chair and SID appointments. It was confirmed that the cycle of business has been updated accordingly therefore action agreed for closure. The Board reviewed the actions closed at the last meeting which ensures actions have been closed in line with expectations and the agreements made at the previous Board meeting. No further requirements were highlighted.	
24/06/06	**Patient Story – A Legacy of Care: Celebrating 80 years of the Trust's Maternity Unit:** The Board viewed the video which features Brenda, Rachel and Charlie (three generations born in the Trust's Maternity Unit). The family members recount their memories of the maternity unit, praising the staff for their professionalism, compassion, and care. They also talk about how the unit has evolved over the years, with the latest technologies and advancements in healthcare making the experience even better. It highlights the NHS healthcare's impact on generations of families and also serves as a reminder of the remarkable work done by our healthcare professionals in the Maternity Unit at the Gateshead Health NHS Foundation Trust. The Board thanked those involved and the staff for their work and dedication.	
24/06/07	**Board Assurance Framework 2024/25 – approval of opening position:** Mrs J Boyle, Company Secretary, presented the opening position of the Board Assurance Framework (BAF) for 2024/25. She explained that the new strategic objectives were approved by the Board at the last meeting in March 2024 and the BAF has been developed based on the strategic objectives and the summary risks identified in relation to their achievement. The risks have been reviewed	

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	by the Executive Team and a short Board development session will be held following today's meeting to debate and discuss the scoring for the summary risks. Following this the scores will be populated ready for the BAF being reviewed at committees during June 2024. After consideration, it was: **RESOLVED:** i) to approve the opening position of the BAF, particularly in relation to agreeing the summary risks behind each objective ii) 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.	
24/06/08	**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. Mrs Marshall congratulated Mr Steve Connolly on his appointment as Lead Governor and Mr Michael Loome as Deputy Lead Governor. Both posts were ratified by the Council of Governors for a period of one year effective from 19th May 2024. On behalf of the Council and Board, Mrs Marshall wished to formally record our sincere thanks to Mr Abe Rabin for his contribution and commitment to the Lead Governor role over the last two years, and the Deputy role prior to this. The latest Membership newsletter was published in May 2024 and highlights planning for the next Medicine for Members event in July 2024, however Mrs Marshall explained that due to the pre-election period this will need to be rescheduled therefore a new date will be circulated soon. Work is being undertaken to promote the benefits of Trust membership to our local communities and patients and in collaboration with the Membership Strategy Group, some new material has been developed to support us to raise the profile of membership. Mrs Marshall highlighted that a number of stakeholder engagement events have taken place including some internal visits to the IVF unit and mortuary as well as meetings with Chairs across the Integrated Care System and the new Chief Executive for Gateshead Council, Dale Owens. In relation to partnership working, Mrs Marshall reported that Mrs Anna Stabler, has been temporarily co-opted onto Newcastle Hospitals NHS Foundation Trust Board of Directors as a Non-Executive Director to support our Alliance partners and will chair the Quality Committee until Newcastle can make new, permanent appointments in the next few	

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	months. Mrs Stabler will continue in her current role as Non-Executive Director 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 was due to be included in a paper on today's agenda however due to the pre-election period it has been removed. Mrs Marshall drew attention to the Star of the Month nominations and highlighted that the winner for March is yet to be announced however congratulated Chris Angus from Paediatrics on winning Star of the Month for April. Following discussion, it was: **RESOLVED:** to receive the report for assurance.	
24/06/09	**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 2: *we will be a great organisation with a highly engaged workforce* – Mrs Davies congratulated Kerry Waterfield and Ruth Sharrock on the opportunity to attend a Royal Garden Party. They have both made significant contributions to the health community. Mrs Davies highlighted that our subsidiary company, QE Facilities Ltd, celebrated its 10th anniversary on 30th April 2024 and emphasised that this is a significant milestone and speaks volumes about the dedication, expertise and support provided by QE Facilities. The report also includes a copy of the latest edition of the Research and Development newsletter and highlights the opportunities to engage across the Alliance. The Research teams from each of the Trusts were invited to have a joint stall at the recent Urgent and Emergency Care event and provided the opportunity to showcase research development. Following a query from Mr A Crampsie, Non-Executive Director, in relation to the Board strategy around research, Dr G Findley, Chief Nurse and Deputy Chief Executive, reported that the Research and Development Strategy and Annual Report are presented to the Quality Governance Committee and Mr N Halford, Interim Medical Director, indicated that developments will be taken forward via the Alliance work and all Trusts are keen to be involved. After further discussion, it was: **RESOLVED:** to receive the report for assurance.	

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24/06/10	**Governance Reports:** **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 19th March 2024 to 22nd May 2024. Dr Findley reported that there are currently 16 risks on the ORR. Following the Executive Risk Management Group meeting in April and May 2024, there have been 2 additions to the ORR, 2 escalations, no reductions and 2 removals. The top three organisational risks have been updated to include finance, implementing the new governance structure and medical staffing and reflects the new risks added to the ORR. The risks that have escalated relate to estates, business continuity and MRI provision however the MRI work is currently on track and it is expected that the risk will be reduced in the near future. Dr Findley highlighted that good governance processes have been demonstrated throughout the period, with reviews of the ORR at the Executive Risk Management Group, as well as relevant committees. Risk review compliance is currently at 81% and support with reviews continue to be offered by the Corporate and Clinical Risk Lead. Dr Findley reported that the Inphase risk management systems has now been fully implemented and all risk data will be extracted from the system going forward. After consideration, it was: **RESOLVED:** to receive the report for assurance.	
24/06/11	**Assurance from Board Committees:** The Board reviewed the Committee escalation and assurance reports which provide improved processes to identify areas of concern and ongoing monitoring of assurances. **Finance and Performance Committee:** Mr M Robson, Committee Chair, provided a brief verbal overview to accompany the narrative reports following the March, April and May 2024 meetings. He drew attention to the most recent meeting which took place on 28th May 2024. Mr Robson reported that there were two issues identified as requiring escalation to the Board for further action which relates to the financial position and the immediate actions that are being put in place. The important role for the Non-Executive Directors on all Committees to	

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	provide challenge in linking finance and sustainability to the work of those Committees was highlighted and was acknowledged by the Board. Mr Robson also drew attention to the agreement of a small amendment to the savings figure in relation to the waiver of the Trust's Standing Orders for a contract award for the provision of a PACS (Picture Arching Communication System) / RIS (Radiology Information System) / VNA (Vendor Neutral Archive) service and this will be ratified by the Board in Part 2 of the meeting. Positive assurances were agreed in relation to the strong performance against the leading indicators and recognition was given to the role of Surgery and the work undertaken on outpatients pathways which has fed into the improved position. **Quality Governance Committee:** Mr A Crampsie, Non-Executive Director, on behalf of the Committee Chair, provided a brief verbal overview to accompany the narrative report following the April meeting. He reported that there were no issues identified as requiring escalation to the Board for further action however drew attention to some areas subject to ongoing monitoring which includes some vulnerabilities within the Patient Safety Team due to staff sickness however cover arrangements have been put in place. **Digital Committee:** Mr M Hedley, Non-Executive Director, on behalf of the Committee Chair, provided a brief verbal overview to accompany the narrative report following the May 2024 meeting. Mr Hedley reported that there were two issues identified as requiring escalation to the Board for further action which relates to concerns raised around the area of Information Asset Owners (IAOs) and actions have been implemented to ensure compliance to improve performance towards the target. Mrs K Mackenzie, Group Director of Finance and Digital, reported that the Information Governance Team are now fully recruited and a new group is being established with senior level responsibility to review education and support around IAOs. The other area of concern related to Freedom of Information (FoI) and Subject Access Requests (SARs) response rates and the Committee agreed to add this as a risk to the ORR. Mrs Mackenzie reported that this has been discussed by the Executive Team and processes have been updated to include Executives in all requests and a collection of frequently asked questions is being developed with the Information Governance Team to try to reduce the burden on staff. Mr Hedley also highlighted that the Committee is partially assured around the work being undertaken in relation to the Electronic Patient	

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	Record and it was felt that further support was required. Mrs Mackenzie explained that this is being addressed via the Trust's strategic objectives and it is expected that a delivery plan will be in place by September 2024. The Trust is also working closely with the Alliance is respect of digital strategy. **People and Organisational Development Committee:** Mr A Crampsie, Non-Executive Director, on behalf of the Committee Chair, provided a brief verbal overview to accompany the narrative report following the May 2024 meeting. Mr Crampsie highlighted that there was one issues identified as requiring escalation to the Board for further action which relates to backlog of obtaining evidence of historic pre-employment checks as this is significantly behind plan. Mrs A Venner, Group Director of People and Organisational Development, reported that there is now 71 staff still to provide all identification documentation and further drop-in clinics have been arranged. The final deadline for completion is the end of this week and Mrs Venner explained that there will be the potential need for disciplinary hearings to take place should any remain. The Committee noted the reduction in the engagement score following the Pulse survey however further wok is being done on the overall engagement with Pulse surveys to give a more statistically significant sample size and meaningful data. Good assurance was received on the improving sickness absence position. Mrs Marshall thanked the Committee Chairs for their reports. After consideration, it was: **RESOLVED**: to receive the reports for assurance	
24/06/12	**Leading Indicators:** **Leading Indicators 2023/24 Closure Report:** Mrs K Mackenzie, Group Director of Finance and Digital, presented the report which highlights progress, risks and assurance in relation to the Trust's Leading Indicators and Elective Recovery Programme for the year ending 31 March 2024. She drew attention to the year end leading indicator summary and highlighted that unplanned care performance metrics have improved particularly around 12 hour trolley rates and ambulance handovers. There are also improvements around planned care metrics with elective day cases and diagnostics over and above plan and all cancer targets have been achieved. Mrs Mackenzie explained that this provides the Trust with a good foundation over the next few months.	

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	Following a query from Mr A Crampsie, Non-Executive Director, in relation to the affordability and sustainability of the position, Mrs Mackenzie reported that discussions are taking place around financial plans however there is increased challenges in relation to maintaining run rates and the delivery of cost reduction plans. Mr M Hedley, Non-Executive Director, acknowledged the exceptional progress being made and thanked staff for their hard work however reiterated concerns around maintaining quality and improving sustainability at the same time. Mrs T Davies, Group Chief Executive, explained that discussions continue to take place with Executives and improvements have been applied around the organisation however further engagement is required around grip and control and ongoing support will be provided. Mrs H Parker, Non-Executive Director, acknowledged that work was being addressed around sickness targets however this was still showing as red on the report. Mrs A Venner, Group Director of People and Organisational Development highlighted that discussions continued to take place across the organisation and a wraparound approach was being undertaken to support staff around training and maintaining policies and procedures. Mr M Robson, Vice Chair, felt that a consistent approach was required around communication and it is also important to celebrate the Trust's successes. After discussion, it was: **RESOLVED:** to receive the report for the year ending March 2024 and note the improvements and ongoing challenges in key areas. **Leading Indicators 2024/25 report:** Mrs J Halliwell, Group Chief Operating Officer, presented the performance reporting metrics for 2024/25 and highlighted that the proposed performance metrics have been developed from the original set used in 2023/24. There are now 15 strategic objectives which provide a more comprehensive oversight of quality, performance, workforce and finance with separate reference to the Green Plan and some complimentary objectives for QE Facilities. Further work is required in relation to the quality metrics and will be determined from the 12 patient safety indicators and 6 Patient Safety Incident Response Framework strategic themes with a focus on mental health, cancer and learning disabilities. The Board discussed internal stretch targets and Mrs Halliwell explained that a stretch target had not been included in relation to sickness absence however Mrs Venner highlighted that discussions are taking	POD Committee

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	place with the People and Organisational Development leads and will be addressed via the People and Organisational Development Committee. Following consideration, it was: **RESOLVED:** to approve the strategic aims and leading indicators for 2024/25 which will be supported by the breakthrough objectives.	
24/06/13	**Maternity Update:** **Maternity Integrated Oversight Report:** Mrs K Parker, Head of Midwifery, presented a summary of the maternity indicators for the Trust for April 2024. She drew attention to the key performance indicators within the Maternity Dashboard and highlighted that the Trust was a positive outlier for smoking at time of booking and the number of births is 11.5% higher than in April 2023. There has been one incident reported to the Maternity and Newborn Safety Investigations (MNSI) team and a rapid review was undertaken with debriefs arranged with multiple specialities across the Trust. Learning and improvements have been made including additional equipment and processes being implemented and provided via a dedicated maternity and neonatal cupboard in the Emergency Department. Discussion took place around the increase of births and sustainability within the unit and Mrs Parker explained that this was a national trend however Mr M Robson, Vice Chair, felt that further information would help to support a strategic view for the future needs of the service and current facilities. Mrs T Davies, Group Chief Executive, felt that it was also important to consider compliance across the Alliance and a discussion will take place at the Executive Management Team meeting to support the team in developing a plan around this. Mr G Evans, Managing Director of QE Facilities, highlighted that this could be discussed at the regional group and would support the development of the estates strategy. It was agreed that a further Board discussion would be held once the proposed strategic intent had been developed in draft. Following a query from Mr M Hedley, Non-Executive Director, in relation to post-partum depression research, Mrs Parker explained that the Trust has a regional mental health link with Tees Esk and Wear Valley NHS Foundation Trust and Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust and a perinatal mental health nurse works closely with the midwifery and medical team. Following discussion, it was: **RESOLVED:** to receive the report for assurance.	Executive Directors /JB

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	Maternity and Midwifery Staffing Report: Mrs Parker presented the findings from the review of staffing in maternity to remain compliant with recommended safe staffing levels in the 2024 Birthrate plus midwifery workforce assessment. Mrs Parker explained that this is three year delivery plan and all Trusts have been asked to review the provision of Maternity Continuity of Care (MCOC). The service commissioned Birthrate plus to perform a midwifery workforce assessment in 2023 and the final report was received by the service in April 2024 which includes recommendations for three different models of community care. Mrs Parker explained that 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. The team 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 birthrate plus safe staffing recommendations. Dr G Findley, Chief Nurse and Deputy Chief Executive, explained that there is further realignment work to do in terms of posts and funding streams prior to the development of the business case however will keep the Board updated on developments. Mr A Crampsie, Non-Executive Director, felt that the recommendations required strengthening and the Board accepted the findings of the report however acknowledged that further work was required to determine how the workforce recommendations could be addressed. After consideration, it was: **RESOLVED:** to accept the recommendations of the 2024 midwifery workforce for safe staffing in the maternity service, noting that the business unit will undertake further work to address the shortfalls after full review of the current funding arrangements. Mrs Parker left the meeting.	GF
24/06/14	**Nurse Staffing:** **Nurse Staffing Exception Report:** Dr G Findley, Chief Nurse and Deputy Chief Executive, presented the report for April 2024 which provides information relating to ward staffing levels (funded against actual) and details of the actions taken to address any shortfalls. Dr Findley highlighted that there are reported shortfalls within the Special Care Baby Unit and Paediatrics due the specialist nature of these	

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	departments however explained that any red flags are escalated and mitigations are put in place by the matron teams using professional judgement and include redeployment of registered nurses and healthcare assistants on a daily and at times hourly basis between wards according to patient acuity and demand. Following a query in relation to establishment and fill rates, Dr Findley explained that the Trust is over-established on medical wards however consideration also needs to be given around student nurses due to be qualifying and some healthcare assistants are also awaiting registration. Dr Findley explained that teams are currently working on understanding the detail around this and ensuring that gaps are filled however consideration is also required around staff being moved to areas that are not their normal working environments and whether this affects sickness rates. Mr A Crampsie, Non-Executive Director, felt that it would be beneficial to have some trend data and Dr Findley explained that a SafeCare live dashboard is available for ward managers and data also includes bank and agency staff. Mrs T Davies, Group Chief Executive, explained that it was important to better understand establishments to ensure that the use of bank and agency staff is reduced across the organisation and this will continue to be reviewed via the People and Organisational Development Committee. Following discussion, it was: **RESOLVED:** to receive the report for information and assurance. **Bi-annual Inpatient Safer Nursing Care Staffing Report:** Dr Findley presented the report which provides an overview of the Safe Staffing Nursing review undertaken by the Trust in January 2024. Dr Findley explained that the bi-annual review of safe staffing using Safer Nursing Care Tool (SNCT) has been undertaken in line with national recommendations however highlighted that there is a revised adult in-patient SNCT that the Trust will need to use in future reviews therefore the exercise will need to be repeated. She explained that the new tool recommends a change to standard headroom of 22% from 21% which will produce different figures therefore it was felt that further discussion will be required by the Executive team to agree outputs. Discussion took place around the implications of this and Dr Findley explained that a risk based decision would need to be made therefore further discussion may be required at the People and Organisational Development Committee. Mrs J Halliwell, Group Chief Operating Officer, commented that benchmarking comparisons may become difficult due to the recalculation and queried whether discussions had taken place nationally. Dr Findley explained that this had been raised at the Chief Nurse forum and peer	GF

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	review work has been suggested to ensure that the tool is applied in the same way across the network. Dr Findley also highlighted that further work was required around the calculations relating to the emergency department therefore the exercise will be repeated and presented to the Quality Governance Committee. Following discussion, it was: **RESOLVED:** to receive the report for information and assurance recognising that a further review will take place using the new SCNT tool and change to the standard headroom of 22%.	GF
24/06/15	**Learning from Deaths Six Monthly Report:** Mr N Halford, Interim Medical Director, presented the report which provides an update on Mortality and Learning from Deaths over the last six months. Mr Halford reported that the Trust's latest publications of national mortality indicators places the Trust with bandings of 'As expected' and 'Higher than expected' for the Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) respectively. He highlighted that all deaths continue to be initially scrutinised by the Trust's Medical Examiner office and are scored or referred for further review where appropriate. No potentially preventable deaths were identified during the period. Mr Halford highlighted that there are some forthcoming changes to the SHMI methodology from May 2024 which includes 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. He explained that the SHMI is calculated using APC data therefore the removal of SDEC activity from the APC data may impact the Trust's SHMI value and may increase it. Following a query from Mrs Marshall in relation to the proposal to focus on one mortality indicator, Dr G Findley, Chief Nurse and Deputy Chief Executive, reported that the North-East Quality Observatory Service (NEQOS) had taken the decision to omit HSMR figures from the quarterly reports it provides to subscriber Trusts as it does not cover deaths within 30 days of leaving hospital however this will be a national decision. Mr A Crampsie, Non-Executive Director, raised a query in relation to unadjusted mortality rates across the region and why some trusts have a lower rate. Mr Halford explained that this was in relation to case mix rather than a population specific issue. Dr Findley highlighted that NEQOS provides a mortality report which is presented to the Quality	

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	Governance Committee and they have indicated that they would be happy to provide further assurances if requested. Following concerns raised in relation to learning disability deaths, Dr Findley reported that there is a national programme to review all learning disability deaths and the regional team are assisting with this. Plans are also in place for a temporary post to assist the Learning and Disability Nurse. After consideration, it was: **RESOLVED:** to receive the report for information and assurance.	
24/06/16	**QE Facilities Six Monthly Update Report:** Mr G Evans, Managing Director for QE Facilities, presented the report which provides an update on work and overall activity over the last six months. Mr Evans drew attention to some of the key highlights including the outturn profit delivered to the Group during 2023/24 and highlighted the strong performance including additional income and efficiency success. Work is being undertaken to further develop business plans and Mr Evans highlighted that Model Hospital data places estates and facilities in the top 25% for services being delivered. The Group have commissioned an external assurance review with AECOM and a draft outcome report is awaited. Mr Evans also highlighted some of the potential opportunities and submission of bids, and he explained that work continues to take place with the Alliance and review of shared services. Mr A Crampsie, Non-Executive Director, thanked Mr Evans for the update however felt that it would be beneficial to review the report content to ensure the key information was being shared. Mr M Robson, Vice Chair, explained that the Finance and Performance Committee receive detailed financial reporting and are comfortable with the level of assurance provided. Mrs M Pavlou, Chair of the QE Facilities Board, explained that the reports were presented in this format to ensure that the Board and Governors received details around services however this can be reviewed. Mr Evans reported that the Group are currently working on the strategic aims and objectives for QE Facilities and will be agreed by the QE Facilities Board therefore this would ensure that clear information flows are in place as well as reviewing the format of the Board report. After consideration, it was:	GE

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	RESOLVED: to receive the report for information and assurance	
24/06/17	**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. After consideration, it was: **RESOLVED:** to review and approve the cycle of business for the forthcoming financial year 2024/25.	
24/06/18	**Questions from Governors in Attendance:** Mrs K Tanriverdi raised a query in relation to the need for additional midwifery staff to move maternity services forward in the long term however Mrs T Davies, Group Chief Executive, explained that there are no current midwifery resourcing issues. She clarified that there is no present funding or plan available to expand maternity services. Mrs K Tanriverdi raised a further query in relation to staff absence and whether there were any mitigations in place to ensure staff were provided with health and well-being support. Mrs Davies reported that there are a number of resources available which is supported by management processes. Mrs A Venner, Group Director of People and Organisational Development, reported that further discussions are taking place however some staff absences are not work related.	
24/06/19	**Any Other Business:** There was no other business to discuss.	
24/06/20	**Date and Time of Next Meeting:** The next meeting of the Board of Directors will be held at 9.30am on Wednesday 31st July 2024.	
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	QEF SFIs and Scheme of Delegation	To undertaken a review of the Articles of Association in line with the approved SFIs	~~05/06/2024~~ 31/07/2024	GE	A review has taken place and will be presented at the QEF Board prior to ratification at Trust Board **July 24** – item on the agenda and also approved by QEF Board – **action recommended for closure**	
24/06/12	05/06/2024	Leading Indicators 2024/25	To discuss stretch target in relation to sickness absence with POD leads and to address via POD Committee	31/07/2024	AV	Detailed presentation on managing absence taken to POD Committee on 09.07.24. Work underway noted and further actions agreed. An update is due back to Committee in September 2024. **Action recommended for closure.**	
24/06/13	05/06/2024	Maternity IOR	To develop an outline strategic intent for maternity and bring this back to Board for a full discussion.	31/07/2024	EMT / JB	June 24 – seeking to schedule a Board development discussion in August on this. **July 24** – a session has been diarised for August. Action recommended for closure.	
24/06/13	05/06/2024	Maternity and Midwifery Staffing Report	Further realignment work of posts and funding to take place prior to development of business case. To keep Board informed on developments	31/07/2024	GF	Meeting scheduled for 30/07/2024. Information from the meeting will be shared in the maternity IOR that comes to each board meeting.	
24/06/14	05/06/2024	Bi-annual inpatient safer nursing care staffing report	Discussion to take place to agree outputs and further work around the calculations relating to emergency department therefore exercise will	31/07/2024	GF	Review of ED staffing has been completed and discussed with the business unit. There is further work to understand the longer term needs within ED (as per the	

Agenda Item Number	Date of Meeting	Agenda Item Name	Action	Deadline	Lead	Progress	RAG-rating
			be repeated and reported back via the Quality Governance Committee and its assurance report to Board			paper “operating in times of pressure” to be discussed on the July Board agenda	
24/06/16	05/06/2024	QEF 6 monthly report	To review information flows and format of the report to Trust Board	31/07/2024	GE	**July 24** – reviewing format in line with comments made. Next report due at Board in November 2024 therefore **action recommended for closure.**	

Closed Actions from last meeting

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 agreed as closed on this basis.**	
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 agreed as closed on this basis.**	
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 agreed as closed on this basis.**	
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 agreed as closed on this basis.**	

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Improving Ambulance Handover Times

Urgent & Emergency Care, Queen Elizabeth Hospital

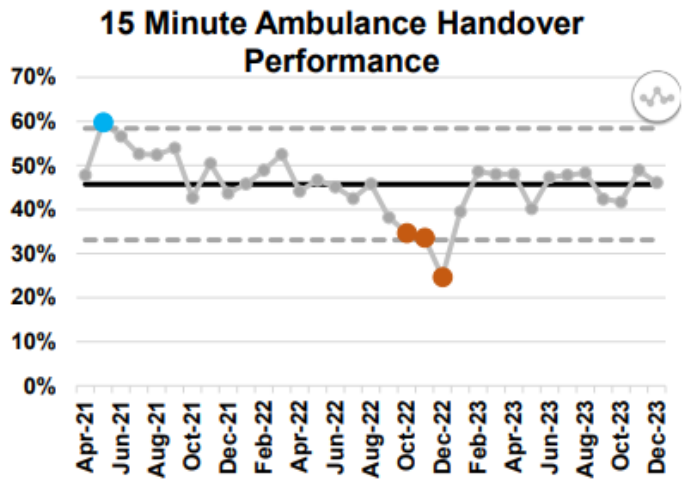
Trust Board, Wednesday 31st July 2024

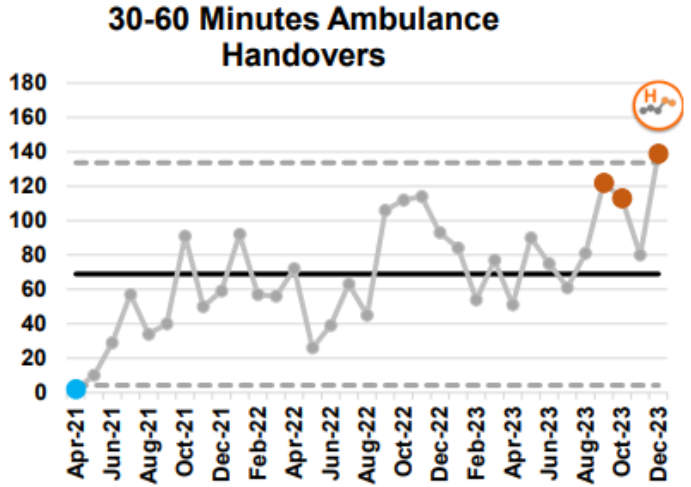
Gateshead Health NHS Foundation Trust

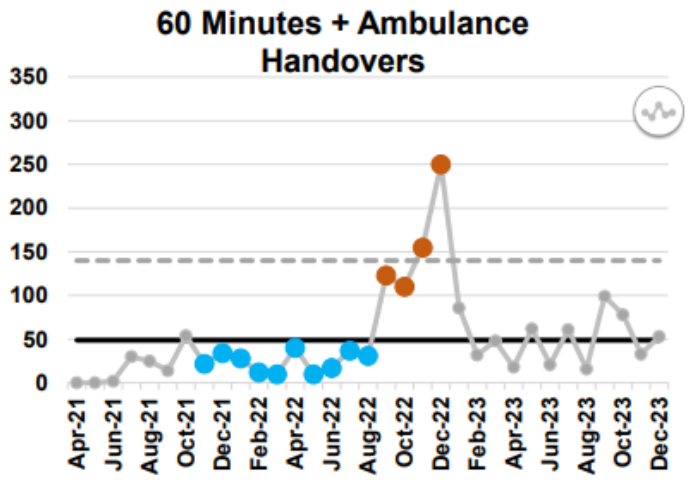
The position in December 2023

- Increasing number of 30-60 minute delays
- National & regional ask to improve performance to manage risk and patient safety concerns

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
% of Handovers <15 Mins	48.0%	40.2%	47.3%	47.8%	48.3%	42.4%	41.7%	48.9%	46.1%
30-minute Ambulance Breaches	51	90	75	61	81	122	113	80	139
60-minute Ambulance Breaches	18	62	21	61	16	99	78	33	53







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Using data to identify opportunities

- When ambulances arrive and when we have most delays (data from 01/04/23-10/11/23)

- Arrivals by ambulance

Day of Week	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	Grand Total
Monday	1			2			3	1			4	9	7	22	26	17	20	23	18	23	20	22	15	4	237
Tuesday	6	2	2	5	4	6	1			4	6	10	11	26	18	17	19	26	23	12	18	30	13	8	267
Wednesday	4	4	2	1	5	2	1			2	3	10	5	15	11	9	9	7	5	10	16	23	11	4	159
Thursday	1	2									1		5	3	5	1	1	6	7	8	13	10	10	5	78
Friday	2	6	10	2	2	1					2	2	8	7	8	10	14	13	9	9	11	14	14	5	149
Saturday	2	1			1						4	3	3	12	13	10	11	12	5	11	11	5	6	5	115
Sunday	1	1	6	1	1	3	1				3		3	13	21	6	7	8	9	3	4	6	4	2	103
Total	17	16	20	11	13	12	6	1	0	6	23	34	42	98	102	70	81	95	76	76	93	110	73	33	1,108

- Handover Delay 30-60 Minutes

Day of Week	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	Grand Total
Monday	1			2			3	1				4	2	12	14	12	10	9	12	11	9	12	6	4	124
Tuesday	3	1		5	2	3	1			1	3	7	11	18	13	10	8	15	12	5	4	15	9	5	151
Wednesday	1	1			4	2	1			2	3	10	2	8	8	2	3	3	4	8	9	6	4	3	84
Thursday		2									1		5	2	4	1	1	5	7	3	7	4	8	1	51
Friday	2	6	7	2	2	1					2	2	8	5	2	4	8	12	4	5	6	9	14	4	105
Saturday	2	1			1						1	3	2	7	9	3	1	8	2	8	5	2		1	56
Sunday			5	1	1	2					1		1	9	13		2	2	4	3		2	3	2	51
Total	9	11	12	10	10	8	5	1	0	3	11	26	31	61	63	32	33	54	45	43	40	50	44	20	622

- Handover Delay >60 minutes

Day of Week	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	Grand Total
Monday											4	5	5	10	12	5	10	14	6	12	11	10	9		113
Tuesday	3	1	2		2	3				3	3	3		8	5	7	11	11	11	7	14	15	4	3	116
Wednesday	3	3	2	1	1								3	7	3	7	6	4	1	2	7	17	7	1	75
Thursday	1													1	1			1		5	6	6	2	4	27
Friday			3											2	6	6	6	1	5	4	5	5		1	44
Saturday											3		1	5	4	7	10	4	3	3	6	3	6	4	59
Sunday	1	1	1			1	1				2		2	4	8	6	5	6	5		4	4	1		52
Total	8	5	8	1	3	4	1	0	0	3	12	8	11	37	39	38	48	41	31	33	53	60	29	13	486

Gateshead Health NHS Foundation Trust

Interventions to support improvement

- Discussed, shared and agreed that the greatest clinical risk was the undifferentiated risk in the community linked to handover delays at hospital reducing ambulance availability to respond
- Supported by evidence of significant patient harm across the country directly linked to delays in response
- Shifted our decision making and internal risk balance evaluations to take this into account across the organisation
- Engaged with clinical and operational colleagues across the Trust to support performance improvement
- Instigated a weekly meeting chaired by the COO to support performance improvement

Interventions to support improvement

- Improved organisational response
  - Tracking of ambulance handover performance improved across the ED, patient flow and senior leadership teams
  - Protocol created to support escalation both in- and out-of-hours – extensively shared with the on call team members to ensure consistency 24/7
  - Clear differentiation of actions which could be taken at different levels of escalation to support the position
  - Clear and documented actions to create space within the ED, amended patient flow actions to improve flow out of the ED department, reduce handover times from ambulance crews and deliver patient care

  - Example extract of protocol in next slide

Interventions to support improvement

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Timescale	In hours escalation	Out of hours escalation	Action /s & Considerations
No plan to handover within **15 minutes**	**Internal** - SLM/ASLM > Divisional Manager	**Internal** - SRT > Tactical on call If ED co-ordinator unable to contact SRT due to clinical emergency, ED co-ordinator should contact tactical on-call via Switchboard	Revisit internal actions as above with: • Utilise rear holding corridor with nursing or healthcare staff (depending on clinical requirements) • Initiate full capacity protocol on EAU and BOH wards to create capacity where clinically safe to do so across BOH wards (8am-8pm only) • NEAS Operations Coordination Centre (OCC) contacted by Divisional Manager – Medicine (in hours) or Tactical on-call (out of hours) to update on position and provide support.
No plan to handover within **30 minutes**	**Internal** - Divisional Manager > Medicine Business Unit Director of Operations (or deputy in their absence) with SRT Awareness to Chief Operating Officer or deputy	**Internal** - Tactical on call > Strategic on call with SRT	Revisit internal actions as above with: • Obtain site update to enact further review of full capacity protocol. • Risk assess staff movement from across site to assist ED with patient care in unplanned areas. • NEAS Operations Coordination Centre (OCC) contacted by Divisional Manager – Medicine (in hours) or Tactical on-call (out of hours) to update on position and provide support. • System Coordination Centre (SCC) contacted by Divisional Manager – Medicine (in hours), or Tactical on-call (out of hours) to update on position and provide support

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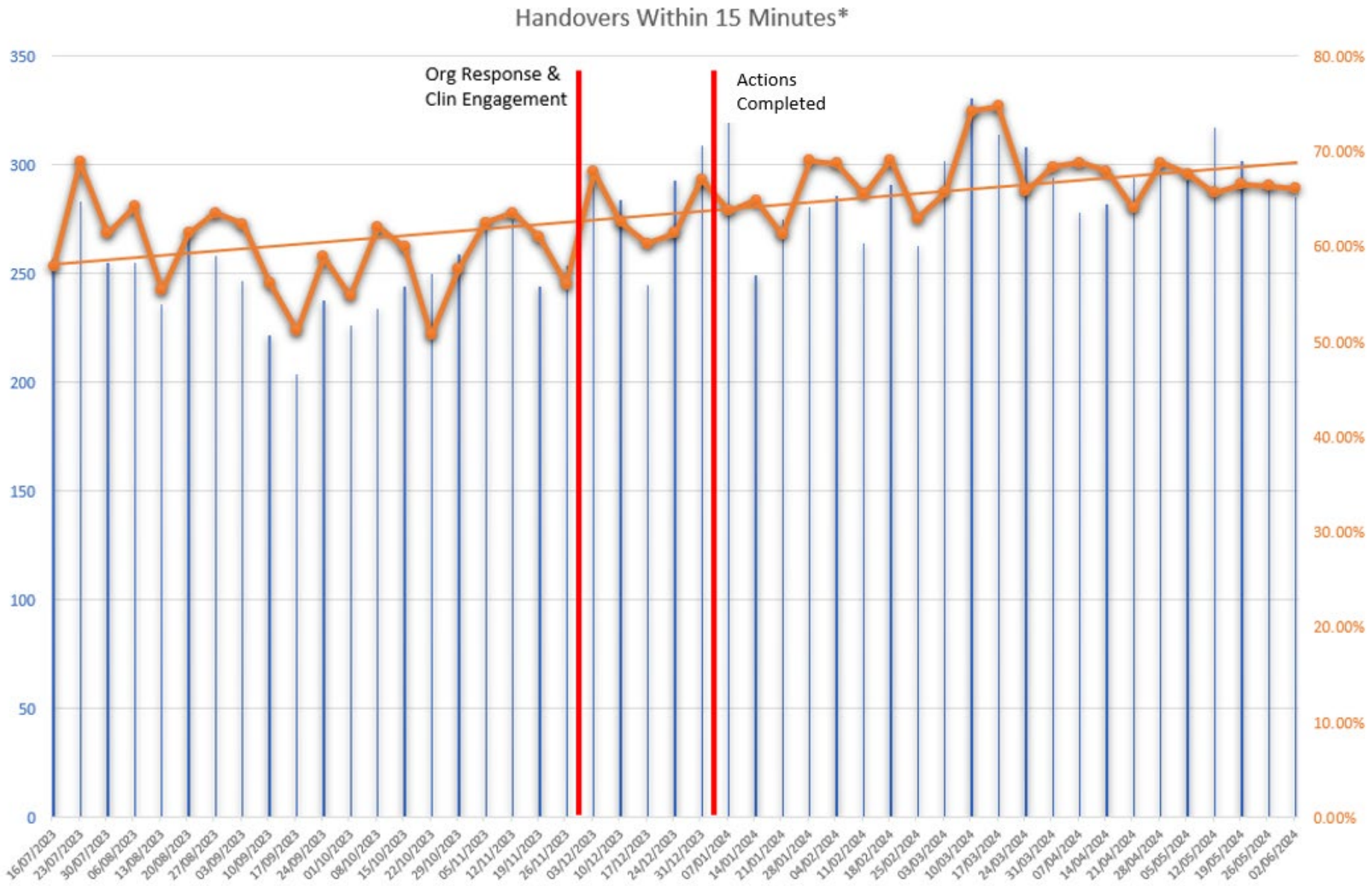
Interventions to support improvement

- Clinical engagement with ED clinical team
  - National ask to balance the risk between hospital and community
  - Recognise our actions may increase risk for ED, how can we best manage this in the department
  - Prioritise patient safety and experience

- Instigation of After Action Reviews for all handovers over 30 mins
  - Reviewed during the weekly meeting to establish any trends

- Utilisation of ICB funding to support additional staffing (1:4 ratio)
  - In line with aforementioned demand and delays, additional shifts requested in the following pattern:

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Shift 1	12:00 – 00:00	12:00 – 00:00	12:00 – 00:00	12:00 – 00:00	12:00 – 00:00	12:00 – 00:00	12:00 – 00:00
Shift 2	14:00 – 02:00	14:00 – 02:00	14:00 – 02:00				14:00 – 02:00



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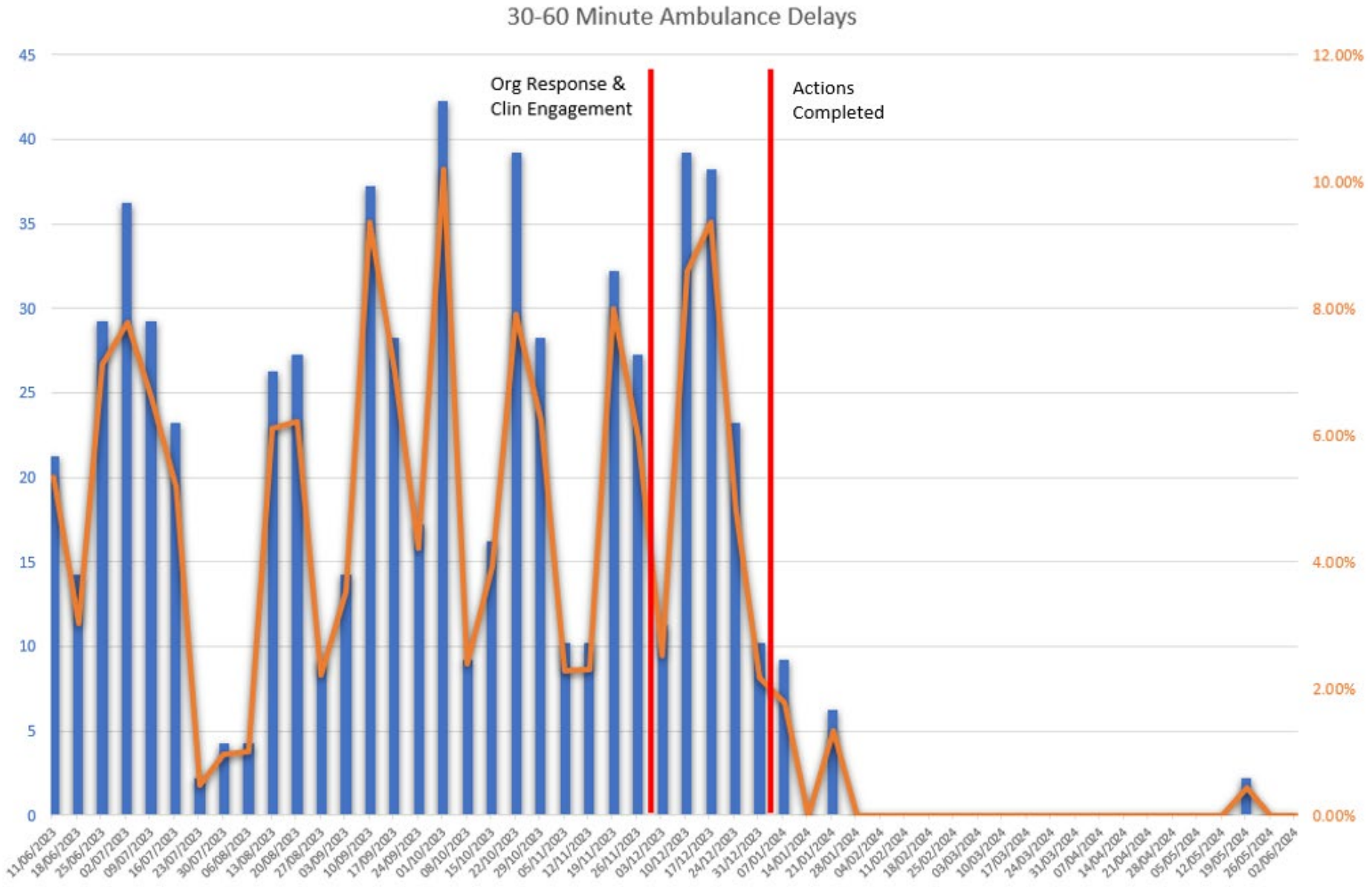

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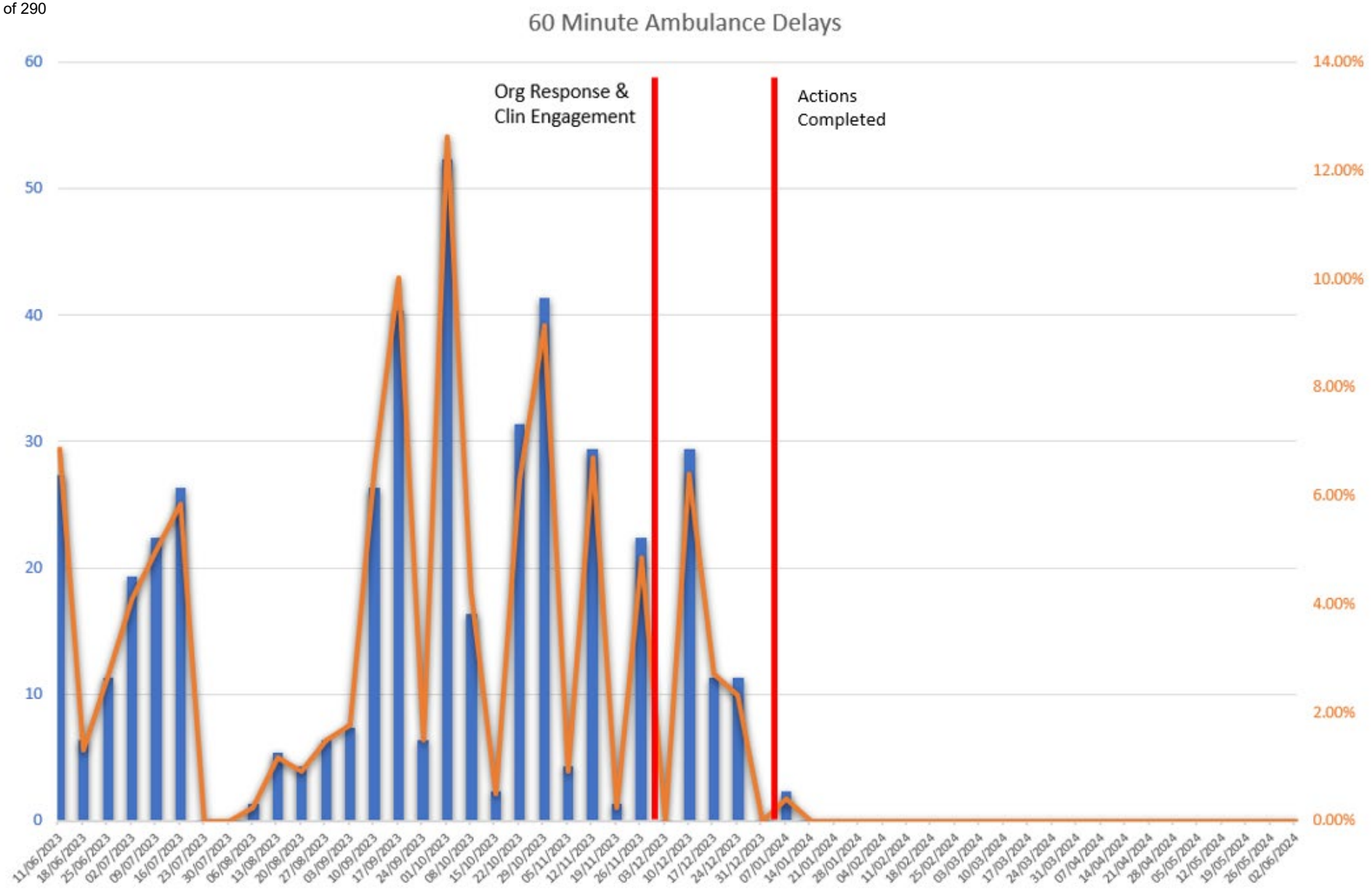

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So what is next?

- Continuous improvement – increasing compliance with 15 minute handover
  - Latest average handover time for week ending 02/06/24 was 14:01 – 2nd best in the region
  - Continue to ensure positive patient / staff experience and improved patient safety position

- Working with regional Task & Finish group to improve compliance in non-ED areas
  - Sharing our learning across the wider Trust (and beyond)
  - Potential consequences on handover performance – closely monitoring

- Transition additional staffing to substantive arrangement
  - Following the success of the pilot – agreed to amend ED staffing to include this element substantively
  - Weekly meeting continuing but now expanded to include four hour performance more explicitly
  - EQIA to be completed as part of the process

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 7

Report Title:	**Articles of Association for QE Facilities Limited**			
Name of Meeting:	Gateshead NHS FT Board Meeting			
Date of Meeting:	31 July 2024			
Author:	Gavin Evans – QEF Managing Director			
Executive Sponsor:	Gavin Evans – QEF Managing Director			
Report presented by:	Gavin Evans – QEF Managing Director			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☒	**Discussion:** ☒	**Assurance:** ☐	**Information:** ☐
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☒ *No gaps in assurance*	**Partially assured** ☐ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	N/A			
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 current Articles of Association for QE Facilities Limited (QEF) have not been updated since the Company's inception in 2014. A number of independent reviews have looked at the Articles (LHSM, 2020 & Deloitte, 2023) and recommended amendments but these have yet to be implemented. Having taken counsel (Sintons LLP) on the recommendations proposed by LHSM Consultancy Ltd in 2020 it is felt that the proposed changes, with the exception of those around the purchase of shares by the Company, are reasonable and as such should be implemented. Further discussions have been taken since the June 2024 board meeting between Sintons LLP and Non-executive director of QEF. Following this it was agreed that the articles, as presented,			

<table>
<tr><td></td><td colspan="5">be submitted for approval by the board. The board since approved the Articles as amended and agreed to be put to the Trust Board for ratification.</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 approve the revised Articles of Association for QEF for ratification.</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"></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>

THE COMPANIES ACTS 2006

PRIVATE COMPANY LIMITED BY SHARES

ARTICLES OF ASSOCIATION OF

QE FACILITIES LIMITED (CRN: 09019497) (“the Company”)

(Adopted by special resolution passed on 2024)

1. INTERPRETATION

1.1 In these Articles, unless the context otherwise requires the following words shall have the following meanings:

"Act"	the Companies Act 2006,
"Appointor"	has the meaning given In Article 7.1,
"Articles"	the company's articles of association for the time being in force,
"Business Day"	any day (other than a Saturday, Sunday or public holiday in the United Kingdom) on which cleaning banks In the City of London are generally open for business,
"Directors"	a director of the Company and "Directors" shall mean more than one director of the Company,
"Eligible Director"	a director who would be entitled to vote on the matter at a meeting of directors (but excluding any director whose vote is not to be counted in respect of the particular matter),
"Health Service"	the of services to Individuals for or in connection with the prevention, diagnosis or treatment of Illness, and the promotion and protection of public health,
"Model Articles"	the model articles for private companies limited by shares contained in Schedule 1 of the Companies (Model Articles) Regulations 2008 (SI 2008/3229) as amended prior to the date of adoption of these Articles,
“SFIs”	the standing financial Instructions relating to the Directors and the authorities agreed by the Chief Executive of the Shareholder as at the date of adoption of these articles, a copy of which is initialled and attached as appendix 1 to these articles, and
"Shareholder"	the sole member of the company.

1.2 In these Articles -

1.2.1 any gender Includes any other gender,

1.2.2 singular includes the plural and vice versa,

1.2.3 references to persons include bodies corporate, unincorporated associations, governments, states, partnerships and trusts (in each case, whether or not having separate legal personality),

1.2.4 words and expressions which have particular meanings in the Model Articles shall have the same meaning in these Articles unless otherwise provided and words and expressions which have particular meanings in the Act shall have the same meanings in these Articles,

1.2.5 a reference in these Articles to an "article" is a reference to the relevant article of these Articles unless expressly provided otherwise,

1.2.6 unless expressly provided otherwise, a reference to a statute, statutory provision or subordinate legislation is a reference to it as it in force from time to time,

1.2.7 the headings in these Articles are for convenience only and shall not affect the interpretation of these Articles, and

1.2.8 general words shall not be given a restrictive interpretation by reason of their being preceded or followed by words indicating a particular class of acts, matters or things.

2. THE MODEL ARTICLES

2.1 The regulations contained in the Model Articles are incorporated into these Articles and shall apply to the Company, except in so far as they are modified or excluded by these Articles.

2.2 Regulations 44(2) and 50 of the Model Articles shall not apply to the Company.

2.3 Regulations 7, 17(1) and (2), 20, 25, 29, 44(3) and 45(1) of the Model Articles shall apply to the Company with the modifications set out below.

3. OBJECTS OF THE COMPANY

3.1 The Company's principal purpose is the provision of goods and services in relation to and for the purposes of the Health Service in England.

3.2 The Company may also carry on any activities other than those mentioned in article 3.1 for the purpose of making additional income available to it and its Shareholder in order to facilitate carrying on its principal purpose.

4. DECISION MAKING BY THE DIRECTORS

4.1 The quorum for decisions made by the directors at a board meeting shall be 3, consisting of 2 from: Chair, appointed by the Shareholder, Non-Executive Director, appointed by

the Shareholder, Managing Director, appointed by the Shareholder, Finance Director, appointed by the Chair; and 1 from the following list: CEO for the Shareholder, Deputy Chief Executive for the Shareholder, Chair for the Shareholder, Group FD for the Shareholder.

4.2 Regulation 7 of the Model Articles shall be amended by –

4.2.1 the insertion of the words "for the time being" at the end of regulation 7(2)(a),

4.2.2 the deletion of the wording in regulation 7(2)(b) “no provision of the articles requires it to have more than one director", and

4.2.3 the insertion in regulation 7(2) of the words "(for so long as they remain the sole director)" after the words "and the director may".

4.3 No changes can be made to the SFIs without the written consent of the Shareholder.

5. RECORDS OF DECISION TO BE KEPT

Where decisions of the directors are taken by electronic means, such shall be recorded by the directors in permanent form, so that they may be read with the naked eye.

6. APPOINTMENT AND REMOVAL OF DIRECTORS

6.1 The Shareholder may at any time and from time to time by notice in writing signed on behalf of it (which shall be effective immediately upon its delivery to the registered office of the Company) appoint any person to be a director of the Company.

6.2 Notwithstanding anything in these Articles or in any agreement between the Company and such director, a director may be removed from office at any time by the Shareholder by notice in writing signed on behalf of the Shareholder which shall be effective immediately upon its delivery to the registered office of the Company such removal shall be without prejudice to any clam such director may have for damages for breach of any agreement between the director and the Company for the purposes of this Article 6, the Chief Executive of the Shareholder or their nominated representative shall act on behalf of the Shareholder.

6.3 The Shareholder, or its nominated representative, will approve all proposed appointments of Directors in writing prior to their appointment, otherwise any appointment made without this approval is not a valid appointment of a Director.

6.4 The Shareholder, or its nominated representative, will approve the appointment of the Chairperson of the Board.

6.5 All proposed remuneration of any directors of the Board must first be approved in writing by the Shareholder, or its nominated representative.

7. ALTERNATE DIRECTORS

7.1 Any director (an "appointor') may appoint as an alternate any other director, subject to prior written approval from the Shareholder, to –

7.1.1 exercise that director's powers, and

7.1.2 carry out that director's responsibilities,

in relation to the taking of decisions by the directors, in the absence of the alternate's appointor.

7.2 Any appointment or removal of an alternate must be effected by notice in writing to the Company signed by the appointor, or in any other manner approved by the directors.

7.3 The notice must –

7.3.1 Identify the proposed alternate, and

7.3.2 In the case of a notice of appointment, contain a statement signed by the proposed alternate that the proposed alternate is willing to act as the alternate of the director giving the notice.

7.4 An alternate director may only act as alternate director to one director and has the same rights in relation to any decision of the directors as the alternate's appointor.

7.5 Except as the Articles specify otherwise, alternate directors –

7.5.1 are deemed for all purposes to be directors,

7.5.2 are liable for their own acts and omissions,

7.5.3 are subject to the same restrictions as their appointors, and

7.5.4 are not deemed to be agents of or for their appointors.

and, in particular (without limitation), each alternate director shall be entitled to receive notice of all meetings of directors and of all meetings of committees of directors of which their appointor is a member.

7.6 A director who is also an alternate director is entitled, in the absence of their appointor, to a separate vote on behalf of their appointor, in addition to their own vote on any decision of the directors (provided that their appointor is an eligible director in relation to that decision but shall not count as more than one director for the purposes of determining whether a quorum is present.

7.7 An alternate director is not entitled to receive any remuneration from the Company for serving as an alternate director except such part of the alternate's appointor's remuneration as the appointor may direct by notice in writing made to the Company.

7.8 An alternate director's appointment as an alternate terminates;

7.8.1 when the alternate's appointor revokes the appointment by notice to the Company in writing specifying when it is to terminate,

7.8.2 on the occurrence, in relation to the alternate, of any event which, if it occurred in relation to the alternate's appointor, would result in the termination of the appointor's appointment as a director,

7.8.3 automatically on the expiry of three months from the date of their appointment, in which case the appointment process under article 7.3 must be undertaken again If the alternate is still required by the appointer,

7.8.4 on the death of the alternate's appointor,

7.8.5 when the alternate's appointor's appointment as a director terminates, or

7.8.6 upon the Shareholder at any time writing to the alternate detailing their termination and the date of said termination, whether immediate or in the future.

7.9 Where there are only two directors of the Company at any time, no director may appoint an alternate and the provisions of this Article 7 shall not apply.

8. DIRECTORS EXPENSES

Regulation 20 of the Model Articles shall be amended by the insertion of the words "(Including alternate directors) and the secretary" before the words "properly incur".

9. SECRETARY

The directors may appoint any person who is willing to act as the secretary for such term, at such remuneration and upon such conditions as they may think fit and from time to time remove such person and, if the directors so decide, appoint a replacement, In each case by a decision of the directors.

10. SHARES AND PURCHASE OF OWN SHARES

10.1 The directors of the Company are prohibited by these Articles from exercising any power of the Company to allot shares or to grant rights to subscribe for or to convert any security into such shares under section 550 of the Companies Act 2006

10.2 Subject to the Act but without prejudice to any other provision of these Articles, the Company may purchase Its own shares with cash up to any amount in a financial year not exceeding the lower of;

10.2.1 £15,000, and

10.2.2 the value of 5% of the Company's share capital.

11. SHARE CERTIFICATES

In regulation 25(2)(c) of the Model Articles, the words "evidence, Indemnity and the payment of a reasonable fee" shall be deleted and replaced with the words "evidence and Indemnity".

12. TRANSMITTEES

Regulation 29 of the Model Articles shall be amended by the insertion of the words or the name of any person(s) named as the transferee(s) In an Instrument of transfer executed under article 28(2),"after the words "the transmitter's name".

13. POLL VOTES

13.1 A poll may be demanded at any general meeting by any qualifying person (as defined in section 318 of the Act) present and entitled to vote at the meeting.

13.2 Regulation 44(3) of the Model Articles shall be amended by the insertion of the words "A demand so withdrawn shall not Invalidate the result of a show of hands declared before the demand was made" as a new paragraph at the end of that regulation.

14. PROXIES

Regulation 45(1) of the Model Articles shall be amended by the insertion of the words 'land a proxy notice which is not delivered in such manner shall be invalid, unless the directors, in their discretion, accept the notice at any time before the meeting" as a new paragraph at the end of that regulation.

15. COMMUNICATIONS

15.1 Subject to these Articles, any notice or document to be sent or supplied to a director in connection with the taking of decisions by directors may also be sent or supplied by the means by which that director has asked to be sent or supplied with such notices or documents for the time being a director may agree with the Company that notices or documents sent to that director in a particular way are deemed to have been received within a specified time of their being sent, and for the specified tame to be less than 48 hours.

15.2 Where a document or information is sent or supplied by the Company by post, service or delivery shall be deemed to be effected at the expiration of 24 hours after the time when the cover containing the same is posted (irrespective of the class or type of post used) and in proving such service or delivery it shall be sufficient to prove that such cover was properly addressed and posted.

15.3 Where a document or information is sent or supplied by the Company by electronic means to an address specified for the purpose by the intended recipient, service or delivery shall be deemed to be effected on the same day on which it is sent or supplied and in proving such service it will be sufficient to prove that It was properly addressed.

15.4 Where a document or information is sent or supplied by the Company by means of a website, service or delivery shall be deemed to be effected when;

15.4.1 the material is first made available on the website, or

15.4.2 If later, when the recipient received (or is deemed to have received) notification of the fact that the material was available on the website.

15.5 Anything to be agreed or specified in relation to documents or information to be sent or supplied to joint holders, may be agreed or specified by that one of the joint holders whose name appears first in the register.

15.6 In proving that any notice, document or other information was properly addressed, it shall be sufficient to show that the notice, document or other information was delivered to an address permitted for the purpose by the Act.

16. INDEMNITY AND FUNDING OF DEFENCE COSTS

16.1 Subject to the provisions of and so far as may be consistent with the Act, the Company shall provide –

16.1.1 for each relevant officer an indemnity out of the assets of the company to the extent that such indemnity is a "qualifying third party Indemnity provision" within the meaning of section 234 of the Act.

16.2 In this article 16 –

16.2.1 companies are associated if one is a subsidiary of the other or both are subsidiaries of the same body corporate, and

16.2.2 a "relevant officer" means any director or other officer or former director or other officer of the company or an associated company (Including any company which is a trustee of an occupational pension scheme (as defined by section 235(6) of the Act), but excluding In each case any person engaged by the company (or associated company) as auditor (whether or not they also are a director or other officer), to the extent they act in their capacity as auditor).

17. INSURANCE

17.1 The directors may decide to purchase and maintain insurance, at the expense of the Company, for the benefit of any relevant officer in respect of any relevant loss.

17.2 In this article 17 –

17.2.1 a "relevant officer' means any director or other officer or former director or other officer of the company or an associated company including any company which is a trustee of an occupational pension scheme (as defined by section 235(6) of the Act) but excluding In each case any person engaged by the company (or

associated company) as auditor (whether or not they are also a director or other officer), to the extent they act In their capacity as auditor),

17.2.2 a "relevant loss" means any loss or liability which has been or may be incurred by a relevant officer in connection with that relevant officers duties or powers In relation to the company, any associated company or any pension fund or employees' share scheme of the company or associated company, and

17.2.3 companies are associated if one is a subsidiary of the other or both are subsidiaries of the same body corporate.

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 8

Report Title:	**Finance and Performance Committee Terms of Reference**			
Name of Meeting:	Board of Directors			
Date of Meeting:	31 July 2024			
Author:	Company Secretary			
Executive Sponsor:	Chair of the Committee Executive Leads			
Report presented by:	Company Secretary			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☒	**Discussion:** ☐	**Assurance:** ☐	**Information:** ☐
	To ratify the revised terms of reference for the Finance and Performance Committee			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☒ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	Finance and Performance Committee – April 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*	• Note that this is an interim update to bring the terms of reference in line with agreed changes to membership, attendance and remit. • All changes are highlighted on the document. • This includes removing references to the Transformation Board and adding in a section on the Great North Healthcare Alliance. • A further full review and update of the terms of reference will be required once the Tier 2 Groups within the governance structure are embedded, enabling the streamlining of reporting to the Tier 1 Board Committees. • The terms of reference have been reviewed and approved by the Finance and Performance Committee. The Committee requested a number of changes, which have been included on the attached version.			
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	The Board is requested to ratify the revised terms of reference on the recommendation of the Finance and Performance Committee, noting that this is an interim update, with a full review to follow.			

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:	Ensuring that there robust terms of reference in place for Board committees should support the seeking of assurance over the delivery of the objectives aligned to the aims.				
Links to CQC KLOE	Caring ☐	Responsive ☐	Well-led ☒	Effective ☐	Safe ☐
Risks / implications from this report (positive or negative):					
Links to risks (identify significant risks and DATIX reference)	-				
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒		

Board Committee (Tier 1)

Terms of Reference

Gateshead Health NHS Foundation Trust

Finance and Performance Committee

Constitution and Purpose – The Finance and Performance Committee is a formal committee of the Board with delegated responsibility to monitor, review and make recommendations to the Trust Board with regard to the detailed financial and operational performance of the Trust.

The Committee is authorised by the Trust Board of Directors to investigate any activity within its Terms of Reference. Any decisions of the Committee shall be taken on a majority basis. All members of the Committee have an equal vote. In the event of a tied vote, the Chair of the meeting will hold the casting vote.

Date Adopted / Reviewed	Finance and Performance Committee – April 2024 Board of Directors – July 2024
Review Frequency	Annual
Review and approval	Finance and Performance Committee
Adoption and ratification	Board of Directors

Membership	The Committee shall be appointed by the Trust Board and shall consist of: • Three Non-Executive Directors • Chief Executive • Group Director of Finance • Chief Operating Officer • Medical Director or Chief Nurse The Committee shall be chaired by a Non-Executive Director with relevant skills and experience. A Non-Executive Director shall be nominated as Deputy Chair for the Committee.
Attendance	• Deputy Director of Planning and Performance • Interim Director of Strategy, Planning and Partnerships • Deputy Director of Finance • Trust Chair • ~~A representative of People and OD will be in regular attendance at the meeting.~~ Executive Directors and senior managers should ensure that a deputy attends in their absence.

	All Non-Executive Directors have an open invitation to attend the meetings. Other Executive Directors and Senior Managers may be invited to attend meetings depending upon the issues under discussion.
Meeting frequency and quorum	Meetings shall be held **monthly** and as required by the national planning timetable. Meetings shall be held prior to the Trust Board to support the timely flow of assurance and items for escalation. To be quorate there should be at **least 2 Non-Executive Directors** ~~(one of whom can be the Trust Chair)~~ and **1 Executive Director** present. Members and regular attendees are expected to achieve **75% attendance** annually.
Meeting organisation	The Committee shall be supported administratively by the Corporate Governance Manager. In accordance with the Trust's Standing Orders, **papers will be circulated to members and attendees six days before the meeting** wherever possible, and no later than three clear days before the meeting, save in emergency. Minutes of the Committee's meetings are held by the Corporate Governance Manager and are circulated (alongside the agenda for the following meeting), to members and attendees.

Committee duties and responsibilities	
Strategy, planning and risk	To undertake **detailed scrutiny** of the adequacy of the Trust's **financial, operational, capacity and demand estimates, forecasts and planning assumptions** (in line with the latest regulatory requirements), making a recommendation to the Trust Board with respect to their approval. To **seek assurance over the delivery of the strategic objectives** mapped to the Committee for monitoring at the commencement of the financial year. To seek assurance over the **delivery of national and local-level strategies** relating to finance and operations. This includes the delivery of the commercial strategy and finance strategy (following Board approval), as well as the approval and monitoring of the Transformation and Quality Improvement strategy. To **review the sections of the Board Assurance Framework (BAF)** mapped to the Committee for oversight and assurance, triangulating the control and assurance assertions on the BAF with the assurances and risks identified during each meeting. To **review the Finance and Operations-related risks from the Organisational Risk Register**, seeking assurance over the effective management of these risks towards the achievement of their target scores.

	The Committee will triangulate the risk registers against the assurances and risks emerging from the meeting for completeness.
Finance	To **review and monitor the Trust's contractual performance** and associated income, considering the implications of longer-term financial strategy for the Trust, taking into consideration the outcomes reported to the Committee from contract review meetings. To undertake detailed scrutiny of the **monthly consolidated finance report** and financial regulatory returns. This includes seeking assurance over the following areas: • achievement of the financial and use of resources metrics identified in the Single Oversight Framework and planning guidance. • Achievement of cost reduction programme (CRP) plans • Budget versus actual performance, including forecasting where appropriate To review **exception reports from business units** and seek assurance over recovery plans, in line with the accountability framework requirements. To review a **register of contracts** and seek assurance over the performance of those deemed to be material – financially or reputationally.
Capital and investment	To receive quarterly reports and to monitor progress against the **capital plan** and make any recommendations to the Trust Board as required. To **review the Trust's Investment Strategy** at least annually, making recommendations for amendments to the Trust Board. To **review and discuss any significant initiatives, projects and issues that impact financially** on the Trust and that the Committee deem appropriate, and make recommendations to the Board as necessary. This should be in accordance with the Trust's Scheme of Delegation. **Review of business cases** in accordance with the delegated limits outlined within the Trust's Scheme of Delegation. To receive assurance reports from the Supplies & Procurement Group highlighting any areas of **non compliance with SFIs and a summary of single tender waivers**.
Performance	**Review the ~~Integrated Oversight Report~~ Leading Indicators and Elective Recovery reports** with a particular focus on performance measures, seeking assurance over the plans in place to deliver against targets and the actions in place to address those areas reported as exceptions (including any major standalone performance recovery plans). ~~This review will include specific focus on the performance metrics outlined in the NHS England and Improvement Single Oversight Framework. Operations Directors should be invited to attend where appropriate to support deep dive discussions into elements of performance and operational service~~

	~~development within the Trust.~~ To monitor capacity, demand and delivery of national standards against planned levels and make recommendations to the Trust Board where required.
Subsidiary governance	To seek assurance over the **performance of the Trust's subsidiary**, QE Facilities, against its contract with the Trust. To monitor the impact of the subsidiary on **group financial performance**.
Great North Healthcare Alliance	To receive for information and assurance update reports in relation to the **Great North Healthcare Alliance**.
~~Transformation~~	~~Via the Transformation Board reporting, seek assurance over the **transformation programme, including its plan, delivery and outputs.** This includes delivery of major transformational schemes which have a significant link to operational and / or financial performance.~~
Regulatory and governance	To receive for information and assurance **Internal Audit reports** pertaining to the remit of the Committee. To review **feedback from NHS England** relating to financial, operational and planning matters. To review any material **emerging regulatory guidance / requirements** in relation to finance and operational matters on behalf of the Board.

Reporting and monitoring	
Sub-groups	The following sub-groups report into the Committee: • ~~Transformation Board~~ • Operations Oversight Group • Financial Planning, Performance and Assurance Group The minutes and summary of assurances and escalations document are received by the Committee as part of the flow of assurance through the Trust's governance structure.
Board reporting	An assurance report from the Committee will be presented by the Chair to the next meeting of the Board of Directors.
Monitoring	Compliance with the terms of reference will be reviewed via an annual self-assessment. This will inform any proposed revisions to the terms of reference and the cycle of business. The outcome of the effectiveness and terms of reference review is

	presented to the Board of Directors following considered by the Committee.

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 9

Report Title:	**Consultation on Governance Structures Outcome**			
Name of Meeting:	Board of Directors			
Date of Meeting:	31/07/2024			
Author:	Dr Gill Findley, Chief Nurse and Professional Lead for Midwifery and Allied Health Professionals			
Executive Sponsor:	Dr Gill Findley, Chief Nurse and Professional Lead for Midwifery and Allied Health Professionals			
Report presented by:	Dr Gill Findley, Chief Nurse and Professional Lead for Midwifery and Allied Health Professionals			
Purpose of Report	**Decision:** ☒	**Discussion:** ☐	**Assurance:** ☐	**Information:** ☐
	The purpose of the report is to provide a summary of the outcome of the formal consultation on the governance and structural review outcome and to ask the Board of Directors to approve the proposed structure and governance changes.			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☐ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☒
Paper previously considered by:	Executive Management Team 29/07/24			
Key issues:	• A total of 43 responses were received • The majority were from the community business unit • The majority of responses received were from Allied Health Professionals • Most responses were positive to most the changes suggested, but wanted more detail on how some of the new arrangements would work such as the new cancer service line and the move of AHPs from community to clinical support and screening • It will be important to retain a focus on community going forward as respondents were concerned about being merged with acute service			
Recommended actions for this meeting:	Board of Directors is asked to note the content of the report and to approve the implementation of the proposed structure.			

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:	All are relevant				
Links to CQC KLOE	Caring ☒	Responsive ☒	Well-led ☒	Effective ☒	Safe ☒
Risks / implications from this report (positive or negative):					
Links to risks (identify significant risks and DATIX reference)					
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐	**No** ☒	**Not applicable** ☐		

Gateshead Health NHS Foundation Trust

Consultation on Governance Structures Outcome

1.0 Introduction

This paper presents a summary of the outcome from the consultation exercise that was undertaken in relation to potential structural and governance changes across the Trust. The Board of Directors has previously agreed the structural changes in principle pending the outcome of the consultation exercise. Board of Directors is asked to note the findings and agree to implement the recommendations.

In total, 43 responses were received. The vast majority were from the community division and the main professional group that responded was the Allied Health Professionals.

2.0 Consultation Findings

A consultation document was prepared and circulated widely within the Trust. A series of meetings were arranged and offered to staff groups. A series of consultation questions were circulated and the responses to those questions form the basis of this summary document. Not all respondents responded to all questions.

2.1 Director level appointments

There was overwhelming support for the suggestion to delay the appointment of the new Director of Strategy and Communications post with a couple of comments asking if the post was really necessary at all, but more comments saying that the post would be welcome when it was appointed to.

2.2 Divisional Structure

In relation to the move to 3 Divisions from 4 Business Units, 10 people responded that they felt that the new division of Medicine and Community was too big and had insufficient managerial support. However, 7 people said that they would foresee no problems with this change. Other respondents either did not reply or said that they would support with the right management support. The majority of comments in this section related to community services being split up as a result of the changes and the risk that community becomes swallowed up into the acute setting.

There were some concerns that the dis-establishment of some senior managerial roles would make workloads unmanageable.

2.3 Service Line Structure – Medicine and Community

There were comments that it is still not clear what is included in each of the service lines, so it is difficult to comment. Some respondents felt that the structure could not be clinically led because the arrangements for clinical (medical) leadership have not yet been agreed. There was a positive response to the separation of the current Med 2 service line into 2 new service lines.

Most of the comments related to what will move out of the community service line and into clinical support and screening and whether this was a justified move. Some staff felt that the practicalities of working in the community would be lost in this arrangement – issues such as the use of EMIS and lone worker devices were mentioned multiple times. Several respondents mentioned that community staff must not be used to fill gaps in acute services.

There was universal support for the extension of Older Person's Mental Health to cover Mental Health in more general terms.

There were some individual queries that will be picked up by the Divisional Leadership teams once the divisional structure is agreed.

2.4 Service Line Structure – Surgery, Women's Health and Children

There were concerns that the service line of trauma and orthopaedics and general surgery is a very big service line and leads to an unequal workload. For example, all the surgical wards would now sit under one matron, whereas previously they were split between 2.

There was support for a separate service line for cancer, but still some confusion and uncertainty as to how it will function and whether or not it should be a corporate function rather than a service line within the Medicine and Community division. There were comments relating to how this service line would link with medicine where there are also many patients with cancer being treated. There were differing suggestions for an alternative arrangement of the service lines, and some isolated comments suggesting that perhaps gynae oncology should sit within cancer, or with general surgery due to the close working relationships, but no strong consolidated views from the teams.

Again, there were a couple of comments about the dis-establishment of some senior management roles and the impact on workloads. As for the division of Medicine and Community there were concerns about the makeup of the service lines and the leadership arrangements being unclear at this stage. There were conflicting views about the management of breast services and whether the SLM should straddled both Surgery, Women's Heath and Children and Clinical Support and Screening as they do currently.

There were no comments in relation to the clinical support and screening service lines other than the comments relating to breast services and breast screening, as discussed above.

2.5 Allied Health Professionals

This is the area where there was the biggest negative narrative response. 12 people responded that they felt that this move was beneficial and 4 said outright that it would not be beneficial. A couple of respondents felt that the AHP voice was strong currently because they are in every division, whereas this would silo them into one division, with the potential to be excluded from meetings in other divisions.

Several respondents felt that AHPs already have a voice through the Lead AHP and the AHP forum and that making structural changes was unnecessary and disruptive. The community AHPs felt strongly that their voice would be lost within the CSS division. Some felt that the AHP voice would only increase if the Lead AHP was sitting at the new Leadership Group Meeting.

There was strong feeling amongst the paediatric therapies team that they feel more closely aligned to the service line for community than they do for the therapies service line in CSS. In short, they would prefer to be grouped as a children's community team within the community service line, rather than be aligned to their professional groupings of physiotherapy, occupational therapy, SALT etc. This also extended to the children's community nursing team and the children's bowel and bladder service. It is recommended that the structure changes to accommodate this response.

2.6 Governance changes

There was strong feedback that the expression "Ward to Board" used in one of the consultation questions excludes community staff and teams working outside the ward environment. Several comments pointed out that the people and their behaviour is far more important than the meeting names and reporting arrangements and that the focus should be on how we share information from the meetings.

Overall, the feedback about the governance structures was positive, with a couple of comments that it would depend on who was in which meetings and that membership needed to be clear to everyone. Many felt that the suggested structure offered a clear escalation route. There was a suggestion that we map out the clinical representation at each of the meetings to show where the clinical voice is throughout the organisation.

One pertinent comment made was that the Executive Team need to engage with all members of the divisional leadership teams and not just the Directors of Operations for the structures to work. This is a fundamental part of the new way of working proposed by the Executive Team.

There was also a question about where the alliance structures such as the committees in common sit as they are not shown in the structure. It is recommended that this is added.

2.7 Other comments

Several comments that clinical leadership underpins this structure and needs to be finalised quickly through "consultation with the staff and not unilaterally imposed by the Medical Director".

There were a couple of specific requests:

- Head of Midwifery to change to Associate Director of Midwifery in line with the changes to the Chief Nurse titles
- Clarify who the Associate Medical Directors within the divisions report to (Medical Director or Chief Operating Officer)
- Request for a recorded session to explain the changes

It is recommended that these requests are actioned.

3.0 Summary and Recommendations

Overall there were relatively few comments about the proposed changes. It is therefore recommended that the changes are implemented as planned. In addition the following actions have been noted:

- Delay the appointment of the Director of Strategy and Communication for up to 6 months
- Review the managerial support to the division on Medicine and Community to determine whether there is sufficient managerial support within the division
- Ensure that community services are well represented at all levels of the governance structure
- Children's therapies including children's community nursing and bladder and bowel to stay within the community service line
- Urgently consult on and agree the clinical (medical) leadership arrangements including the line management of the Associate medical Directors in the divisions
- Change the title of the Head of Midwifery to Associate Director of Midwifery
- Clarify the contents of each of the service lines and the management arrangements
- Add the alliance structures such as the Committees in Common
- Record a session explaining the changes to be circulated widely

Gill Findley

Chief Nurse, Professional Lead for Midwifery and AHPs, Deputy Chief Executive

24.07.24

Gateshead Health NHS Foundation Trust

Chair's Report

Alison Marshall, Chair of the Board of Directors

31 July 2024

Gateshead Health NHS Foundation Trust

Announcements

We start this month's report with the sad news of the loss of a valued colleague.

Alison Clark, a receptionist in outpatients, sadly passed away at the beginning of June.

Alison was a valued member of the team with over 12 years of service to the NHS.

She is very much missed and on behalf of the Board I express our deepest condolences to Alison's family, friends and colleagues.

Board updates and Partnership working

Gateshead Health NHS Foundation Trust

Board of Directors

- At an extraordinary meeting on 26 June (scheduled to approve the annual accounts and annual report) the Board of Directors approved two key Board appointments.
- Maggie Pavlou has been appointed as Deputy Chair from 1 July 2024 to 30 June 2027 and Martin Hedley has been appointed as Senior Independent Director from 1 July 2024 to 30 June 2026 (terms are for 3 years or until the end of the individual's term, whichever is soonest).
- Maggie and Martin take over from Mike Robson who has served as Deputy Chair and Senior Independent Director for the last five years. Mike Robson will remain as a Non-Executive Director until 30 June 2025 and will support the new appointees as they transition into their new roles.
- On behalf of the Board I would like to formally record our sincere thanks to Mike Robson for his excellent commitment and contributions in the Deputy Chair and Senior Independent Director roles.

Great North Healthcare Alliance

- Since the last Board meeting the Great North Healthcare Alliance Committees in Common governance model has formally commenced, with two meetings held in this time.
- Further updates on the Alliance are included in a separate paper on the agenda.

Governance – fit and proper persons

- Assurance is provided that the annual fit and proper persons return was been completed and submitted to the NHS England Regional Director on 26 June 2024 ahead of the deadline of 30 June.
- The return covers the period September 2023 to June 2024 (i.e. since the NHS England Fit and Proper Person Framework came into effect).
- I have completed the return which provides assurance that all Board Members have been confirmed as ‘fit and proper’ in line with the NHS England Fit and Proper Person Framework. It also confirmed that Board Member references have been completed for all leavers.
- I can confirm to the Board that all Board Members have been tested and concluded as being fit and proper in line with the Framework. There are no issues arising from the fit and proper persons test being managed for any Board Member.
- Mike Robson, as Senior Independent Director at the time of the test, also completed the return in respect of my own fit and proper test outcome.
- Full assurance is provided to the Board with regards to the outcome of the testing.

Governor and Member Updates

- The Council of Governors held an informal private meeting to further discuss the results of the Council of Governors' effectiveness survey (which was largely positive) and ways in which we can collectively work together to support Governors in the delivery of their roles. The opportunity to meet informally was welcomed and there are plans to hold more informal meetings going forwards.
- The Lead and Deputy Lead Governors held a private meeting with Governors to gather feedback on the Chair and Non-Executive Director colleagues as part of the multisource assessment element of the annual appraisal process. This was aligned to the domains in the new NHS England Leadership Competency Framework.
- The Chair of the Governor Remuneration Committee, Chris Toon, acted as an independent advisor to ensure Governor consultation and input in the appointment of both the Deputy Chair and the Senior Independent Director.
- We are commencing the preparation for the forthcoming Governor election, which will start over the summer. There will be 10 seats included in the election. This includes 3 vacant seats in Eastern Gateshead. Governor colleagues are supporting us in identifying opportunities to promote membership and Governor nominations, with a particular emphasis on Eastern Gateshead given the vacancies here.
- The Governor Remuneration Committee met this month to seek assurance over the completion of the Chair appraisal process and to commence the planning for a forthcoming Non-Executive Director vacancy (with a focus on NHS finance experience).
- Monthly meetings have been held with Steve Connolly, Lead Governor, and Michael Loome, Deputy Lead Governor. This provides a valuable opportunity for timely discussions on key issues of importance to our Governors and helps to plan future Governor events.

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:

- Attended Alliance Steering Groups
- Meeting with ICB Chair and Chief Executive and Alliance Committees in Common
- Attended a meeting of the North Area ICP
- Attended Clinical Strategy Group Away Day
- Gateshead Council key partner event
- Visits to departments to present Star Award cards– Rapid Response Office at Bensham , Theatres and the Undergraduate Medical Education Team
- Meeting of FT Chairs and a meeting with the ICB Chair Forum
- Met with the new Chief Executive of Gateshead Council
- Women's Health Conference Dinner with the ICB

Star of the Month Nominations

March

- **Kerry Donnelly & Katie Mulholland**
- **Lois Lincoln**

May

- Maizee Hart - Paula Gordon
- Ellie Mae Jackson - Brian
- Abbey Simpson - Louise Sore
- Karen Haley - Sharon Makepeace
- Bob Harker - Dr Helen Curtis
- Wendy Oliver - Emma Baptist
- Paul Baxter - Julia Nevin
- Lisa Langley - Lois Brown
- **Katherine Smiles** - Leanne Slasor
- Jasmine Mallaburn - Michael Bowe
- Molly Adamson - Stacey Dudley
- Jayne Wright

June

- Michelle Newton
- Lia Webb
- Leanne Crawford
- Alison Ryder

You're a Star Winner

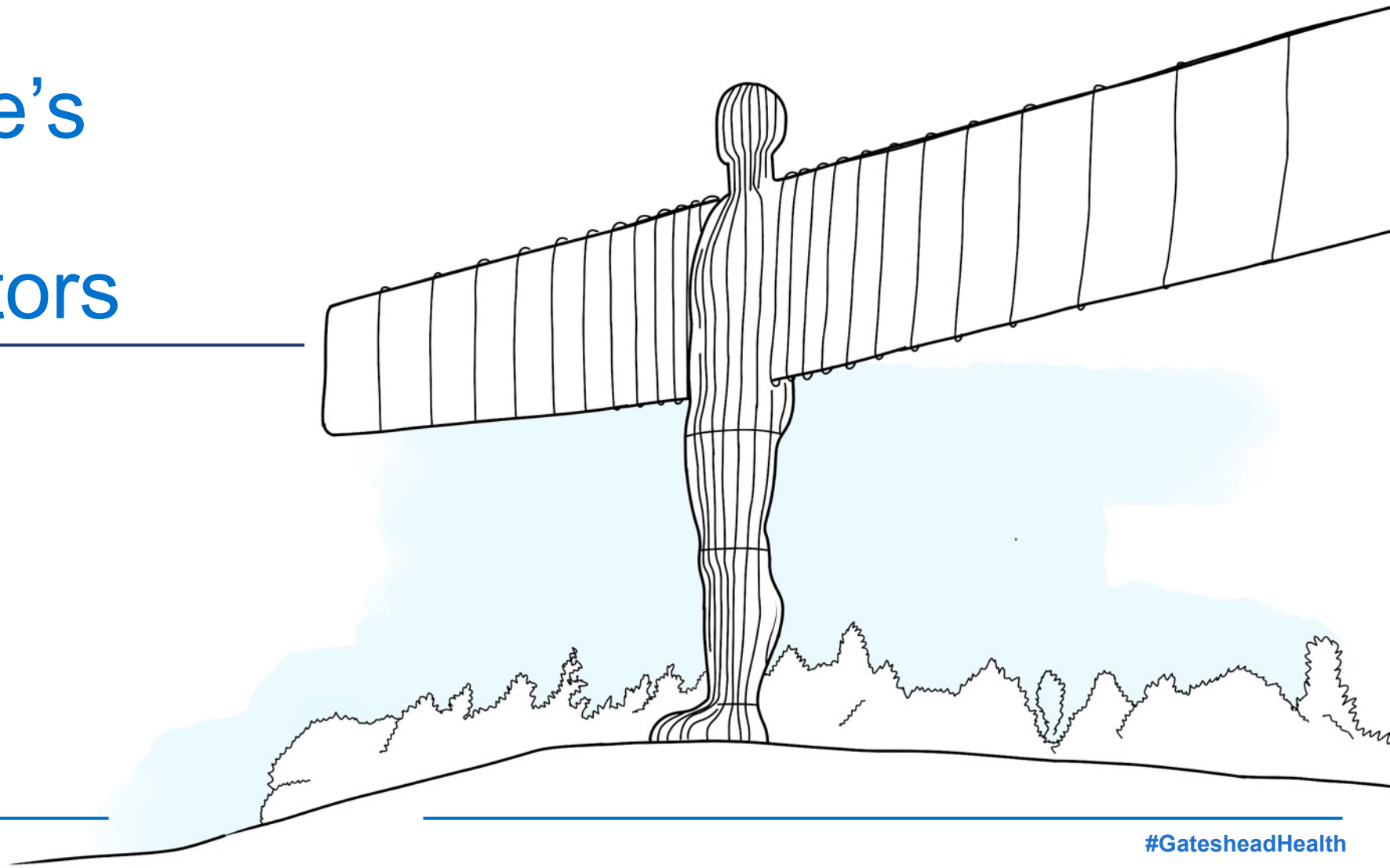
Katherine Smiles

NHS
Gateshead Health
NHS Foundation Trust

Chief Executive's Update to the Board of Directors

Trudie Davies, Chief Executive

31 July 2024



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

- Our liver service was recently inspected and has achieved full **Improving Quality in Liver Services (IQILS) accreditation**. This is a fantastic achievement for the team and the accreditation will be in place for 5 years, subject to completion of annual reviews. The team were congratulated on their high standard of achievement and their hard work during the accreditation process.
- Our **older persons' mental health services** were recently subject to an unannounced inspection by CQC, receiving a positive report with minimal actions. This is an excellent achievement and demonstrates that real progress has been made in these services.
- Our **new second MRI scanner** has been installed on the QE site. This is a great development for our patients and aligns with our ambition to be a diagnostic centre of excellence. The new scanner is technologically advanced, enabling faster scanning and therefore more patients to be seen.
- Executive Directors and clinical leaders met with the Surgery and Maternity teams to look at the future strategic needs of the maternity service, including the estate.

Engagement, involvement and visits:

- Meeting with Surgery and Maternity colleagues
- Attended the newly formed first meeting of the Medical Education Group
- Feedback from the UKAS visit to Pathology

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

NHS Gateshead Health NHS Foundation Trust

- Our colleagues worked hard to plan for and keep our services running as much as possible during the most recent **junior doctors' strike**, which was held from Thursday 27 June to Tuesday 2 July. There were only minimal cancellations for planned procedures.
- We are delighted to welcome **Dr Carmen Howey as our new Medical Director** following a rigorous appointment process. Carmen has an established career at the Trust, both as a paediatrician and mostly recently as Clinical Head of Service within our Medicine Business Unit.
- We have continued our work with colleagues and unions in relation to the **Healthcare Support Workers rebanding process**. We have confirmed to those affected that the uplift will be in effect from 1 August. Following a productive meeting with Unison colleagues it was agreed that the grievance process will continue and a date of early August will be agreed for this to take place.
- We have continued our focus on **speaking up**, recognising the importance of being comfortable with the uncomfortable in order to learn, improve and make our Trust the best it can be for our patients and our colleagues.
- We launched a **consultation on our organisational restructure** at the end of last month, following extensive engagement with teams prior to this point. The formal outcome of the consultation process is included as a separate item on today's agenda. The structure puts the principle of clinically-led and management supported at the heart of our team structures and decision-making.
- Congratulations to our **internationally-educated nurses who all passed their OSCEs** (Observed Structural Clinical Examinations). We are delighted to welcome them to the Gateshead nursing team!
- We have **six of our apprentices** across the Trust and QE Facilities **nominated for the 2024 North East Apprenticeship Awards**. This is a fantastic achievement for each and every apprentice - well done to all and thank you to those who have nominated them and supported their apprenticeships. Huge congratulations to Emily Henry, Pathology Support Worker from Microbiology, who was recognised as a Highly Commended Finalist in the Health and Public Service Apprentice of the Year category.

Engagement, involvement and visits:

- Deputy Chair and SID process
- Medical Director interviews
- Consultant interviews

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

- Our clinical Trust systems were unaffected by the global IT issue which commenced on 19 July. Our community and mental health teams were impacted by the EMIS system downtime (the appointment and patient record system used by GPs) and business continuity plans were enacted, ensuring minimal disruption to patients and colleagues. EMIS systems became operational again on 22 July and our teams have worked hard to ensure all patient contacts from during this time are entered retrospectively on EMIS. Our sincere thanks and gratitude are expressed to all teams for their hard work and support.
- We submitted our **audited accounts and annual report** in line with the national NHS deadline of 28 June. The external auditors, Forvis Mazars LLP, concluded that the accounts provided a true and fair view and had been properly prepared in accordance with legislation and regulatory requirements. A full presentation of the financial accounts and annual report will be delivered at our AGM on 25 September.
- **Financial sustainability** has continued to be a key focus for us. We are working together with colleagues to ensure that our Trust is sustainable and able to provide the best care to our patients.
- We continue to experience **challenges due to the age of our estate**, particularly in relation to maternity services. Our teams and estates and facilities colleagues in QE Facilities have worked incredibly hard to respond and ensure that we continue to deliver high-quality and safe care to our patients despite these challenges. We recognise the need for a longer-term solution and have planned dedicated time to consider this, given the limitations on capital funding and the significant amount of capital that this would require.
- Our **capital plan** for the year has been agreed and a number of projects are due to commence in the coming months, including theatre ventilation upgrades, the replacement of the pharmacy robot and essential electrical upgrades to improve resilience and safety.
- We celebrated **national healthcare estates and facilities day** with colleagues from QE Facilities, combining this with celebrations for the 10th anniversary of QE Facilities.

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

- Our **diabetes team** has been recognised for their commitment to digital inclusion. The North East and North Cumbria Child Health and Wellbeing Network, led by Gateshead Health won at the HSJ awards 2024. Our project - Healthier Together Champions Supporting Access in Underserved Communities was awarded the Digital Equality, Diversity and Inclusion Award. The project uses mobile phones and laptops donated by the Trust to support families to access new technologies for diabetes care.
- We attended a key **event for Gateshead partners at place hosted by Gateshead Council**. This was an excellent opportunity to engage with partners to develop a collective ambition for the people of Gateshead.
- Thanks to **kind donations to our Gateshead Health Charity** our **St Bede's palliative care unit** now has a newly renovated garden, offering a welcoming sanctuary for patients and their families. The garden is accessible from all patient rooms and provides a peaceful space for spending time outdoors. A summer fete was held to celebrate the opening and unveil a special 'memory tree' donated as a gift by Dale Fabrications.

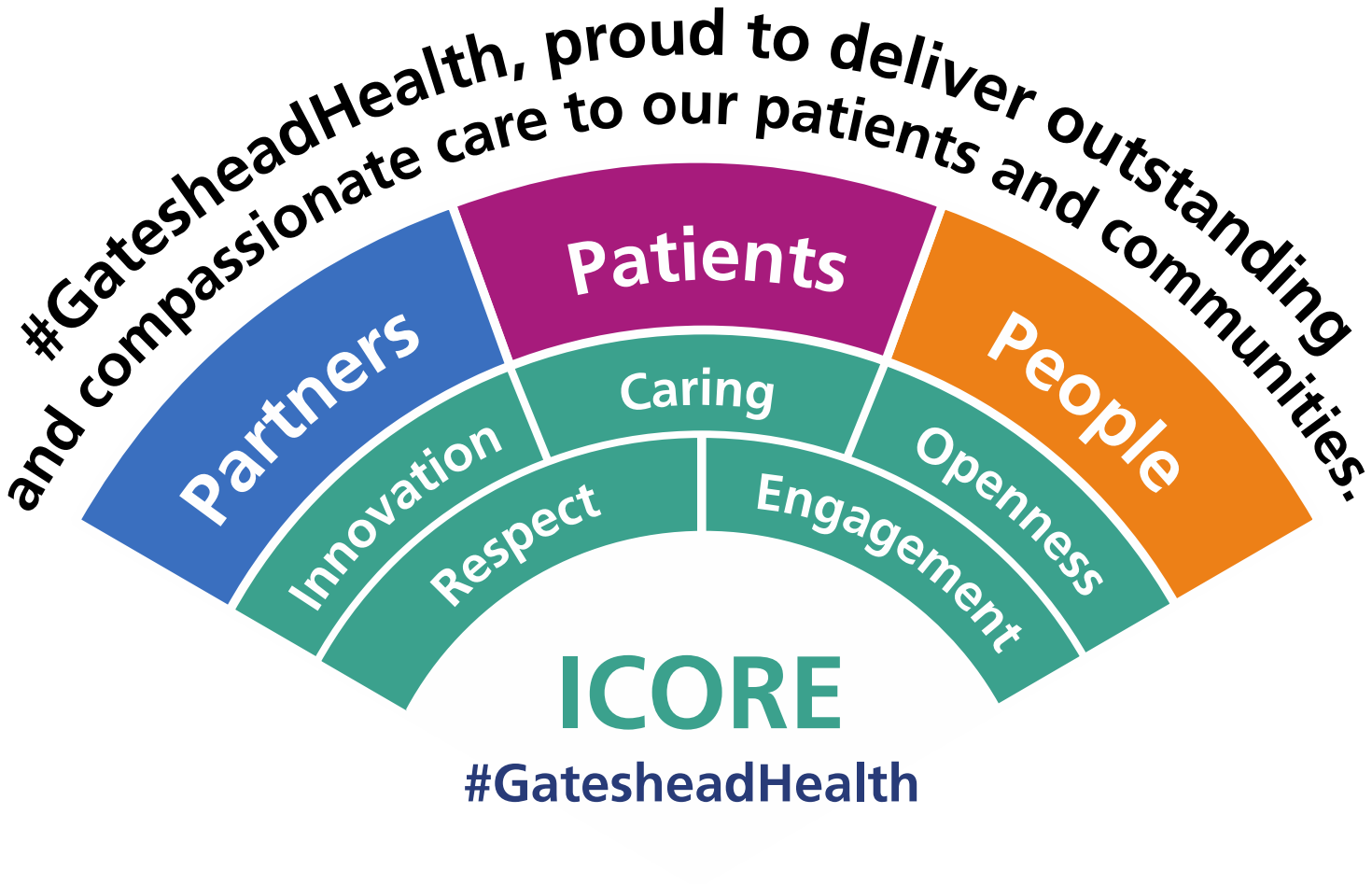
Engagement, involvement and visits:

- Provider Collaborative workforce meetings
- Great North Healthcare Alliance meetings ICS Chair and CEO workshop
- Place-based meetings
- Meetings with MPs
- Urology collaboration meetings
- Gateshead Council – partner event
- Meeting with the Royal College of Surgeons President

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

- A meeting was held with the **leaders of the Community Diagnostic Centre (CDC) project** in which the Trust has partnered with Newcastle Hospitals. The estates and preparation work continues at the Metro Centre site ahead of an autumn launch date for this important development in our diagnostic services for patients.
- Our **Community Services contract** has been extended for two years. This provides an excellent opportunity to continue to develop our place-based working with key stakeholders.
- Colleagues from our **Cervical Screening Service** hosted a mobile screening unit at the 2024 Pride in the City Festival in Newcastle. Since January 2024, the mobile screening pilot project has significantly progressed, processing around 200 samples so far. This project aims to raise awareness and improve accessibility for individuals facing barriers to screening services. This unique initiative is delivered with support from the Northern Cancer Alliance, NHS England, Roche, and the dedicated local Healthworks team. Sharon Denise Clark, Joint Lead Clinical Nurse for the service, discussed and promoted this unique service on BBC Radio Newcastle.

NHS
Gateshead Health
NHS Foundation Trust



Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 12

Report Title:	**Great North Healthcare Alliance**			
Name of Meeting:	Trust Board – Part 1 (Public Board)			
Date of Meeting:	31st July 2024			
Author:	Nicola Bruce, Interim Director of Strategy, Planning and Partnerships and other members of the Alliance Formation Team			
Executive Sponsor:	Trudie Davies, Chief Executive Alison Marshall, Chair			
Report presented by:	Nicola Bruce, Interim Director of Strategy, Planning and Partnerships			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☐	**Information:** ☒
	This paper provides an update on the ongoing work to form and develop the Great North Healthcare Alliance which brings together: • Gateshead Health NHS Foundation Trust • North Cumbria Integrated Care NHS Foundation Trust • Northumbria Healthcare NHS Foundation Trust • The Newcastle upon Tyne Hospitals NHS Foundation Trust.			
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*	This is a new report for the Board of Directors and builds on updates provided at recent meetings.			
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*	There are clear opportunities and benefits for patients from closer working, whilst recognising there are also benefits that come from each individual Trust's identity and integrity as a separate organisation. Specific areas of focus for Alliance working have been agreed, with leads from across the four organisations identified. These fall into the following categories:			

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

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

- Clinical projects and pathways;
- Professional issues and opportunities; and
- Cultural and enabling work.

We have established the Alliance with a Collaboration Agreement signed by each of the four organisations. This agreement underpins meetings of Trust Board Committees in Common to steer and govern the Alliance work plan.

There is a desire to ensure that Boards receive the same information across the Alliance. The content of this update adds to a previous update from May, which was not heard at all Trust Boards due to the timing of the announcement of the July 2024 General Election.

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

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Members of Trust Board are asked to:

- note the progress made

</td></tr>
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Trust Strategic Aims that the report relates to:

</td><td>

Aim 1
☒

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

Aim 2
☒

</td><td>We will be a great organisation with a highly engaged workforce</td></tr>
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Aim 3
☒

</td><td>We will enhance our productivity and efficiency to make the best use of resources</td></tr>
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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 strategic objectives that the report relates to:

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

The Alliance will support the delivery of 2024/25 strategic objectives including:

- SA1.2 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.
- SA1.3 Evidence an agreed strategic approach to the development of an EPR supported by a documented and timed implementation plan.
- SA2.2 Growing and developing our people in order to improve patient outcomes, reduce reliance on temporary staff and deliver the 24-25 workforce plan.
- SA3.1 Improve the quality of care delivery and accessibility for patients by meeting the locally agreed stretch standards by March 2025.

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- SA3.2 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.
- SA4.3 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’.
- SA5.1 Contribute effectively as part of the Great North Healthcare Alliance to maximise the opportunities presented through the regional workforce programme.
- SA5.2 Evidenced business growth by March 2025 with a specific focus on Diagnostics, Women’s health and commercial opportunities.

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<tr><td>Links to CQC Key Lines of Enquiry (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 – new risks, or those already recognised on our risk management system with risk reference number):</td><td colspan="5">NMQ 3089 - Quality - Risk of quality failures in patient care due to external causes such as delayed discharges and external pressures. (12)
FIN 3102 - Activity is not delivered in line with planned trajectories, leading to reduction in income (16)
FIN 3103 - Risk that efficiency requirements are not met. (16)</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>

Great North Healthcare Alliance – July 2024

Executive Summary

This paper provides an update on the ongoing work to form and develop the Great North Healthcare Alliance, which brings together:

- Gateshead Health NHS Foundation Trust;
- North Cumbria Integrated Care NHS Foundation Trust;
- Northumbria Healthcare NHS Foundation Trust; and
- The Newcastle upon Tyne Hospitals NHS Foundation Trust.

There are clear opportunities and benefits for patients from closer working, whilst recognising there are also benefits that come from each individual Trust's identity and integrity as a separate organisation.

Specific areas of focus for Alliance working have been agreed, with leads from across the four organisations identified. These fall into the following categories:

- Clinical projects and pathways;
- Professional issues and opportunities; and
- Cultural and enabling work.

We have established the Alliance with a Collaboration Agreement signed by each of the four organisations. This agreement underpins meetings of Trust Board Committees in Common to steer and govern the Alliance work plan.

There is a desire to ensure that Boards receive the same information across the Alliance. The content of this update adds to a previous update from May, which was not heard at all Trust Boards due to the timing of the announcement of the July 2024 General Election.

The Trust Board is asked to note the progress made.

<u>Overview</u>:

1. Gateshead Health NHS Foundation Trust, The Newcastle upon Tyne NHS Foundation Trust, Northumbria Healthcare NHS Foundation Trust and North Cumbria Integrated Care NHS Foundation Trust have agreed to work more closely together as a Great North Healthcare Alliance. The Trusts believe that there is huge potential to work together to deliver significant benefits to our patients and staff within our own organisations and in the wider region.

2. The overarching vision of the Alliance is to deliver:
    a) Improved patient outcomes and reduced inequalities by optimising and simplifying existing pathways and clinical services, and by jointly tackling existing service resilience issues;
    b) The best staff experience, recruitment and retention, through workforce opportunities;
    c) Pioneering innovation, transformation, research and development, maximising our academic and commercial opportunities;
    d) Greater economic, environmental and social impact, reducing health inequalities alongside clearer partnership working with local and national stakeholders; and
    e) An improved and sustainable financial position with value for public money that maximises resources for front-line care.
    f) Short-term priorities include working together to stabilise fragile clinical services to ensure that patients always have access to the best possible care. The Trusts will also explore opportunities for closer working on support services and estates/facilities management, collaborate on data collection and analysis, and share expertise in organisational development, technology, research, commercial activities and innovation.

3. Work to form and iterate closer working between the four Foundation Trusts is progressing positively. The partners have agreed guiding principles, including:

    a) Working together where it makes sense, where there is clinical leadership and agreement, and the proposed activity is supported by data and/or patient voice;
    b) The independence and interdependence between partners is recognised – with all partners retaining the autonomy to move at the pace, phasing and degree that is appropriate to them and their communities;
    c) Resources can be shared where the opportunities arise and where it contributes to achieving the overall vision; and
    d) Honest and constructive challenge will be crucial to building trust.

4. The principal focus has been to prioritise alliance working on shared areas of interest, as well as beginning to establish the ways of working that will be central to the success of the Alliance and the work that it takes forward in future.

5. This work is directed through monthly Alliance Steering Group meetings, made up of the Chairs and CEOs from the four organisations. Since the last update, all four Trust Boards agreed to establish Committees in Common across the Alliance. The first Committees in Common meeting was held on 6th June 2024. Part of the agenda for the meeting included the signing of a Collaboration

Agreement and Memorandum of Understanding, which underpin consistent Terms of Reference for each Trust Committee.

6. This is a positive step forward to demonstrate Alliance working and the collaborative nature of the relationship between our Trusts. Committees in Common are an established and externally recognised means to formalise and strengthen the governance of collaborative work. It has been established in such a way to not change the independence of Trust Boards and Governing Bodies, or the delegations, powers and authorities that Chief Executive Officers already have. Minutes of the Committees in Common will be shared with Trust Boards in the same manner as any other Board Committee.

7. This formal governance is supplemented by more regular meetings of the CEOs who in turn work with their Boards, Governing Bodies and Executive teams to input and shape the Alliance formation work. This input is central to building the momentum of alliance working, and ensuring that the views of a wide range of colleagues within the organisations is an integral part of shaping the strategy and work plan as it develops. The input from Governors and Non-Executive Directors in particular has been helpful.

<u>Areas of focus and work to date</u>

8. The main areas of focus have been to prioritise alliance working in specific areas where there is agreement that there is value to be obtained from alliance working. This emerging work plan falls into the following themes, with specific areas of work within each set out below:

   i. Clinical projects and pathways theme, including:

   a. *Paediatric services* – bringing together paediatric teams to identify opportunities to improve pathways of care between local and regional services and address capacity pressures leading to longer-term pathway improvements.
   b. *Urgent and emergency care* – examining where improvements can be made, and where best practice sharing and strengthened mutual support can best help. Aiming to improve and standardise the offer to patients, alongside improving performance overall.

   c. *Urology* - strengthening collaboration, communication and cooperation across the Alliance members to improve performance and resilience of the services as a whole. The underlying objective is to ensure equity of access to a safe, high quality services for all patients regardless of location.

d. *Obstetrics and gynaecology* – assessing and addressing challenges across the four services, with a particular focus on performance, resilience and workforce pressures.

ii. Professional issues and opportunities theme, including:

a. *Patient and staff experience* – sharing learnings to provide consistency of approach and expanding programmes.

b. Supporting *clinical, in particular medical, recruitment* and *education and training*.

c. Sharing approaches to *implementing the Patient Safety Incident Response Framework (PSIRF)*, and identifying areas for congruent thinking.

d. Sharing our *learning safety and quality expertise*.

iii. Cultural and enabling work theme, including:

a. *Corporate services* – scoping where specific resilience issues exist in trusts, and what options exist to improve and optimise services.

b. *Subsidiaries* – exploring where benefits can be achieved from closer working between subsidiaries.

c. *Working across Alliance Trusts* – exploring what practical steps can be made to make it easier to work in and with other Alliance Trusts.

<u>Developing the work plan in collaboration</u>

9. Work has been also underway to bring together Board level colleagues in similar roles across the four trust Boards to identify what should be in the Alliance work plan.

10. Peer groups of relevant executive director leads from across the Alliance have been coming together to collectively review and prioritise potential collaboration opportunities in their areas and to develop shared pieces of work.

11. Where this was not already in place informally, non-executive directors who chair Board committees in the four trusts are also linking together at the request of Trust Chairs. These discussions are intended to provide an opportunity for colleagues to build relationships across our Non-Executive teams, to generate ideas on how closer collaboration through the Alliance may lead to opportunities

relevant to their areas, and to identify any concerns or risks which may arise from the Alliance work.

12. All Board members were invited to attend a Great North Healthcare Alliance leadership event on 2nd May. This event intended to bring together colleagues from all four Trust Boards as a positive, forward-looking session to strengthen team working and further establish the Alliance work plan.

Recommendation

13. The Trust Board is asked to:

i. Note the progress made.

Nicola Bruce
Interim Director of Strategy, Planning and Partnerships

9th July 2024

Note paper jointly prepared by the Great North Healthcare Alliance Formation Team: Martin Wilson, Newcastle; Nicola Bruce, Gateshead; Stephen Park, North Cumbria; and Andrew Edmunds, Northumbria

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 13

Report Title:	**Integrated Care Board Quality Strategy**			
Name of Meeting:	Board of Directors			
Date of Meeting:	31 July 2024			
Author:	Gill Findley, Chief Nurse and Deputy Chief Executive			
Executive Sponsor:	Gill Findley, Chief Nurse and Deputy Chief Executive			
Report presented by:	Gill Findley, Chief Nurse and Deputy Chief Executive			
Purpose of Report	**Decision:** ☐	**Discussion:** ☒	**Assurance:** ☐	**Information:** ☐
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☐ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☒
Paper previously considered by:	Executive Management Team			
Key issues:	The ICB has developed a Quality Strategy and has requested comments prior to the launch of the strategy in September 2024. The strategy has 5 strategic themes: • Culture • Patient Safety • Clinical Effectiveness • Multi Professional Leadership • Positive Experiences The strategy tells us that the ICB is expecting to set the required standards for quality of care in all sectors. They expect to set out a clear governance framework and have clear accountability arrangements for providers, including use of a self-assessment tool for providers. It is expected that any changes to services within systems will be coproduced with patients and the public. The ICB has a role in sharing learning and embedding best practice across all provider organisations. The strategy also fits well with the strategy that we have within the Trust and does not contradict any of the work we have underway in this area.			
Recommended actions for this meeting:	Board of Directors is asked to note the content of this paper for discussion.			

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)	None				
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒		

NHS
North East and North Cumbria

ICB Quality Strategy

David Purdue

Quality Strategy headlines

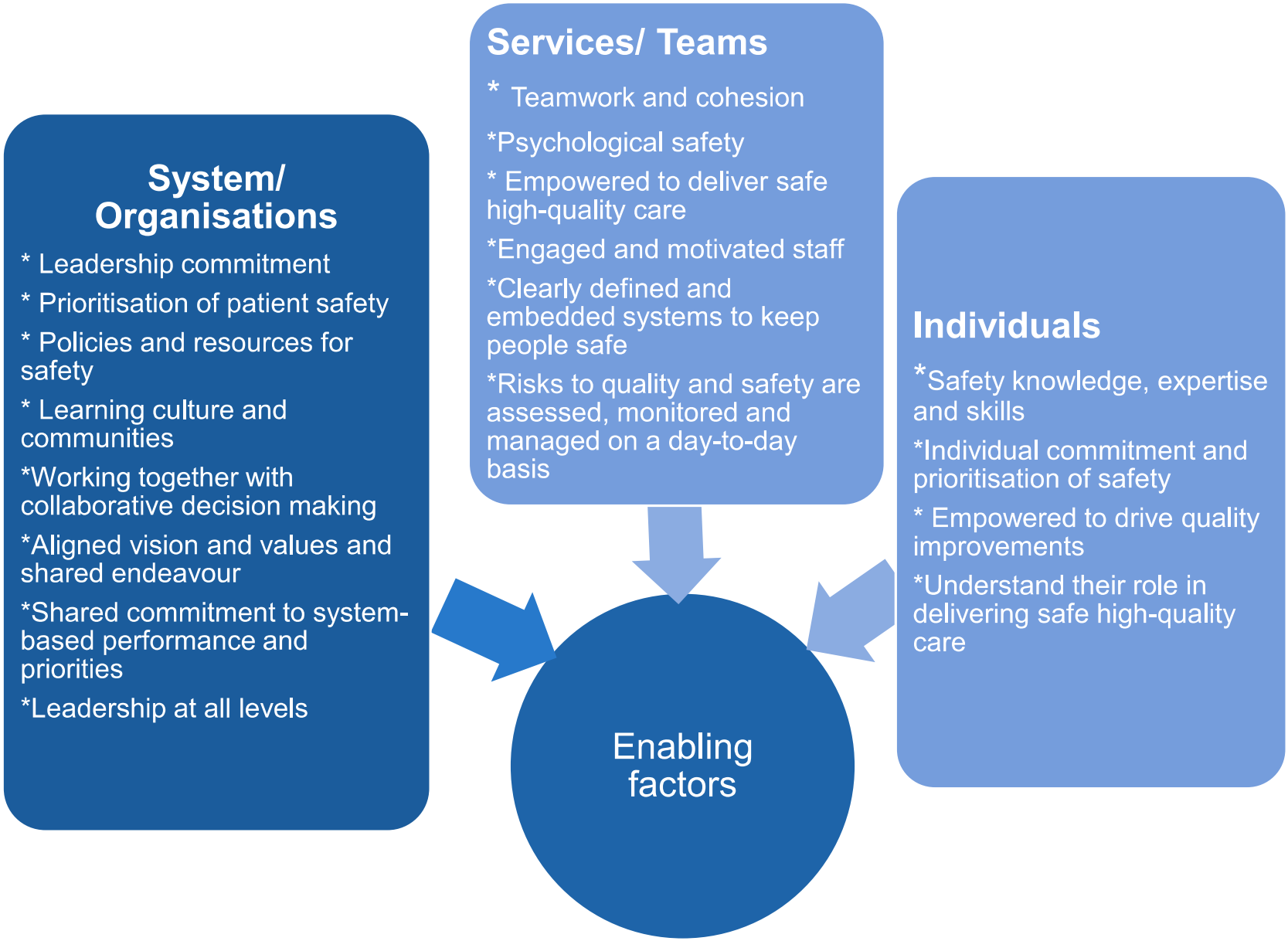
- Quality strategy underpins our ICB strategy, Better health and wellbeing for all
- Link between health inequalities and avoidable harm
- Five strategic themes to enable us, as a system to continue to improve and be ‘the best at getting better’
- Culture and Climate are key
- Focus on what it means for our citizens and what it means for our system
- Working together across the system

Our Strategic Themes

Culture and Climate

- Culture matters
- Safety and high-quality care needs to be a priority for all
- Enabling factors and enacting behaviours that will help us to build a safer culture
- We will adopt the following principles:-
  - Professional Curiosity
  - Just Culture
  - Freedom to speak up
  - NHS People promise
  - Equality, diversity and inclusion
- Tackle closed cultures

Creating the culture



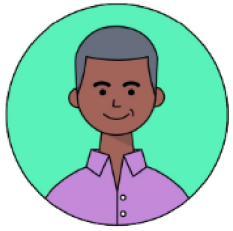
I/ we statements- enhancing people's experience of care

I statements:

- help people understand what a good experience of care looks and feels like
- They reflect on what people say matters to them

We statements:

- highlight the collective efforts of individuals, teams, services, organisations and the system in fostering a culture of unity, mutual respect, and shared responsibility in delivering high-quality care.
- From a CQC perspective; the standards against which they hold providers, LA's and ICSs to account



‘I’ statement: When I move between services, settings or areas, there is a plan for what happens next and who will do what, and all the practical arrangements are in place.

‘We/quality’ statement: We work in partnership with others to establish and maintain safe systems of care in which people's safety is managed, monitored and assured, especially when they move between different services.

Patient Safety

Patient safety

- Safety is a priority for everyone with a clear commitment to improve safety.
- We will embed processes and systems across the ICS that promotes high quality, safe and effective care.
- We foster a culture of openness, transparency and learning to improve safety for people.
- Care across the system is delivered in a way that minimises things going wrong and maximises things going right.
- We will recognise and celebrate outstanding health and care so we can learn when things go well and when things have not gone well.
- We identify risks and use these as an opportunity to put things right, learn and improve.
- We will consider the impact of health inequalities on patient safety and identify actions that reduce the risks of harm.

What this means to our citizens

- I feel safe and am supported to understand and manage any risks.
- If something goes wrong, I will be supported in an open and honest way and will receive an apology.
- I understand the service recognises when things haven't gone well and uses these to improve the service.
- I am cared for by staff who have the skills and experience to support me.
- I am empowered to be a partner in my care and staff understand my individual needs that promotes my safety.
- I know staff understand my specific needs and vulnerabilities; they tailor care that promotes and delivers better outcomes for me, and that reduces the risk of avoidable harm.

What this means for the system

- We have a culture of safety and learning where staff can raise concerns, these are investigated and learning opportunities are identified.
- There is an environment where we can share learning across organisational boundaries.
- We can demonstrate improvements have been driven across the system that improves people experiences of care, reduces variation and health inequalities.
- We deliver care to meet the individual needs of people, that improves outcomes by reducing disadvantage and the risks of avoidable harm.
- We have encompassed human factors to underpin our approach to patient safety and quality improvement.
- The approach to the patient safety incident response framework across the system has been embedded.
- We have established and developed our communities of practice.
- Staff understand their role and responsibilities in delivering safe care and contributing to quality improvements.

Clinical Effectiveness

Clinical Effectiveness

- Across the system people receive the right care, at the right time, in the right place.
- We will adopt and share evidence-based practices to the care and treatment people receive.
- We will use data and intelligence to drive improvements to ensure effective high-quality care.
- We will measure and publish quality-measuring what matters to people, monitoring quality and safety consistently and use data to inform decision-making.
- We will set clear standards for what high quality care and outcomes look like based on what matters to people and communities.
- We ensure there's co-ordination of services across the system, that considers the needs and preferences of different people, including those with protected characteristics and those at most risk of a poorer experience of care.
- We are alert and responsive to health inequalities, and social determinants of health which may lead to poorer outcomes and premature deaths.

What this means to our citizens

- I have care and support that is co-ordinated, and everyone works well together and with me.
- I am empowered to get the care, support and treatment that I need.
- I know my care is the most effective it can be and is in line with recognised standards.
- I know the services that care for me, are working together to ensure I receive high quality care.
- When I move between services, there is a plan for what happens next, and all the arrangements are in place.

What this means for the system

- We have systems to use data, intelligence and knowledge to inform our decision making.
- Our clinical conditions strategic plans are improving outcomes for people and reducing variation and health inequalities.
- We are staying ahead by embedding research and adopting innovation to ensure progressive high-quality care across the system.
- We have a quality improvement methodology to support our improvement work across the system.
- We design services to meet the needs of our diverse population by promoting equitable access, excellent experience and better outcomes for all, that reduce disadvantage, and the risks of avoidable harm.
- Staff keep up to date with best practice, by delivering care that optimises people's health and improves patient experience and outcomes.

Positive Experiences

Positive Experiences

- We make it easy for people to share feedback and ideas or raise complaints about their care, treatment and support.
- We involve people in decisions about their care and tell them what's changed as a result.
- We actively seek out and listen to information about people who are most likely to experience inequalities in experience or outcomes.
- Services across the system are designed by what matters to people, that empowers them to make informed choices and is delivered with compassion, dignity and respect.
- We will co-produce with people with 'lived-experience' as they are often best placed to advise on what support and services will make a positive difference to their lives

What this means to our citizens

- I have care and support that enables me to live as I want to, seeing me as a unique person with skills, strengths and personal goals.
- I am supported to manage my health in a way that makes sense to me.
- I am involved in decisions about my care.
- My feedback was taken seriously, and I know what changes have been made as a result.
- I felt that my voice was heard and that I was listened to and understood.
- I am encouraged and enabled to feedback about my care in ways that work for me, and I know how it was acted on.
- My individual needs and preferences are understood, and these are reflected in my care, treatment and support, and takes account of my personal, cultural, social and religious needs.

What this means for the system

- We listen to people's views and experiences, and they are seen as an integral part of our quality improvement work.
- We use people's experiences as a central component to quality assurance and identification of risk.
- We recognise people's experience could be early warning signs of poor care.
- We understand the diverse health and care needs of people and our local communities, so care is joined-up, flexible and supports choice and continuity.
- Our patient and public involvement strategies are embedded into our work across the system.
- Staff understand their role in supporting and empowering people to make informed decisions about their care.

Clinical and Multi-Professional Leadership

Clinical and Multi-Professional Leadership

- We will be driven by collective and compassionate leadership which champions a shared vision, values, and learning, delivered by accountable organisations and systems.
- We have inclusive leaders at all levels who understand the context in which we deliver care, treatment and support and embody the culture and values of the system.
- Clinical and care professionals are involved in all aspects and every level of system decision-making.
- We have a transparent approach to identify and recruit leaders that promotes equity of opportunity, that also recognises the different kinds of leadership styles required, when working across professional and organisational boundaries.

What this means to our citizens

- When I receive care, services meet my needs and that of the wider community, and all leaders and staff support this.
- I will be involved in designing services and my feedback is heard and valued by leaders in the system.
- I am confident leaders and staff are able to identify poor care and address this quickly.
- I know that staff and leaders with the right skills and experience are making decisions about care services.

What this means for the system

- We have high-quality leadership throughout the system which is sustained through safe, effective and inclusive recruitment and succession planning.
- Our leaders are skilled and confident and can contribute effectively to quality improvement.
- We are alert to examples of poor culture that may affect the quality of people's care and have a detrimental impact on staff and our leaders address this quickly.
- We have embedded leadership strategies and development opportunities within the system.
- Leadership is front and centre of system and service delivery; all staff understand their role and contributions to delivering high quality care.

Working together to deliver Quality

How we will do this together?

As an ICB and commissioner

- Set clear quality standards and expected outcomes when commissioning as part of quality and performance management.
- Developed the system as the 'best at getting better' with established communities of practice.
- Have clear governance frameworks for quality.
- Quality assurance gives a clear and accurate picture of safety, and there are steady improvements in safety over time.
- Develop a positive safety culture that is embedded at all levels of the system.
- Work together across the system to ensure seamless pathways between services that focus on delivery of high-quality care.
- To co-produce with communities to shape services to meet their needs.
- Share learning, best practice, and innovations across the system to influence and improve the quality of services.
- We have consistency in approaches which leads to more standardised practices in services.

For people and communities

- People in our communities know what good care looks like, what they have a right to expect, and what to do when their experience doesn't meet expectations.
- People are partners in their care and are supported in making decisions about the care they want to receive.
- People have care that is personalised, and they are treated with dignity and respect.
- People's voices are heard, listened to, and understood and feedback is used to drive improvements in quality.
- People are included in reviews and contribute to improvements in care.

For all health and care providers

- Experience a coherent system of quality assurance and performance management.
- Are accountable for the quality of care they provide, and driving quality improvements which translates into improved health outcomes.
- Care is co-ordinated across services, organisations and the system and they work collaboratively to meet people's needs.
- Support the system to continually improve and maintain quality and safety standards.
- Work as system partners and understand their role in improving health outcomes, reducing variation and health inequalities.

For all staff

- Staff are seen as partners in delivering safe high-quality care,
- Staff feel safe and confident to speak up without fear of retribution.
- Staff are supported to learn and make improvements to care at every level of the system.
- Staff are engaged and motivated to develop and drive improvement plans.
- Staff are supported to learn and develop to embed quality and safety practices in their everyday work.

Our Quality Strategy foundations and next steps

Culture and Climate

Strategic theme

Culture and climate

Foundations

*Established FTSU processes across the ICB
*ICB assessment of FTSU processes in NHS trusts
*Adoption and implementation of NHS People promise/ Just culture.
*Quality assurance tools developed for some services with specific prompts around closed cultures.
*Recognise the need for clear values and behaviours both within the ICB and across the system
*Closed cultures highlighted as a strategic quality priority.
*Intelligence sharing between stakeholders

Next steps

*Clear set of values and behaviours for the ICB as an organisation and the wider system.
*Review of tools for both commissioning and quality assurance to ensure they include key culture prompts.
*Staff at all levels, regardless of role understand their roles and responsibilities.
*Learning packages about culture/ closed cultures for all staff in the system.
*Staff at all levels understand the inherent risk factors and warning signs of a closed culture.
*Cultural assessment of the system against the 37 features of an open culture and develop culture metrics .
*Develop system wide plan to tackle closed cultures.

Patient Safety

Strategic theme

Patient Safety

Foundations

*Concept developed for our patient safety centre.
*Development and implementation of the ICB PSIRF policy and approach. This includes:-
*Support to organisations and sign off PSIRP plans,
*Training and development including raising awareness, patient safety specialist training and patient safety partner identified and agreed.
*System wide never event deep dive
*System approach identified to the implementation of Martha's rule.
*Data and intelligence monitoring information available for the ICB.

Next steps

*Launch of our patient safety centre in September 2024; the centre will be our focal point to drive patient safety improvements.
*Develop the ICB and system wide patient safety framework.
*Roll out of PSIRF training for all staff, existing patient safety specialists to complete training, approval of the model for patient safety specialists, and learning support specialists.
*Specific learning and improvement sessions starting with never events and sepsis.
*Development and embedding communities of practice.
*Patient safety improvement plans developed, identified by people's experience, data and intelligence.
*Further enhancements to data and intelligence monitoring to incorporate people's experiences.
*Enhance routine reporting requirements for all commissioned services as part of contracts.

Clinical Effectiveness

Strategic theme

Clinical Effectiveness

Foundations

*Clinical conditions strategic plans for adults and children developed.
* NENC healthy and fairer programme including:- prevention, health inequalities and broader social and economic determinants.
* Part of CQC stakeholder forum for the development of the health inequalities self-assessment.
*Women's health conference/ collaborative
*Development of clinical effectiveness committee within the ICB
*Medicine optimisations
*Monitoring of mortality themes and trends.
*Quality improvement methodology approach being developed.

Next steps

*Launch our clinical conditions strategic plans with monitoring of progress.
*Programmes from healthy and fairer including :- tobacco, CORE20PLUS5, and poverty proofing.
*Women's health innovation conference July 2024
* Quality improvement methodology developed and used as part of our quality improvement work

Positive Experiences

Strategic theme

Positive Experiences

Foundations

*Patient and public engagement ongoing work
*Healthwatch- programme of activities
*ICB- complaints management
*Ongoing monitoring of patient experience surveys including CQC.
*Work with voluntary sector groups
*Assessment tool developed to assess the quality of provider complaints systems.
*National learning from the resuscitation council on outcomes for people in our communities.
*In response to patient feedback, identified a need for further work to support those waiting for a CAMHS appointment.

Next steps

*Continue to gather and learn from people's experiences to improve quality of care
*Quality of complaints to be part of quality assurance framework for commissioned services.
*Roll out of restart a heart campaign to targeted groups/ places to tackle health inequalities.
*Develop a practical waiting well approach to support people waiting for CAMHS.

Clinical and Multi-Professional Leadership

Strategic theme

Clinical and Multi-Professional Leadership

Foundations

*Clinical and Multi-professional leadership framework developed.
*System leadership group established across the system.
*Senior leaders meetings/ forums within ICB
*Clinical and Multi-professional leadership framework - wider engagement to take place on the framework.
Boost our learning community offers leadership development to be effective convenors of system change.
*AHP council established

Next steps

*Clinical and Multi-professional leadership framework - wider engagement to take place on the framework.
*Self-assessment/ gap analysis to be undertaken.
*Decision making map to be developed - to show how clinical leaders are involved in every level of decision making.
*Learning and development needs to be reviewed- including generic and profession specific.
*System leadership development at every level.

Quality Governance framework

Quality Governance framework

Foundations

*Quality assurance and monitoring; developing a consistent approach across the ICB- pilot tools developed.
*Standardised tool developed to support assessment of complex care caseload and responsive safety assessment tool.
*System Equality and Quality Impact assessment policy developed including equality and health inequalities- pilot of tool being undertaken.
*Internal audit in relation to governance of commissioned services.
*Independent investigation reports reviewed, and thematic analysis completed of ICB recommendations.
*Some policies identified as requiring updating- tools developed and process established to review all ICB policies.
*Incidents and risk registers- gaps in assurance identified.
*Quality governance meeting proposal developed- engagement started.

Next steps

*Quality assurance and monitoring of commissioned services; developing a consistent approach across the ICB- programme to develop tools for all service types.
*Independent reviews- Key themes identified and plan to be developed to identify actions/ action owners.
*Training and development for all staff about governance.
*Overarching improvement plan linked to audit plan to improve quality governance arrangements and how this correlates with corporate governance.
*NHSE ICS quality functions- Self-assessment tool developed to assess our compliance with the quality functions, this needs to be undertaken.
*Self-assessment against CQC standards- tool to be developed for Key ICS quality statements and also CQC well-led framework for NHS trusts.

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 14

Report Title:	**Response to NHS England letter on maintaining quality of care and experience in pressurised services**			
Name of Meeting:	Board of Directors			
Date of Meeting:	31.7.24			
Author:	Gill Findley, Chief Nurse and Deputy Chief Executive Jo Halliwell, Group Chief Operating Officer			
Executive Sponsor:	Gill Findley, Chief Nurse and Deputy Chief Executive			
Report presented by:	Gill Findley, Chief Nurse and Deputy Chief Executive			
Purpose of Report	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☒ *No gaps in assurance*	**Partially assured** ☐ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by:	Executive Management Team			
Key issues:	Following the letter received on 26.6.24 (National reference PRN01417) in relation to maintaining focus and oversight on quality of care and experience in pressurised services; the Chief Nurse and Head of Nursing visited all ward areas where care could be provided out with the core bed compliment. They have provided assurance in relation to: • Maintenance of privacy and dignity • Toileting • Pressure area care • Medication administration • Provision of food and drink • Access to an emergency supply of oxygen and an emergency trolley All staff were aware that these areas were only to be used in times of extreme pressure as directed by the full capacity protocol or by the strategic / tactical on call manager. It is the ambition of the Trust that patient flow improvements across the system would make the requirement for invoking additional capacity usage redundant.			

<table>
<tr><td></td><td colspan="6">It is recommended that the provision of domestic services into the early evening is reviewed as better cover would support moves to happen earlier in the day.</td></tr>
<tr><td>Recommended actions for this meeting:</td><td colspan="6">Board of Directors is asked to note the content of this paper for assurance.</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:</td><td>Aim 1
☒</td><td colspan="5">We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>Aim 2
☐</td><td colspan="5">We will be a great organisation with a highly engaged workforce</td></tr>
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☐</td><td colspan="5">We will develop and expand our services within and beyond Gateshead</td></tr>
<tr><td>Trust corporate objectives that the report relates to:</td><td colspan="6"></td></tr>
<tr><td>Links to CQC KLOE</td><td>Caring
☒</td><td>Responsive
☒</td><td>Well-led
☒</td><td>Effective
☒</td><td colspan="2">Safe
☒</td></tr>
<tr><td colspan="7">Risks / implications from this report (positive or negative):</td></tr>
<tr><td>Links to risks (identify significant risks and risk reference)</td><td colspan="6">XXX</td></tr>
<tr><td>Has a Quality and Equality Impact Assessment (QEIA) been completed?</td><td colspan="2">Yes
☐</td><td colspan="2">No
☐</td><td colspan="2">Not applicable
☐</td></tr>
</table>

1.0 Introduction

On 26 June 2024, the Trust received a letter from NHS England Medical Director and Chief Nurse, entitled “Maintaining Focus and Oversight on Quality of Care and Patient Experience in Pressured Services”. Following the Channel 4 Dispatches programme highlighting some very poor care filmed in the Emergency Department at the Royal Shrewsbury Hospital, the letter asked Trusts to review the quality of care provided during times of pressure. The Chief Nurse and Head of Nursing have visited the areas where care may be provided out with the core beds and which are in alignment with our agreed internal escalation protocols. The arrangements for providing care in these areas was discussed with staff. This paper aims to give assurance about the care being provided with Gateshead Health NHS Foundation Trust in times of pressure.

2.0 Current Processes

2.1 Emergency Department

Our emergency department staff work hard to provide the best possible care in very challenging circumstances. We aim to move patients through the department in as short a time as possible whilst delivering the care that is needed. The Trust takes a balance risk approach to care where there is a dynamic risk assessment of the risks not only to patients directly within our care, but also to undifferentiated patients waiting at home for support from our ambulance service.

The emergency department has a series of “pods” each of which have a separate nursing compliment. It is not unusual for all the rooms within the emergency department to be full. In these circumstances a number of options are available to staff to use for patient care depending on the needs of the patient:

- the main waiting area within the emergency department
- the directly observed seated area within the emergency department
- Ambulance handover corridor within the emergency department
- Full Capacity Protocol – Trust wide

2.1.1 The main waiting area

The main waiting area is used primarily for patients who have not yet been seen. The area can be observed by staff in the reception area and there is a good flow of staff through the area to observe patients. The whole area is covered by CCTV, which is constantly observed by the ED coordinator. Occasionally, when a patient has been seen and discharged, but is waiting for transport they may be asked to wait in the main waiting area. There are toilets and water available in the area, with vending machines for hot drinks.

2.1.2 The Observed Sitting Area

This area is sometime referred to as the “fit to sit” area. It is an open area between 2 pods. There is direct line of sight from the ED coordinators desk and it is a thoroughfare so that patients can be observed while they wait. Patients are only asked to wait here when they are able to walk to the toilet unaided or where they have a carer with them who can call for assistance. The seats are fixed and no trollies are allowed in this area as they would obstruct

staff movement. There are toilet facilities easily available and privacy and dignity is maintained due to the nature of patients using this area.

2.1.3 Ambulance Handover corridor

There is a short corridor immediately to the right of the ED coordinators area. When a large volume of ambulances arrive in the department or if the rooms are all full, a dynamic risk assessment is undertaken and this area may be used to ensure ambulance handovers happen in a timely manner.

The corridor is shown in the photograph below. The area has been set up with 5 trollies and a number of wheelchairs. Each of the trollies is screened from the next and oxygen, suction and a resuscitation trolley is available within the area. At the far end of the corridor there is a bereavement room, which is used in the event that someone on one of the trollies needs toilet facilities. The patient would be wheeled into the room and left to use a bottle or bedpan whilst maintaining their privacy and dignity. When any patients are in this area Registered Staff are allocated to provide for their care needs. Medications and food and drink are provided in this area as required by the staff allocated. If required pressure relieving mattresses can also be provided.

2.1.4 Full capacity protocol

Where the emergency department is full and clinical care is compromised. A risk assessment will be undertaken to look to decompress the department. One option that is available to the teams is to enact the full capacity protocol. This is a prescribed set of actions which can be invoked to move patients who require an admission into the body of the hospital – this may result in patients waiting for a bed within the ward environment which is not yet available. The Chief Nurse and the Head of Nursing have visited each ward area to discuss the arrangements for the full capacity protocol.

2.2 Emergency Admissions Unit

The main areas where this would happen is the emergency admissions unit (EAU) and Ward 21 (trauma). EAU has an escalation bed that would be the first option for a patient awaiting a bed. This is in a single room but does not have an ensuite toilet. If this area is full patients will be nursed in the corridor area on a trolley or seated in a wheelchair. Staff report that it is very unusual for this to happen for longer than 2-3 hours. The staff will make a dynamic risk assessment of the patients on the ward to decide whether it is safer to nurse the patient to be admitted on the corridor or whether it is safer to move a patient out of a room who is about to be discharged / admitted to another ward. Patients in the escalation area or on the corridor use the ward bathroom / toilet. Staff are allocated to care for any patients on the corridor/escalation area from the ward compliment. As all other rooms are en suite, this provides a good standard of care in the circumstances.

Staff identified that a patient who needed a pressure relieving mattress could not be nursed on the corridor as there is nowhere to safely access a power supply. Such patients would be prioritised for movement into a room immediately.

The staff identified that provision of domestic services in the evening is a potential problem. The domestics are not available from 3-4pm and from 5-6pm as they are engaged in delivering the meal service. This is often the peak time for discharges and staff reported that there is frequently a waiting time for rooms to be cleaned before patients can be moved into empty rooms.

2.3 Surgical areas

The main surgical area that would be affected by the full capacity protocol is ward 21, which takes the trauma admissions. Ward 21 has an MDT room that was previously a 2 bed bay. It has oxygen and suction and curtained areas for 2 beds. If the full capacity protocol is enacted, furniture is removed from the area and beds are added. At the time of the Chief Nurse's visit, the area was in use with a patient who was awaiting admission. A toilet is designated for use of patients in this area. Oxygen and suction is available in the area and staff are provided from the ward compliment. Food and drinks are provided along with the rest of the patients and pressure area care can be provided whilst maintaining dignity and privacy.

Ward 26 and 27 both have all single rooms. When full capacity protocol is enacted patients have to wait in the reception area. Staff informed the Chief Nurse that they are never in this area for longer than 2-3 hours. The area is open but is in full view of the reception desk and so the patients would be easily observed. Food and drink and medications would be

provided as for all other patients, pressure area care and toileting for anyone on a trolley would be performed in the ward bathroom, which again, would only be used for these patients, so provides a good level of privacy and dignity. There is no oxygen and suction available in the immediate proximity, but both wards have an emergency trolley that is wheeled to the area as necessary. The staff who will be receiving the patient are allocated to care for the patient and to apologise for the fact that they are being cared for in an open area.

Both wards mentioned that there is only 1 domestic for both wards after 3pm and this does cause delays in getting patients into their allocated rooms.

2.4 Medical areas

Wards 8 (cardiology) and ward 9 (respiratory) are excluded from the full capacity protocol because of the nature of their patients and the relative risk factors which preclude the use of these wards as part of the full capacity protocol. In the other medical/care of the elderly areas there is a combination of the use of day rooms and using space near the nurses' station. Each of the wards confirmed that food and drink and medications would not be an issue and that a Registered Nurse is always allocated to care for the patient(s). The risk assessments undertaken frequently results in a patient who is about to be discharged being moved out of a bed and the new patient being admitted. This raises the issue of why the discharge lounge is not being used for these patients

3.0 Flow Challenges and improvement focus

Clearly the use of the full capacity plan and the nursing of patients out with standard ward accommodation is an artifact of poor patient flow and a capacity / demand imbalance which cannot be met.

As a consequence there are a number of pieces of work which are being undertaken to improve flow both within the hospital and at system level. These include

- Focus on reducing the number of patients who do not meet the criteria to reside
- Improving the processes associated with pathway 1 and 2 discharges linked to more collaborative working with system partners
- Development of a transfer of care hub within Gateshead place
- Implementation of condition specific discharge pathways linked to stroke / trauma & orthopaedics
- Identifying and embedding a series of pre agreed actions which are undertaken linked to the Gateshead Escalation Level to prevent further worsening of the flow position

These are part of the continuous improvement workstream in collaboration with system partners and is led by the Director of Operations for Medicine and Community Services and is supported by the Strategic System Lead – Transfer of Care (a joint post funded by both the Trust and Local Authority).

4.0 Summary

The Chief Nurse and Head of Nursing have visited the areas that are used in times of extreme pressure. They are assured that there are suitable arrangements to cover:

- Maintenance of privacy and dignity
- Toileting
- Pressure area care
- Medication administration
- Provision of food and drink
- Access to an emergency supply of oxygen and an emergency trolley

All staff were aware that these areas were only to be used in times of extreme pressure as directed by the full capacity protocol authorised by the strategic / tactical on call manager.

The ambition of the organisation is that we have sufficient flow across the system that the need to invoke our Full Capacity Plan is rendered redundant.

It is recommended that the provision of domestic services into the early evening is reviewed as better cover would support moves to happen earlier in the day.

Gill Findley

Chief Nurse, Professional Lead for Midwifery and Allied Health Professionals and Deputy Chief Executive

Jo Halliwell

Group Chief Operating Officer

5.7.24

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 15

Report Title:	**Paediatric Audiology CQC IQIPS Accreditation**			
Name of Meeting:	Board of Directors			
Date of Meeting:	31.07.24			
Author:	Gill Findley, Chief Nurse, Professional Lead for Midwifery and AHPs and Deputy Chief Executive			
Executive Sponsor:	Gill Findley, Chief Nurse, Professional Lead for Midwifery and AHPs and Deputy Chief Executive			
Report presented by:	Gill Findley, Chief Nurse, Professional Lead for Midwifery and AHPs and Deputy Chief Executive			
Purpose of Report	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☐	**Information:** ☒
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☒ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by:	Executive Management Team			
Key issues:	The Trust received a letter from the CQC into the organisation detailing some steps expected to be taken by Trusts to improve audiology services. Unfortunately this letter was not received via the usual communication channels and the deadline for response was missed. A gap analysis against the IQIPS standards has now been completed and the Trust is 67.5% compliant. In order to achieve a greater compliance level there would need to be significant investment in staffing and estates. The Executive Team recommends that we continue to strive to achieve the standards where that is possible within the constraints of the estate and qualified staff that we have within the service. This is a similar position to our regional colleagues. The Trust is continuing to engage with the regional and national incident management programmes led by the ICB and NHS England.			
Recommended actions for this meeting:	Board of Directors is asked to note the content of this paper for information and that progress will be monitored at the Safe Steering Group. Any lack of progress will be escalated to Quality Governance Committee.			
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:	All are relevant				
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 Inphase reference)	4491 – Risk of non-compliance with paediatrics hearing service guidelines				
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐	**No** ☒	**Not applicable** ☐		

Gateshead Health NHS Foundation Trust

Paediatric Audiology – CQC IQIPS Accreditation

1.0 Introduction and Background.

Board of Directors has previously been made aware of potential failings in the paediatric audiology service via the reportable issues log. The internal Trust action plan and monitoring arrangements have been discussed at Quality Governance Committee with the ICB in attendance.

We have neem made aware of a letter from the CQC that was sent to Trusts in April outlining the CQC view that discussed the CQC's plans for monitoring audiology services. The letter states that the UKAS IQIPS (Improving Quality in Physiological Services) accreditation is the only recognised accreditation for services and that Trusts are strongly encouraged to participate in this accreditation scheme. The letter states that participation in the scheme will be "used as evidence to inform the CQC's judgements about the safety and quality of care". In the letter the ICB is also asked to ensure that there is oversight of quality monitoring tools within Trusts. The letter asks that Trust Boards should consider the assurance that they have about the safety, quality and accessibility of children's hearing services. A report should then be submitted to the CQC that confirms:

- Whether you have achieved IQIPS accreditation, including whether there were any improvement recommendations made.
- Whether you are working towards IQIPS accreditation.
- What stage that work has reached and the assurance the board has about paediatric audiology, using the IQIPS standards as a guide for the areas to tell CQC about.
- The expected timeline for gaining accreditation.
- The number and severity of incidents where a child has suffered detriment due to delayed or missed diagnosis or treatment or not received timely follow up care and support.

The letter requires a response by 30th June 2024. As we did not receive the letter via the usual route this deadline has been missed. We have made contact with the CQC and explained the position and that we will submit our report as soon as possible after the Board of Directors meeting on 31.07.24.

2.0 Progress to date

Gateshead Heath NHS Foundation Trust, does not have the IQIPS accreditation. Attached is a gap analysis completed by the service that shows that we are currently 67.5% compliant with the standards set out in the IQIPS accreditation self- assessment. Many of our regional colleagues are in very similar positions.

The document shows that a realistic timeframe for achievement of the standards is between 4 and 5 years as it involves a significant amount of staff training and capital building. There is a significant cost associated with the IQIPS accreditation with the accreditation visit itself

costing in the region of £45k. it is also noted that some providers who already have the IQIPS accreditation were identified as having significant concerns in relation to their services following the recent reviews.

The CQC has asked that services that do not have the IQIPS accreditation should make a suitable entry on their risk register. This has been completed and is risk number 4491.

Quality Governance Committee received the original information in relation to paediatric audiology non-compliance following a peer review and the committee has received an internal action plan. This action plan did not aspire to reach IQIPS accreditation as it was not felt to be necessary at that time. The internal action plan continues to be monitored at Quality Governance Committee and also forms part of the regional oversight and monitoring arrangements with the ICB and NHS England. They are satisfied with our progress in making the necessary improvements to paediatric audiology services.

The Trust is now part of a formal incident management response being coordinated by the ICB in relation to paediatric audiology services. We are awaiting the opinion of a subject matter expert in relation to whether any children require further investigation. Oncer we have further details they will be shared with Board and any affected families.

3.0 Recommendation

In light of the significant cost associated with the IQIPS accreditation and the lack of assurance that it will cover all the required improvements necessary. It is recommended that the Trust should respond to the CQC outlining the current compliance level as 67.5% compliant. Also, that we will continue to try to implement the standards and will work with the regional and national monitoring regimes to determine whether further work and investment is recommended to achieve the IQIPS accreditation.

Gill Findley

Chief Nurse, Professional Lead for Midwifery and Allied Health Professionals and Deputy Chief Executive

24.07.24

Gateshead Health
NHS Foundation Trust

Paediatric Audiology – CQC Assurance and IQIPS

Following receipt of the letter from CQC received 8th April, this paper sets out Gateshead Health Audiology Service's response to the requested information.

IQIPS Accreditation

Gateshead Audiology Paediatric and Adult services are not IQIPS accredited and are not currently working towards accreditation.

We are working collaboratively with NENC ICB to achieve agreed actions to address the concerns raised through the National Paediatric Service Improvement Programme as a priority before progressing towards accreditation. It is unclear whether we will be required to undertake a 5-year look-back exercise until we receive feedback from Subject Matter Experts following a review of our initial cohort. This will be a resource intensive exercise to complete and will need to be our priority.

Evidence-based assessment

We have undertaken a benchmarking exercise against the IQIPS Quality Standards with full assessment located in (Appendix 1).

In summary we are currently achieving 67.5% of the standards.

We will continue our collaborative approach with NENC Audiology Group to address the gaps identified and identify those actions that can adopt a system-wide approach and reduce workload.

Timeline for expected accreditation

A realistic timeframe for achieving IQPIS accreditation is 4-5 years. This is based upon the significant ask both for finance and associated resources to become an accredited service. Audiology services are significantly stretched with workload and workforce pressures in balancing the requirement to reduce backlogs and associated long waiting times, whilst working to complete our service improvement action plans. We would require dedicated staff to achieve accreditation so that we do not deplete qualified audiologist capacity which would require investment to recruit. We are developing our estates plan to relocate our facilities from 2 sites into 1 which will allow us to address some of the quality standards which will also support accreditation.

UKAS
A world of confidence

Appendix 1.

IQIPS v 2.1 2023 GAP ANALYSIS REQUIREMENTS

1. Introduction

Any Physiological Sciences Service(s) wishing to gain UKAS accreditation will need to demonstrate compliance against the requirements of the Improving Quality in Physiological Sciences (IQIPS) Standard:2023.

The accreditation standard is split into domains, which cover leadership and management, clinical, facilities, resource and workforce, safety and risk and patient experience requirements. If an organisation is looking to cover multiple disciplines the majority of management system requirements will be the same and can be managed centrally.

A copy of the IQIPS Standard:2023 v2.1 is available on the UKAS website.

2. Objective

This document is aimed at providing all potential UKAS applicants for the IQIPS scheme with a mechanism to identify gaps between their current documented management system and supporting evidence against the standard requirements.

3. UKAS requirements for applicant IQIPS organisations

Please complete this Gap Analysis form and confirm compliance with each clause. If you are currently compliant, please indicate where in your management system the clause is addressed. If your management system is currently non-compliant please detail what actions you plan to take to address the gap and the associated timescale for completion.

Annex 1

Gap Analysis and Transition Plan

Name of Organisation	Gateshead Health NHSFT
Technical Discipline	Audiology
Date of Submission	**30 June 2024**

GAP ANALYSIS

SECTION	CLAUSE	COMPLIANT			EVIDENCE WHICH SUPPORTS COMPLIANCE STATEMENT (e.g. Reference to Procedure/Clause, Reference Material, Reports, agreements, minutes of meetings)	ACTIONS PLANNED TO ADDRESS ANY GAPS (e.g. Update specific Procedure, develop Work Instruction, design/implement quality checks)
		YES	NO	N/A		
Leadership & Management						
Legal entity	LM1 **The healthcare provider is or must be part of a legal entity** The healthcare provider for specific clinical services can be either autonomous or part of a larger parent organisation. It must where applicable:					
Be part of an entity that can be held legally responsible for its activities;	1.1				Gateshead Audiology is hosted in its entirety by Gateshead Health NHS Foundation Trust	

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		YES	NO	N/A		
Be licensed to operate according to relevant international and UK regulatory frameworks;	1.2				Gateshead Health NHS Foundation Trust is fully licensed to operate under NHS regulatory frameworks	
Where applicable, be clearly recognised in the published organisational structure of the parent organisation;	1.3				Audiology sits within the Clinical Support and Screening Services Business Unit and is a core service provided by the Trust. The service if clearly identified and accessible in the Directory of Service	
Have clearly documented processes in place to inform users, staff, and stakeholders of its purpose and core values (culture). This is normally defined and published as a mission, vision and values statement.	1.4				Gateshead Health ICORE values Gateshead Health strategic aim to be the Diagnostic Centre of Choice Audiology mission statement and strategy in development	
Governance including Roles & Responsibilities	LM2 **The healthcare provider must define, document and communicate governance arrangements including leadership, roles, responsibilities and accountabilities** The healthcare provider must deliver clearly defined clinical service(s) to meet					

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		YES	NO	N/A		
	the needs of the target population, whether at static, mobile and/or domiciliary settings. System(s) must ensure, where applicable:					
A leadership and management team consisting of individual(s) with defined responsibilities and accountabilities for clinical and professional leadership, advice, budget control and risk management.	2.1				Job descriptions / plans	
A leadership and management team that is visible, approachable and available to staff;	2.2				Organisation structure, meeting attendance etc.	
The leadership team identify and document details of individuals with specific roles and responsibilities across the Quality Management System (QMS)	2.3				Lack formality and dedicated time to complete desired level of QM.	

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		YES	NO	N/A		
All staff have: • An agreed contract of employment; • A current job description/job plan that specifies his/her role, responsibilities, authorities and relationships;	2.4				JD, org. structure, appraisal, meeting minutes.	
All staff understand their specific role and responsibilities, authorities and relationships;	2.5				JD, org. structure, appraisal, meeting minutes.	
All staff understand the processes in place to manage conflicts of interest;	2.6				Policy shared and declarations made.	
All staff understand how to differentiate and manage feedback and complaints;	2.7				Trust policy	
All staff can give feedback and raise matters of concern, in confidence,	2.8				Freedom to speak up included with core skills.	

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		YES	NO	N/A		
and without fear of recrimination.						
Quality Policy & Objectives	LM3 **The healthcare provider must operate within its quality policy and monitor performance against measurable quality objectives** System(s) must ensure, where applicable:					
The leadership team develop, and publish an appropriate quality policy and measurable quality objectives that are regularly reviewed;	3.1					Plan to be included in Audiology vision and Strategy
Agreed local targets and key performance indicators/outcomes for service activities and clinical procedures, in line with local and national targets e.g. outcomes of objectives, equipment breakdown times, staff retention rates, patient/client satisfaction rates, workloads etc;	3.2				compliant with waiting time standards and KPIs for some activities staff retention rates, patient/client satisfaction rates, collated and reported monthly	All identified KPIs will be included in a monitoring and audit cycle, with an appropriate quality management system

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		YES	NO	N/A		
Consistency in performance across the provider's activities with internal and external benchmarking.	3.3				Waiting times benchmarked despite being incomparable.	
QMS	LM4 **The healthcare provider must establish, implement, and maintain a quality management system (QMS)** The healthcare provider must establish an appropriate QMS to integrate all agreed processes, monitor their effectiveness and ensure continuous improvement of its service(s). The QMS will:					
Be described in a quality manual;	4.1					
Be sufficiently robust to ensure that staff only have access to the latest and current versions of documents;	4.2					InPhase to be used to support quality management system process and access to most up to date versions of all documentation
Ensure availability of supporting documentation to include, but not be limited to:	4.3				SOPs and documentation in the process of being updated	Requires further time investment to fully complete

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		YES	NO	N/A		
• Processes (ways of working) for all activities; • Pathways and clinical protocols; • Records of resources (staffing, equipment etc) available to support delivery; • Forms in use; • Internal audits; • Publications;						
Be subjected to regular management reviews, at least annually, to include at least the following: • Quality improvement initiatives to include business planning; • Periodic review of referrals received; • Results and outcomes from user feedback and complaints; • Staff and stakeholder consultation and feedback;	4.4				RPIW August 2023 Weekly capacity meetings reviewing referrals and associated capacity Monthly monitoring of DMO1 performance Faily and friends and extended patient questionnaire following accessing service Annual staff survey and associate people promise action plan Monthly MDT meeting discussing outcomes from audits, safecare feedback from Matron. Monthly update of risk register ICB Site visit as part of paediatric service improvement programme March 2024	Audiology mission statement and strategy in development with plan to launch September 2024 which will align with Gateshead Health strategy and national audiology performance standards

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		YES	NO	N/A		
• Results and outcomes from internal audits; • Risk management reports, and update of risk register; • Reviews conducted by external organisations; • Objectives aligned to local and national performance targets with outcomes of inter-service comparison programmes/benchmarking; • Performance of suppliers; • Identification and control of non-conformities; • Follow-up actions from previous management reviews; • Changes to the volume and scope of work including capacity and demand, staffing, premises, equipment						

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		YES	NO	N/A		
consumables and resources;						
Where the healthcare provider is required to follow the QMS of a parent organisation, they must demonstrate that the parent organisation's system is appropriately implemented and where necessary the management review output is taken forward to the parent organisation.						
Document control	LM5 **The healthcare provider must ensure that documents and records (including clinical records) are controlled** System(s) must ensure, where applicable:					
Agreed format and media for documents and records;	5.1				Gateshead Health agreed format for documentation used	
Data is processed, handled, maintained and secured in line with applicable regulation and professional guidance;	5.2				Gateshead Health policies and procedures followed including information governance. All staff compliant with training and the Trust has a dedicated Caldicott Guardian. Audit base is the audiology data management system	
All documents and records supporting delivery of services are current, reviewed, approved and available;	5.3					Action plan in pace to update and approval all documents, dedicated time to complete is a limiting factor

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		YES	NO	N/A		
All documents and records created and revised contain: • A title; • Unique identifier on each page; • Date of current edition, review, edition number; • Page number to total number of pages; • Authority for issue;	5.4				Gateshead Health Trust template used	
Appropriate controls for the identification, collection, indexing, access, storage, maintenance, and amendments of current and obsolete records and documents;	5.5				Audit base	
Documents and records are protected from unauthorised alterations and where necessary kept confidential.	5.6				Secure location, levels of access, IG training, Audit base settings	
Subcontracting	LM6					

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		YES	NO	N/A		
Specification of the minimum information needed for different types of agreements;	6.1					
Timely review of all agreements;	6.2					
Assurance that the selected sub-contractor is competent to perform the activity for which it has been selected. If not accredited the healthcare provider will need to demonstrate how competency has been established and what criteria were used;	6.3					
Maintenance of patient/client confidentiality;	6.4					
Monitoring and review of performance against contract requirements, including remedial actions;	6.5					

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		YES	NO	N/A		
Transparency of outsourcing/subcontracting to users and in clinical service outputs.	6.6					
Advisory Services	LM7					
Communication to users and stakeholders on the range and choice of clinical procedures currently available, and on emergent practice;	7.1				Audiology service included in the Directory of service for Gateshead Health Intranet page accessible to all members of the public and potential service users	Need forum to do this and Trust buy in on investment for emergent practices.
Communication on clinical, professional and logistical matters;	7.2					
Users and stakeholders can access advice on interpretation of results;	7.3				Via letter, email, telephone, appointment	
Sufficient capacity for staff to attend multidisciplinary meetings with users/ stakeholders about patient/client management.	7.4				Currently able to do this on an adhoc basis due to establishment and currently waiting times for patients accessing the service	Job planning review being undertaken Workforce review to commence reviewing banding of staff and funded establishment and how this meets to clinical demand for the service and provision of education, training and development of all staff

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		YES	NO	N/A		
Non-conformity management	LM8 **The healthcare provider must identify, manage, eliminate and prevent non-conformities by taking preventative and corrective actions** System(s) must ensure, where applicable:					
Designated responsibilities for non-conformities and non-conformity prevention;	8.1				Awaiting feedback from subject matter experts following initial cohort review to understand if any non-conformities	
Training for staff to detect and record non-conformities;	8.2					
Review of data/information to determine where future non-conformities could occur (e.g. as part of clinical review meetings such as 'Discrepancy' or 'Morbidity and Mortality');	8.3				Peer review	
Immediate actions are taken to mitigate the	8.4					But no auditable documented evidence

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		YES	NO	N/A		
effect of non-conformities;						
Determine and document the root cause/s and extent of the non-conformity or potential non-conformity;	8.5					
Further actions are taken to remove the root cause and prevent reoccurrence of the non-conformity;	8.6					
The need for preventative action is evaluated and implemented when required;	8.7					
Mechanism(s) for recording non-conformities and resultant changes in practice	8.8				Inphase incident reporting and associated actions taken and learning	
Mechanisms for communicating non-conformities and resultant changes in	8.9				Monthly team MDT Trust Monthly Safety Triangulation Group Service Line Business Meeting for wider sharing Business Unit Ops Board Meeting	

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		YES	NO	N/A		
practice to relevant users, staff and stakeholders;						
Regular review of non-conformities to identify trends;	8.10					
Results and effectiveness of preventative actions are reviewed and documented;	8.11					
Criteria are available to determine the following in the case of a clinical non- conformity: • Whether clinical activities should be halted; • Whether reports should be withheld; • Who authorises the recommencement of any halted clinical activities; The need for previously released results to be recalled; • The medical significance of a non-	8.12				Yet to be determined and associated standards	

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		YES	NO	N/A		
conformity to patient/client management; • Responsibilities for reporting the non-conformity to the relevant referrer, users, staff and for escalating to the regulatory authority and/or equipment manufacturer as appropriate.						
Internal audit	LM9					
The QMS including clinical activities is evaluated and assured with a regular audit cycle. This would usually be annually;	9.1				Audit plan shared with department at staff meeting May 2024	Audit plan to be fully embedded and implemented with all staff
Use of different audit methods (vertical, horizontal and/or witnessing) to comprehensively cover the requirements of this standard;	9.2				All vertical and record based. New audit plan includes horizontal however audit has not started yet.	Adjust audit plan to improve scope and spread of methods.

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		YES	NO	N/A		
The scope, criteria, methodology and frequency of audits are defined, documented and reported in an agreed format;	9.3				Methodology and format follow Gateshead Health audit template and processes	
That the service assures appropriate training in audit.	9.4				Trust audit training provided to key staff. Ongoing support available from Trust audit Lead and department	
Major Incidents	LM10					
Availability of an agreed, published and up to date business continuity plan;	10.1					In development
That staff are aware of their roles and responsibilities in the event of a major incident and are provided with accessible up-to-date contact details, key action prompts and appropriate training;	10.2				Majax Plan	Discuss at team meeting
Management of the return to routine service following the incident,	10.3				Gateshead Health policy with support of the dedicated EPPR Team	

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		YES	NO	N/A		
including management of any backlog;						
Accessibility of counselling and support services;	10.4				Gateshead Health have a dedicated health and well-being service accessing a range of counselling services and support materials. Rapid referral to Occupational Health Department	
Analysis and review of performance following a major incident;	10.5				Gateshead Health Trust Documentation and process EPPR Team support and co-ordination	
Regular review and communication of any changes to major incident procedures and action plans.	10.6				Gateshead Health Trust Documentation and process EPPR Team support and co-ordination	
Clinical						
Pathways	CL1 **The healthcare provider must define and deliver its services from referral to discharge or further management** System(s) must ensure, where applicable:					
Publication of the diagnostic and interventional service(s) description, range of	1.1				DOS	

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		YES	NO	N/A		
clinical activities offered, and their locations;						
Publication of evidence-based agreed pathways developed with stakeholder involvement;	1.2					Pathways in the process of being updated. Stakeholder involvement to be sourced
Agreement and publication of metrics and key performance indicators for monitoring the patient pathway e.g. Did Not Attend (DNA), Referral to Treatment (RTT). These could be based on a review of relevant guidelines, clinical pathways, quality standards and benchmark data;	1.3				Performance clinic / DMO1 & RTT returns Audiology weekly capacity meetings and weekly reporting to Gateshead Health Access and Performance meeting	
Performance is communicated to users and stakeholders, as appropriate;	1.4				Performance regionally and nationally reported for users and stakeholders to access	
Referrals	CL2					

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		YES	NO	N/A		
	The healthcare provider must manage referrals and prepare patients/clients for their clinical activity System(s) must ensure, where applicable:					
Mechanisms for the referral process are clearly communicated	2.1				Example form. RTS.	
Requests are vetted in advance of the appointment;	2.2				Triage SOP	
Request forms seek appropriate information including: Patient/client identification details; • Name and contact details of the person making the request (who must be authorised to sign and request the specific clinical activity); • The clinical activity being requested including the specific anatomic site, where relevant;	2.3				Form. Triage SOP.	

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		YES	NO	N/A		
• Clinically relevant information pertaining to the requested activity; • Date of the request; • Requirements for specified equipment, drugs, radioactive medicinal products and/or reagents if relevant; • Additional information to support patient/client needs e.g. need for wheelchair access, interpreter, infection status and any known allergies.						
Technical Quality	CL3 The healthcare provider must assure the technical quality of clinical activities System(s) must ensure, where applicable:					
Patients/clients are correctly identified, and appropriate consent is obtained;	3.1				Journal hotkeys in audit base state if consent has been obtained.	

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		YES	NO	N/A		
Equipment has been calibrated, serviced and is fit for purpose;	3.2				Trust policy.	
Availability of appropriate positioning and supporting devices to ensure the integrity and quality of the clinical activity;	3.3					All calibrated. Records held by RMPD. Equipment carries expiry tag. Need to bring records in house.
Availability of protocols for each clinical activity. Protocols must: •Be evidence-based and appropriate; • Fully describe the critical procedural steps; • Include diagnostic criteria and measurement uncertainty, as appropriate; • Include arrangements for safe sedation, analgesia and or anaesthesia where necessary; • Include health and safety considerations,	3.4					Protocols currently being updated

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		YES	NO	N/A		
contraindications and infection control; • Include guidance for onward referral, management of incidental or clinically urgent findings, and post-procedure care.						
Regular review of protocols, communication of protocol changes to relevant staff, and training on the changes where necessary;	3.5					In development
Competent and appropriate supervision of staff;	3.6					Informal. Need formal peer review process agreed following paediatric service improvement programme direction
Quality control measures are in place to ensure that the intended outcome of the testing/measurement/assessment stage is achieved, and that if	3.7				Stage A, cal cert, qualifications, annual peer review	

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		YES	NO	N/A		
there is a problem with quality, data is not released for reporting before the patient/client is discharged from the service;						
Results are reported in an appropriate time frame.	3.8				All results are reported during clinic and sent to referrer and GP	
Quality of records & results	CL4 **The healthcare provider must ensure the clinical and technical quality of records, interpretations and reports** System(s) must ensure, where applicable:					
Defined responsibilities for reporting clinical activities. If certain clinical activities are not reported then an agreement for transferring responsibility for the evaluation must be in place;	4.1				Audit base and Careflow used to record and schedule all clinical activities Gateshead Health Trust Records management policy and audit process	
Adequate numbers of competent reporting staff	4.2				Audiology workforce and competency workbooks	

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		YES	NO	N/A		
are available and documented;						
Reporting formats are agreed with referrers and stakeholders;	4.3					
Availability of locally agreed reporting structures/templates to reporting staff, including those external to the healthcare provider;	4.4				Templates	
Clear identification of the report issuer. This is particularly relevant where outsourcing arrangements are used;	4.5				Examples of reports with trust logo, clinician name and designation	

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		YES	NO	N/A		
Reports include, as appropriate: • Referral information • Date and time of clinical activity • The clinical activity performed • Relevant findings/observations, including unexpected findings; • A conclusion and/or diagnosis; • How certain the conclusion is, and advice on further diagnostic tests; • Signature(s) with the name(s) of the reporter(s) and their position(s);	4.6				Service templates utilised	Plan to streamline templates using audit base
Mechanisms for auditing reports and processes for feedback and remedial actions;	4.7				Documentation audit part of audit plan	Will modify records audit to design reports audit.

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		YES	NO	N/A		
Access to a second opinion, where appropriate;	4.8				Internal or external via GP.	
Deviations from the reporting requirements are justified, documented and communicated to referrers.	4.9					
Release of reports	CL5 The healthcare provider must manage the release of reports System(s) must ensure, where applicable:					
Reports are issued by staff who are authorised to do so;	5.1					
Definition of local agreed reporting timescales/turnaround times for each type of clinical procedure particularly those with critical, urgent or unexpected findings	5.2					

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		YES	NO	N/A		
Locally agreed mechanisms are in place for communication of reports. Communication mechanisms must be secure and monitored;	5.3					
Records are maintained of all reports including those transmitted by telephone;	5.4					
Where an interim report is issued it is clearly identified as such and a final report is issued according to locally agreed timescales;	5.5					
Timely identification of reporting backlogs/delays and associated patient/client risks with escalation to the highest level within the parent organisation;	5.6					
Where amendments are made to an issued report,	5.7				Gateshead Health Documentation policy	

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		YES	NO	N/A		
that the changes are authorised and dated. The revised report must be communicated to the referrer with a clear explanation of the reason for the amendment and the implications for the management of the patient/client including any necessary urgent actions and lessons learnt.						
Clinical Information Systems	CL6 The healthcare provider must manage clinical information systems System(s) must ensure, where applicable:					
Confidentiality of patient/client data in compliance with national requirements for data protection;	6.1				Gateshead Health Trusts policies Information Governance policy and associated staff training records	
Validation of any clinical information system(s) for the collection, processing, recording, reporting,	6.2				Gateshead Health Trusts policies Information Governance policy and associated staff training records	

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		YES	NO	N/A		
storage and retrieval of data;						
Any changes to the clinical information system(s) are authorised, documented and verified prior to implementation. Where applicable, this includes checking the proper functioning of interfaces with other information systems, instrumentation and administrative systems used to deliver patient/client services;	6.3				Gateshead Health Trusts policies Information Governance policy	
Secure transmission of data	6.4				Gateshead Health Trusts policies Information Governance policy Local Records Management Policy	
Availability of documentation (e.g. user guides), to support day-to day functioning of clinical information system(s);	6.5				e-manual, web-based training materials.	
Protection from unauthorised access,	6.6				IT security and back up regime.	

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		YES	NO	N/A		
safeguards against tampering and data loss, investigation of non-compliances, and remedial action after non-compliances;						
Non-computerised systems should have safeguards against errors of manual recording and transcription;	6.7				All systems electronic	ENT clinics are paper based however this is transferred to electronic format the same day. ENT patient log uses stickers with printed patient details directly from the patient notes.
Information systems are operated in compliance with supplier specifications;	6.8				IG, policy, manuals, training	
Recording, investigation, correction and reporting of breaches of data integrity or system failures;	6.9				Gateshead Health Trusts policies Information Governance policy Local Records Management Policy InPhase reporting	
Compliance with the requirements of this standard where information system(s) are managed and maintained	6.10					

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		YES	NO	N/A		
off-site or sub-contracted;						
Patient experience						
Patient/client focused care	PE1 The healthcare provider must ensure that care is patient/client focused System(s) must ensure, where applicable:					
Equality of access;	1.1				Gateshead Health Patient Access policy	
Privacy, respect, dignity and compassion regardless of age, gender, religion, culture, language, disability, circumstances or any other factors;	1.2				Gateshead Health ICORE values Audiology staff core skills training compliance	
Patient/Client identity is confirmed throughout their contact with the service;	1.3				Gateshead Health Policies and processes	
Chaperone provision;	1.4				Gateshead Health Policy accessible when appropriate	
Appropriate clinical management adapting to individual needs;	1.5				Person centered approach, IMP	

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		YES	NO	N/A		
Counselling for those who become distressed during their contact with the provider, for example following bad news;	1.6				Limited explore to this due to service provided, however, access available form Gateshead Health support teams	
Streamlined scheduling of appointments;	1.7				Weekly schedule which is planned 6 weeks in advance. Trust booking team book appointments Implementation of partial booking process to ensure patients are scheduled in date order	Manual process, looking to standardise and automate this to make it more streamlined and efficient
Opportunities to provide feedback.	1.8				FFT, Review Q, PALS, Pt surveys.	
Information for users & stakeholders	PE2 **The healthcare provider must ensure that information is available for users and stakeholders** System(s) must ensure, where applicable:					
Development of patient/client-friendly information;	2.1					Need to update and improve range.
Lay involvement in the development and review of information;	2.2					
Availability of location-specific information	2.3				Current information needs to be revised and updated	Need to update and improve range.

SECTION	CLAUSE	COMPLIANT			EVIDENCE WHICH SUPPORTS COMPLIANCE STATEMENT (e.g. Reference to Procedure/Clause, Reference Material, Reports, agreements, minutes of meetings)	ACTIONS PLANNED TO ADDRESS ANY GAPS (e.g. Update specific Procedure, develop Work Instruction, design/implement quality checks)
		YES	NO	N/A		
including but not limited to: • address; • list of available activities; • opening hours; • contact details; • parking arrangements;						
Information is accessible in a range of formats and media and in various languages relevant to the population;	2.4					Need to update and improve range.
Information addresses specific patient/client care aspects such as: Explanation of the procedure to include preparation, side-effects and or risks; Preventative measures to minimise risk e.g. infection, fasting requirements; How long the appointment is likely to take;	2.5					Need to update and improve range.

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		YES	NO	N/A		
Who is performing the examination/treatment/intervention; Access to interpretation and chaperones, if required; On arrival, the length of any known delay to appointments; Aftercare and return to normal activity; Communication of results and awareness of second opinions; Peer/self-help support information;						
Communication to users in regards their responsibilities to: • Notify the provider of appointment changes and cancellations; • Providing feedback where expectations are not being met; • Abiding by any behavioural codes of conduct.	2.6				Appointment letter	

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		YES	NO	N/A		
Consent	PE3 **The healthcare provider must ensure that consent is obtained** Procedure(s) must ensure, where applicable:					
Valid informed consent for the specific clinical activity;	3.1				Consent for assessment recorded in Audit base but not for each specific clinical activity. Verbal usually obtained for each activity.	SOP to be written and audit added to plan to demonstrate compliance with consent process
Sufficient information is provided for valid consent, including information about risks;	3.2				Audit base record	SOP to be written and audit added to plan to demonstrate compliance with consent process
Appropriate arrangements where the patient/client lacks the capacity to consent, for example, children and young people, vulnerable adults and users with intellectual disabilities;	3.3				Audit base record Gateshead Health Consent Policy and mental capacity policy	SOP to be written and audit added to plan to demonstrate compliance with consent process
Consent is documented in the patient/client's record where relevant;	3.4				Documented in Audit base	

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		YES	NO	N/A		
Acknowledgment of the patient/client's right to withhold or withdraw consent;	3.5				Documented in Audit base	
Gaining consent when data is likely to be used for training or research purposes and/or if it will be shared electronically within or outside of the provider organisation.	3.6				Gateshead Health Trust policy and processes with signed authorisation	
Feedback & complaints	PE4 The healthcare provider must manage feedback and complaints System(s) must ensure, where applicable:					
Feedback/complaints procedures and materials are available in a variety of formats and media;	4.1				Paper, electronic, PALS	
Confidentiality for those giving feedback and/or making a complaint;	4.2				Gateshead Health Trust Policy	
Regular review of feedback and complaints	4.3				Complaints and complements / PALS reports. Monthly MDT Meeting presentation	

SECTION	CLAUSE	COMPLIANT			EVIDENCE WHICH SUPPORTS COMPLIANCE STATEMENT (e.g. Reference to Procedure/Clause, Reference Material, Reports, agreements, minutes of meetings)	ACTIONS PLANNED TO ADDRESS ANY GAPS (e.g. Update specific Procedure, develop Work Instruction, design/implement quality checks)
		YES	NO	N/A		
with collation, analysis, actions and dissemination to all relevant parties;						
Involvement of users in the development and review of feedback and complaints materials, where relevant.	4.4				Gateshead Trust Policy and support of Communications Team and PALS Team	
Safety & Risk Management						
All service risks	SR1 **The healthcare provider must manage all service risks** Systems must ensure, where applicable:					
An overall health and safety and risk management strategy that has been developed in collaboration with the parent organisation;	1.1				Gateshead Health Trust Policy	
Risk assessments to identify: • Risks associated with clinical activities e.g. infection control; • Non-clinical risks e.g. COSHH, moving and	1.2				Risk assessments file located in department and reviewed and monitored by Matron	

SECTION	CLAUSE	COMPLIANT			EVIDENCE WHICH SUPPORTS COMPLIANCE STATEMENT (e.g. Reference to Procedure/Clause, Reference Material, Reports, agreements, minutes of meetings)	ACTIONS PLANNED TO ADDRESS ANY GAPS (e.g. Update specific Procedure, develop Work Instruction, design/implement quality checks)
		YES	NO	N/A		
handling, violence and aggression etc;						
Maintenance of a comprehensive and up-to-date risk register to document, escalate and report risks, as necessary;	1.3				Monthly review and update on InPhase Escalation to Business Unit Operational Board Meeting Escalation to Trust Risk Management committee	
Tools are in place to record, report, investigate and manage adverse incidents and near misses within specified timescales	1.4				Gateshead Heath Trust policies PSIRF Framework	
Management of patient safety alerts, and appropriate actions;	1.5				Gateshead Health Trust policy	
Regular health and safety training for all staff;	1.6				Department staff Core skills compliance	
Readily available, well-maintained health and safety and risk-reduction equipment and devices;	1.7				Gateshead Health Trust Risk assessments and associated actions	
Facilities, Resource & Workforce						

SECTION	CLAUSE	COMPLIANT			EVIDENCE WHICH SUPPORTS COMPLIANCE STATEMENT (e.g. Reference to Procedure/Clause, Reference Material, Reports, agreements, minutes of meetings)	ACTIONS PLANNED TO ADDRESS ANY GAPS (e.g. Update specific Procedure, develop Work Instruction, design/implement quality checks)
		YES	NO	N/A		
Facilities & Environment	FR1 **The healthcare provider must manage facilities and environment to support service delivery.** System(s) must ensure, where applicable:					
Sufficient suitable space to deliver all aspects of the service;	1.1				Facilities at Queen Elizabeth Hospital and Bensham Community Hospital are not fit for purpose and pose significant clinical risk	Estates plans in development to relocate departments that are not suitable as part of the Trust Capital Estates plan 2024/25
Enough suitable facilities for patient/client confidentiality and privacy and dignity;	1.2					
Appropriate access for users and staff who use wheelchairs, trolleys/beds, have impaired vision, hearing, or have other needs;	1.3				Photos	
Management and monitoring of the condition of facilities and environment including cleaning and maintenance;	1.4				Matron walkabouts and documented checks Maintenance records for equipment	

SECTION	CLAUSE	COMPLIANT			EVIDENCE WHICH SUPPORTS COMPLIANCE STATEMENT (e.g. Reference to Procedure/Clause, Reference Material, Reports, agreements, minutes of meetings)	ACTIONS PLANNED TO ADDRESS ANY GAPS (e.g. Update specific Procedure, develop Work Instruction, design/implement quality checks)
		YES	NO	N/A		
Display of relevant signage to notify users, staff and visitors of access and specific hazards.	1.5				Photographs	
Facilities and environment are fit for their intended purpose, in particular:	1.6				Facilities at Queen Elizabeth Hospital and Bensham Community Hospital are not fit for purpose and pose significant clinical risk	Estates plans in development to relocate departments that are not suitable as part of the Trust Capital Estates plan 2024/25
Clinical facilities • Records relating to environmental conditions that allow for correct performance (assure quality and integrity) of the clinical activity concerned e.g. noise reduction, ventilation, variable lighting and temperature, equipment performance; • Appropriate facilities for decontamination of equipment and consumables	1.6.1				Facilities at Queen Elizabeth Hospital and Bensham Community Hospital are not fit for purpose and pose significant clinical risk	Estates plans in development to relocate departments that are not suitable as part of the Trust Capital Estates plan 2024/25
Reception, waiting and changing facilities	1.6.2				Waiting area space is limited in all locations No separate waiting area for children	Will be addressed in the plans for the relocation of department.

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		YES	NO	N/A		
• Sufficient and appropriate seating facilities for all patients/clients including space for those waiting in wheelchairs, needing bariatric support, waiting for hospital transport, as appropriate; • Appropriate waiting areas for children, vulnerable adults and their carers and those waiting on trolleys; • Screened areas for patients/clients dressed in gowns or those waiting on trolleys or in beds; • Secure storage facilities for patient's/clients' valuables;						No changing area
Staff facilities • Sufficient and appropriate changing facilities for staff including those with disabilities;	1.6.3					

SECTION	CLAUSE	COMPLIANT			EVIDENCE WHICH SUPPORTS COMPLIANCE STATEMENT (e.g. Reference to Procedure/Clause, Reference Material, Reports, agreements, minutes of meetings)	ACTIONS PLANNED TO ADDRESS ANY GAPS (e.g. Update specific Procedure, develop Work Instruction, design/implement quality checks)
		YES	NO	N/A		
• Access to safe storage for personal items; • Access to toilet facilities and drinking water; • Storage of personal protective equipment.						
External service/suppliers selection	FR2					
Maintenance of an approved list of suppliers;	2.1				Gateshead Health procurement processes, IT, Crown Commissioning, NHSSC	
Availability of purchasing criteria that clearly describe the requirements for the product(s) and or service(s) to be purchased;	2.2				Gateshead Health procurement processes	
Review of budgets/funding for equipment, reagents, gases, drugs, radioactive medicinal products and consumables, at least annually, and where appropriate managed in conjunction with the parent organisation;	2.3				Gateshead Health annual budget setting Monthly budget meetings Scheme of delegation for budget management	

SECTION	CLAUSE	COMPLIANT			EVIDENCE WHICH SUPPORTS COMPLIANCE STATEMENT (e.g. Reference to Procedure/Clause, Reference Material, Reports, agreements, minutes of meetings)	ACTIONS PLANNED TO ADDRESS ANY GAPS (e.g. Update specific Procedure, develop Work Instruction, design/implement quality checks)
		YES	NO	N/A		
Regular monitoring of all purchases to ensure consistency with specified criteria.	2.4				Gateshead Health procurement process and budget monitoring	
Storage of reagents, drugs, medicinal products & consumables	FR3 **The healthcare provider must receive, store and manage equipment, reagents, drugs (includes contrast media), radioactive medicinal products and consumables.** System(s) must ensure, where applicable:					
Verification that the receiving location/facility has adequate storage and handling capabilities to maintain the purchased items in a manner that prevents damage and deterioration;	3.1					
Verification of the performance of any new batch or shipment before use in clinical procedures;	3.2					Add line to each SOP ‘consumables must be checked prior to use’

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		YES	NO	N/A		
Maintenance and routine implementation of an inventory control system;	3.3				Managed by QE Facilities Asset register Maintenance records	
Appropriate instructions for use for all items are readily available;	3.4				Add screenshot of manuals folder	Electronic instructions to be stored on CEDAR?
Investigation and reporting of any adverse incidents or accidents that can be attributed directly to use of an item;	3.5				Gateshead Health Trust policy, InPhase	
Maintenance of records for each item that contributes to the performance of clinical procedures.	3.6				Cal certs and stage A docs	Documents in place however recording of calibration needs to be audited.
Procurement & installation of equipment	FR4 **The healthcare provider must manage procurement, installation and replacement of all equipment** System(s) must ensure, where applicable:					
Any equipment used (including that on loan to patients/clients for use	4.1					

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		YES	NO	N/A		
outside of the healthcare provider) meets the specific requirements of the clinical activities offered and the target population concerned (e.g. weight, age, disability etc);						
Maintenance of an equipment inventory and rolling replacement programme Including software, upgrades (including diagnostic software) and accessory devices (e.g. couches, chairs etc);	4.2				Asset register Capital replacement programme	
Regular review of equipment budget, at least annually, and where appropriate managed in conjunction with the parent organisation;	4.3				Equipment replaced as part of capital replacement programme. Any additional equipment business case approval through Gateshead Health financial approval process	
Acceptance testing upon installation and before use;	4.4				Use Audit Base as example	

SECTION	CLAUSE	COMPLIANT			EVIDENCE WHICH SUPPORTS COMPLIANCE STATEMENT (e.g. Reference to Procedure/Clause, Reference Material, Reports, agreements, minutes of meetings)	ACTIONS PLANNED TO ADDRESS ANY GAPS (e.g. Update specific Procedure, develop Work Instruction, design/implement quality checks)
		YES	NO	N/A		
Maintenance of training and authorisation records for staff to operate specific equipment;	4.5					Med Devices training system – we are working towards this.
Agreed minimum information is maintained for any equipment that contributes to the performance of clinical activity. The expectation is that records will include: • Identity of the equipment; • Manufacture's name, model and serial number or their unique identification; • Contact information for the supplier or the manufacturer; • Date of receiving and date of entering use within the service;	4.6				Department assets register	

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		YES	NO	N/A		
• Location of the equipment; • Condition when received (new, used or reconditioned); • Manufacturer's instruction manual; • Confirmation of acceptability for use; • Maintenance carried out and the schedule for preventative maintenance; • Performance records (reports/calibration certificates) that confirms ongoing acceptability for use; • Record of any damage to, malfunctions, modification and or repairs						
Calibrate & maintain equipment	FR5 The healthcare provider must calibrate and maintain equipment System(s) must ensure, where applicable:					

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		YES	NO	N/A		
Use of an authorised/accredited body to conduct calibration;	5.1				RMPD	
That calibration and maintenance takes account of conditions of use and manufacturer's instructions;	5.2				RMPD	
Traceability between the equipment and the calibrated reference standard;	5.3				Calibration certificates	
Verification of the measurement accuracy at defined measurement intervals;	5.4				Calibration certificates	
Timely and accurate updating of correction factors as necessary;	5.5				Photograph of calibration label.	
Safeguards to prevent adjustments or tampering that might invalidate clinical results;	5.6				Procedures. Equipment seals.	

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		YES	NO	N/A		
Reporting of faults and management of equipment breakdowns and repairs, in line with legislation, manufacturer's guidelines and organisational policy;	5.7				Gateshead Health Trust policy Inphase reporting	
Mechanisms to communicate health and safety warnings and alerts to staff, which are formally acknowledged, and acted on within specified timescales;	5.8				Gateshead Health Trust Communications and Safety Team Email, team meeting	
Regular review of electrical safety, emergency stop devices (where relevant);	5.9				PAT testing	
Regular cleaning and decontamination of all equipment, including ancillary equipment following direct contact with patients/clients;	5.10				IPC policy	

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		YES	NO	N/A		
Maintenance of training and authorisation records for staff who calibrate, clean and decontaminate equipment;	5.11					Added to training log
Timely Investigation and reporting of adverse incidents and accidents caused by defective equipment to manufacturers and relevant authorities;	5.12				Trust policy	
Labelling and removal from service of any equipment found to be defective.	5.13				Trust policy, local procedure QE Facilities decommissioning policy and process	
Recruitment, training & competence	FR6 The healthcare provider must recruit, select and train staff to assure competence System(s) must ensure, where applicable:					
Recruitment and selection criteria for each staff group in line with	6.1				Examples JD and criteria. Policy	

SECTION	CLAUSE	COMPLIANT			EVIDENCE WHICH SUPPORTS COMPLIANCE STATEMENT (e.g. Reference to Procedure/Clause, Reference Material, Reports, agreements, minutes of meetings)	ACTIONS PLANNED TO ADDRESS ANY GAPS (e.g. Update specific Procedure, develop Work Instruction, design/implement quality checks)
		YES	NO	N/A		
professional registration requirements;						
Completion of pre-employment checks;	6.2				Recruitment Policy	
Verification that each member of staff including locum staff is qualified, trained and authorised (registered where necessary) to perform their intended functions and this is reflected in job description / job plan;	6.3				Recruitment policy	
Tailored induction training and supervision programmes are available specific to each role, circumstance and/or environment. For example, staff taking on new roles, temporary staff, those returning to work following extended leave and students;	6.4				Local induction template	

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		YES	NO	N/A		
Collaboration with education institutions for education and training support to meet current and predicted staffing needs of the service;	6.5				Details of Sunderland Uni	
Maintenance of records of staff training activities, professional qualifications, professional registration status, induction and refresher training courses attended, and certificates of competence with authorisation to carry out specific tasks;	6.6				PARTIALLY MET ESR records	Staff local training records to be updated
Regular review of performance and assessment of competence for all staff;	6.7				Regular meetings with staff Appraisal records	Competency frameworks need completion and implementation across the whole team. Internal peer review needs to be implemented and external peer review temporarily halted during Paediatric Service Improvement Programme
Protected time for staff to engage in continuous professional	6.8					Job plan review Training budget currently not available Needs investment in establishment

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		YES	NO	N/A		
development activities and to undertake improvement initiatives;						
Defined mandatory training is specified, available and completed for all staff;	6.9				Core skills administered and monitored via ESR	
Systematic monitoring of staff retention and succession planning.	6.10				PARTIALLY MET Workforce report includes staff recruitment and retention	Workforce plan in progress

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 16

Report Title:	**Board Assurance Framework (BAF) 2024-25**			
Name of Meeting:	Board of Directors			
Date of Meeting:	31 July 2024			
Author:	Jennifer Boyle, Company Secretary Executive Directors			
Executive Sponsor:	Dr Gill Findley, Chief Nurse			
Report presented by:	Jennifer Boyle, Company Secretary			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
	To review the current Board Assurance Framework position, triangulating its content against the items discussed on the agenda.			
Proposed level of assurance *– to be completed by paper sponsor:*	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☒ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	Board of Directors – 5 June 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*	• The Board of Directors reviewed the summary risks, current scores and target scores as part of a development session in June 2024. The BAF was updated to reflect the agreed wording and scores for each risk. • The BAF for 24/25 has now been reviewed by each Board committee. • Updates agreed at each committee meeting are shown in red text in enable the changes to the BAF to be tracked. • Note that the BAF extract relating to the Alliance is mapped directly to the Board of Directors for monitoring and therefore has not been reviewed by a Board committee. Going forwards the Gateshead Health Leadership Group will review this BAF extract routinely and report this to Board. • The controls, assurances and actions to address identified gaps will continue to be populated by the Executive leads.			

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

At present no summary risks have reduced in score, but this is to be expected given that the opening scores for the year were only set by the Board in June 24.
The BAF key is as follows:

<table>
<tr><th>Key</th><th>Description</th></tr>
<tr><td></td><td>Not yet started</td></tr>
<tr><td></td><td>Started and on track no risks to delivery</td></tr>
<tr><td></td><td>Plan in place with some risks to delivery</td></tr>
<tr><td></td><td>Off track, risks to delivery and or no plan/timescales and or objective not achievable</td></tr>
<tr><td></td><td>Complete</td></tr>
</table>
</td></tr>
<tr><td>Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper</td><td colspan="6">To review the BAF for completeness, accuracy and triangulation against the assurances and risks discussed as part of the Board meeting. The Board is to be assured that the committees have undertaken detailed discussions on the BAF since its development in June 2024.

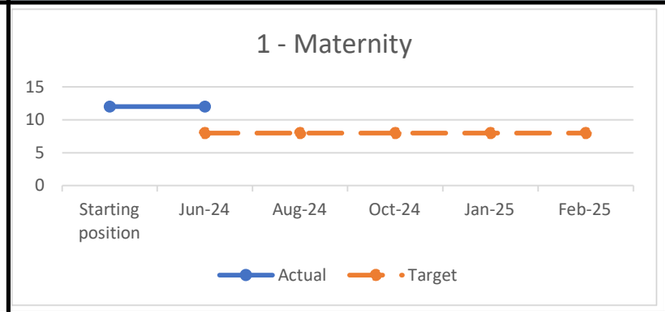
The Board is asked to specifically review whether based on the assurances and risks identified through the meeting the current risks scores continue to reflect the current operating environment.</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:</td><td>Aim 1
☒</td><td colspan="5">We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>Aim 2
☒</td><td colspan="5">We will be a great organisation with a highly engaged workforce</td></tr>
<tr><td>Aim 3
☒</td><td colspan="5">We will enhance our productivity and efficiency to make the best use of resources</td></tr>
<tr><td>Aim 4
☒</td><td colspan="5">We will be an effective partner and be ambitious in our commitment to improving health outcomes</td></tr>
<tr><td>Aim 5
☒</td><td colspan="5">We will develop and expand our services within and beyond Gateshead</td></tr>
<tr><td>Trust strategic objectives that the report relates to:</td><td colspan="6">As outlined on the BAF itself</td></tr>
<tr><td>Links to CQC Key Lines of Enquiry (KLOE):</td><td>Caring
☒</td><td>Responsive
☒</td><td>Well-led
☒</td><td>Effective
☒</td><td>Safe
☒</td></tr>
<tr><td colspan="7">Risks / implications from this report (positive or negative):</td></tr>
<tr><td>Links to risks (identify significant risks – new risks, or those already recognised on our risk management</td><td colspan="6">Risks identified on the BAF</td></tr>
</table>

system with risk reference number):			
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:	Jun-24
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.



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

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 – 16 (was 12 - increased subsequent to the meeting)

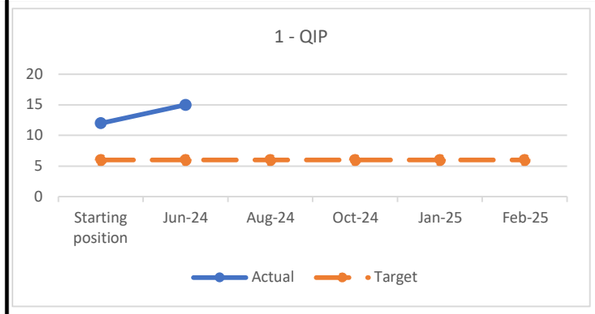
2425 - Activity is not delivered in line with planned trajectories, leading to reduction in income - 16

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	Pest control issues identified linked to the age of the estate. Corrective actions being taken to mitigate any risks to patients and staff and minimise the issue within the parameters of what is possible given the aged estate.	QEF Managing Director	Jul-24	Immediate actions taken by the teams with support of external pest control company	
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)	[redacted]					
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:	Jun-24					
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.		**CURRENT RISK SCORE**			**TARGET RISK SCORE**		
		Likelihood	Impact	Score	Likelihood	Impact	Score
		5 (was 4)	**3**	**15**	**2**	**3**	**6**

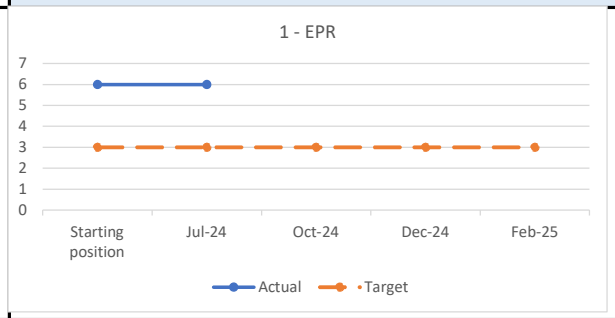
Links to risks on the ORR:	3107 - Risk that MDT are delayed to a maternity emergency/delayed CCU transfers for maternity patients due to separate buildings – 15 2438 - Quality - Risk of quality failures in patient care due to external causes such as delayed discharges and external pressures – 8 2341 - There is a risk to ongoing business continuity of service provision due to ageing Trust estate – 16 (was 12 - increased subsequent to the meeting) 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	Quality Improvement Plan not yet reviewed by the Committee	Chief Nurse	Aug-24		
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	Further assurance required regarding the complaints re: pace of progress	Chief Nurse	Aug-24		
Quality improvement plan is reviewed at the Group Leadership Meeting	Further assurance required regarding falls given the increase - action to provide a regular report on this	Chief Nurse	Aug-24		

	[redacted]					
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:	Jul-24
Summary risk	

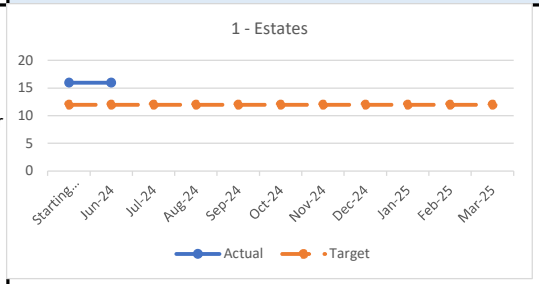
There is a risk that the Trust does not develop an effective EPR system delivery plan, caused by a lack of resource (financial, digital team capacity, lack of strategic clarity) or lack of a robust process for identifying the most appropriate EPR system. This may result in clinical disengagement, continued clinical risk presented by the current system (i.e.. lack of joined-up system containing all patient records) and a reduced ability to deliver future efficiencies and productivity gains.



CURRENT RISK SCORE			TARGET RISK SCORE		
Likelihood	Impact	Score	Likelihood	Impact	Score
2	3	6	1	3	3

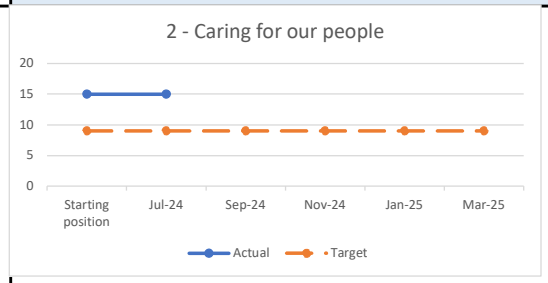
Links to risks on the ORR:	4405 - Risk that data is not accessed appropriately, leading to misuse or inappropriate disclosure - 16 4402 - Inability to support legislation and best practice associated with records management - 16 2424 - Risk that efficiency requirements are not met - 16

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:	Jun-24							
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)		**CURRENT RISK SCORE**			**TARGET RISK SCORE**		
		Likelihood	Impact	Score	Likelihood	Impact	Score
		4	**4**	**16**	**4**	**3**	**12**
Links to risks on the ORR:	2341 - There is a risk to ongoing business continuity of service provision due to ageing Trust estate – (was 12 now 16)							

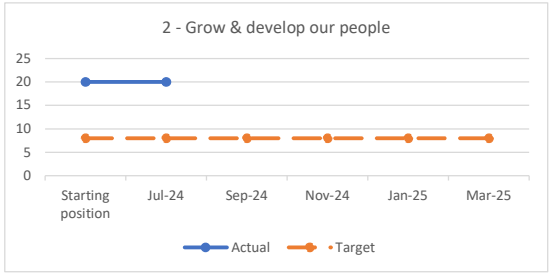
Controls	**Gap in controls and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Asset condition survey carried out by external specialists resulting in risk based condition scoring of all fixed assets.	The current Estates Strategy 2023-2028 has not been agreed by Board and no 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	25/06 - Committee noted that the capital plan was approved by Board in June 2024 and therefore this gap has been addressed and closed.	
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		
Capital plan for 2024/25 in place following Board approval					
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 submitted to the Group Board for approval.	QEF Managing Director	Jun-24	25/06 - Committee noted that the capital plan was approved by Board in June 2024 and therefore this gap has been addressed and closed.	

		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:	Jul-24					
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		**CURRENT RISK SCORE**			**TARGET RISK SCORE**		
		Likelihood	Impact	Score	Likelihood	Impact	Score
		5	**3**	**15**	**3**	**3**	**9**
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					

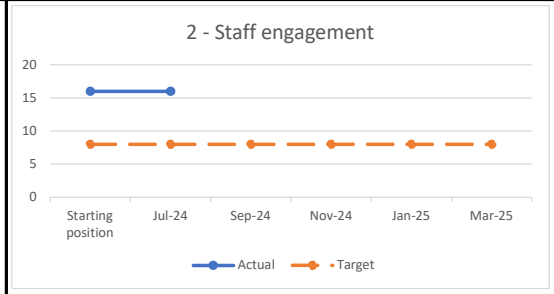
Controls	**Gap in controls and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Health and wellbeing lead in place	New governance structure currently being implemented and requires time to fully launch and embed	Chief Nurse / Company Secretary	Sep-24		
Dedicated health and wellbeing 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	Executive Director of POD	TBC		
Zero tolerance campaign in place	Low uptake of exit interviews	Executive Director of POD	TBC		
Show Racism the Red Card training provided with further sessions planned	Lack of adherence to Managing Attendance policy	Executive Director of POD	TBC		
Nursing is fully established	Sickness absence policy not adhered to by managers in respect of progressing individuals through the stages. More focus required on sickness actions to strengthen control environment	Executive Director of POD	Sep-24		
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:	Jul-24							
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.		**CURRENT RISK SCORE**			**TARGET RISK SCORE**		
		Likelihood	Impact	Score	Likelihood	Impact	Score
		5	**4**	**20**	**2**	**4**	**8**
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							

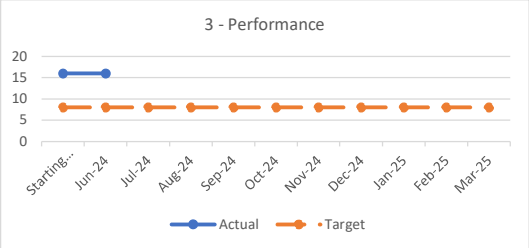
Controls		**Gap in controls and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Operational plan for 24-25 developed in consultation with the Board and Governors.		Integrated approach to workforce planning not currently in place - plans to adopt an approved methodology	Executive 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	Executive Director of POD	TBC		
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	Executive Director of POD	TBC		
Professional Nurse Advocacy programme in place to support reflection and learning		Training space limited and not always fit for purpose	Executive Director of POD	TBC		
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:	Jul-24					
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.		**CURRENT RISK SCORE**			**TARGET RISK SCORE**		
		Likelihood	Impact	Score	Likelihood	Impact	Score
		4	4	16	2	4	8
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						

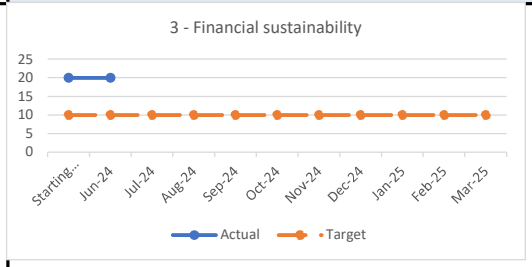
Controls	**Gap in controls and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Zero tolerance programme in place	New governance structure currently being implemented and requires time to fully launch and embed	Chief Nurse / Company Secretary	Sep-24		
FTSU resource and focus increased with a full time FTSU Guardian and a network of champions	Staff networks not providing strategic input to the Board or EMT	Executive Director of POD	TBC		
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	Executive Director of POD	TBC		
Anti-racism charter in place with Unison	Board Member appraisals do not all include an EDI objective - to address through latest appraisal round	Executive Director of POD	Sep-24		
Pulse surveys held during the year	Strategic direction and timescales for EDI work requires further development	Executive Director of POD	Sep-24		
Tea and chat engagement events	Low uptake of Pulse survey - identify mechanisms to encourage greater response rate to provide greater insight and assurance	Executive Director of POD	Sep-24		
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					
Zero tolerance programme in place					

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						
Internal audit 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:	Jun-24							
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				**CURRENT RISK SCORE**			**TARGET RISK SCORE**		
				Likelihood	Impact	Score	Likelihood	Impact	Score
				4	**4**	**16**	**2**	**4**	**8**
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							

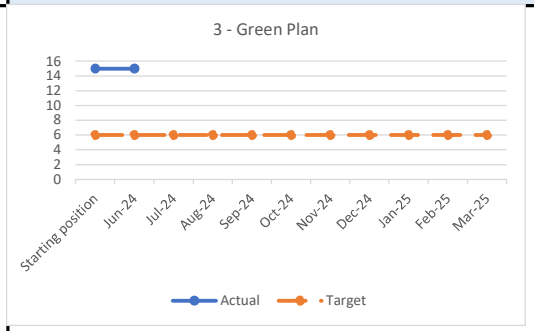
Controls	**Gap in controls and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Annual plan developed and in place	New governance structure currently being implemented and requires time to fully launch and embed	Chief Nurse / Company Secretary	Sep-24		
Leading & Breakthrough Indicators 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	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)	[redacted]					
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:	Jun-24							
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				**CURRENT RISK SCORE**			**TARGET RISK SCORE**		
				Likelihood	Impact	Score	Likelihood	Impact	Score
				4	5	20	2	5	10
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 - (was 12 now 16)							

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	25/06 - Committee noted that the capital plan was approved by Board in June 2024 and therefore this gap has been addressed and closed.	
New business intelligence post in place					
Capital plan for 2024/25 in place following Board approval					
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	[redacted]					
	[redacted]					
Assurance (Level 3 – external)	[redacted]					
	[redacted]					

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:	Jun-24					
Summary risk						
There is a risk that the Group cannot articulate or fully understand 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.		**CURRENT RISK SCORE**			**TARGET RISK SCORE**		
		Likelihood	Impact	Score	Likelihood	Impact	Score
		5	**3**	**15**	**2**	**3**	**6**
Links to risks on the ORR:	~~2272 - People may lose trust and confidence in our services - 12~~ Risk de-escalated from ORR						

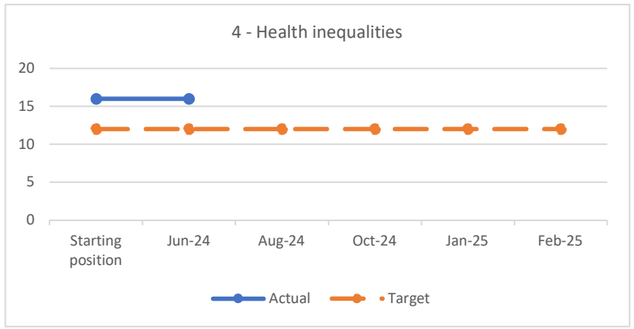
Controls	**Gap in controls and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
The Green Plan has been agreed by Board covering the period for 22-25.	The governance arrangements detailed in the Green Plan are not reflected in the new Governance arrangements - A new reporting 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	25/06 - Committee discussed gap in assurance. KM to discuss further with GE to determine if quarterly updates to come via F&P	

		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:	Jun-24
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
4	4	16	3	4	12

Links to risks on the ORR:

~~2272 - People may lose trust and confidence in our services - 12~~ Risk removed from ORR subsequent to the meeting

2582 - Risk of ineffective and inefficient management of services due to availability and access to appropriate and timely BI - 12

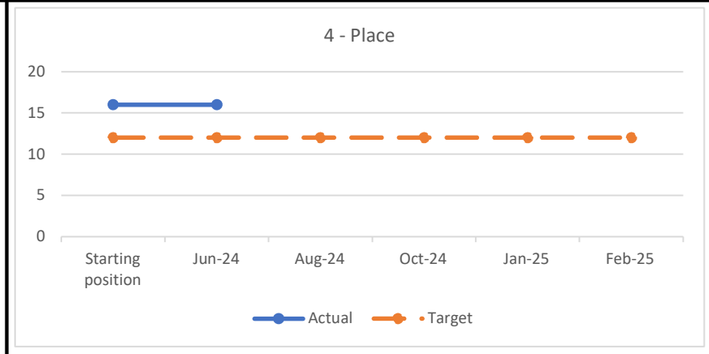
4402 - Inability to support legislation and best practice associated with records management - 16

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		

	[redacted]					
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:	Jun-24
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.



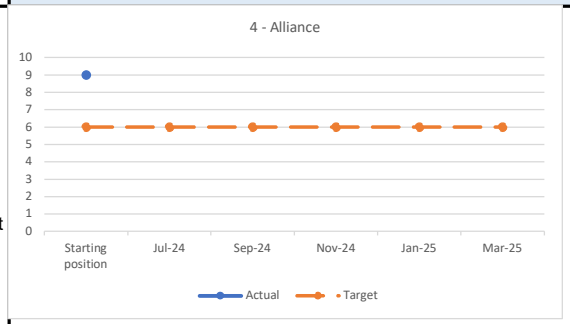
CURRENT RISK SCORE			TARGET RISK SCORE		
Likelihood	Impact	Score	Likelihood	Impact	Score
4	**4**	**16**	**3**	**4**	**12**

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~~ Risk removed from ORR subsequent to the meeting

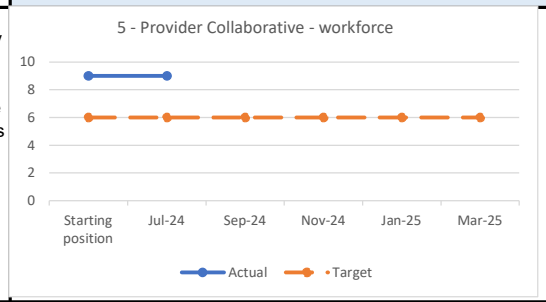
Controls	Gap in controls and corrective action	Owner	Timescale	Update	Action status
Senior engagement in Gateshead Cares meetings	Review and monitor external meeting membership and attendance to ensure appropriate engagement	Medical Director / Company Secretary	Sep-24		
Appropriate director level attendance 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 (via Gateshead Health Leadership Group)							
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				**CURRENT RISK SCORE**			**TARGET RISK SCORE**		
				Likelihood	Impact	Score	Likelihood	Impact	Score
				3	3	9	2	3	6
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~~ Risk removed from ORR							

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	Model now in place and reporting to Board - 2 meetings held to-date	
Alliance Steering Group in place		Alliance risk management framework under development	Interim Director of Strategy, Planning and Partnerships	Jun-24	Risk management framework developed and risks reported to and reviewed at every Committee in Common meeting	
Alliance Formation Team member in place - Interim Director of Strategy, Planning and Partnerships						
Weekly CEO meeting in place for Alliance						
Risk management framework and risk register in place at Alliance level						
Committees in Common established						
Assurance (Level 1: Operational Oversight)		**Gaps in assurance and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Regular updates provided to internal leadership forums and to JCC/LNC etc						
Assurance (Level 2: Reports / metrics seen by Board / committee etc)						

Alliance updates provided at every Board meeting	[redacted]					
Alliance updates provided at Finance and Performance Committee	[redacted]					
Alliance updates provided to COG on quarterly basis	[redacted]					
Alliance update monthly at PLB	[redacted]					
	[redacted]					
Assurance (Level 3 – external)	[redacted]					
	[redacted]					

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:	Jul-24							
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				**CURRENT RISK SCORE**			**TARGET RISK SCORE**		
				Likelihood	Impact	Score	Likelihood	Impact	Score
				3	**3**	**9**	**2**	**3**	**6**
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	Executive Director of POD	TBC		
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)						
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:	Jun-24								
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				**CURRENT RISK SCORE**			**TARGET RISK SCORE**		
				Likelihood	Impact	Score	Likelihood	Impact	Score
				3	2	6	2	2	4
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~~ Risk de-escalated from ORR								

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		

	[redacted]					
Assurance (Level 2: Reports / metrics seen by Board / committee etc)	[redacted]					
	[redacted]					
Assurance (Level 3 – external)	[redacted]					
	[redacted]					

Gateshead Health NHS Foundation Trust

Agenda Item: 16ii

Report Title:	**Organisational Risk Register (ORR)**			
Name of Meeting:	Board of Directors			
Date of Meeting:	31st July 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 June and July, and the following updates and movements agreed. The accompanying Report shows the following changes and is detailed within this report. -There were 5 risks added, 2 risks removed/closed. 0 escalations.			

• *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	-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. -Compliance with reviews sits at 58% for risks and 77% for associated actions. This is a decline since the last meeting.
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	The Board are asked to: • Review the risks and actions on the attached report and discuss and seek further information relating to risks as appropriate. • Note compliance with risk reviews has declined in period. • Be clearly sighted on the top 3 risks for the organisation.

Trust Strategic Aims that the report relates to:	**Aim 1** ☒	We will continuously improve the quality and safety of our services for our patients
	Aim 2 ☒	We will be a great organisation with a highly engaged workforce
	Aim 3 ☒	We will enhance our productivity and efficiency to make the best use of resources
	Aim 4 ☒	We will be an effective partner and be ambitious in our commitment to improving health outcomes
	Aim 5 ☒	We will develop and expand our services within and beyond Gateshead
Trust corporate objectives that the report relates to:	Each risk is linked to a corporate objective, see report.	

Links to CQC KLOE	Safe ☒	Effective ☒	Caring ☒	Responsive ☒	Well-led ☒
Risks / implications from this report (positive or negative):					
Links to risks (identify significant risks and Inphase reference)	Included in report				

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

Organisational Risk Register

Executive Summary

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

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

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 23rd May-19th July 2024 (extraction date for this report).

Organisational Risk Register

Movements:

Following ERMG meeting in June and July 2024, as well agreement at Digital Committee, 5 risks have been added to the ORR. There have been 0 escalations, 0 reductions and 2 closures.
There are currently 19 risks on the ORR, agreed by the group as per enclosed report.

New Risks:

5 new risks added in period:

- **4559 (POD)** There is a risk that the appropriate support is not available to our medical staff to support good rota management and strategic medical workforce modelling. This could result in errors and non-compliance with contractual obligations as well as a lack of engagement and morale. As such a negative impact on the Trust's reputation as a training provider and employer (20)
    - The board are asked to note there are Limited controls and assurances currently in place to support mitigation.

- **4564 (COO)** Risk of clinical safety for patients out-of-hours due to junior workforce currently in deteriorating patient service. Limited governance structure in place. No clear escalation process in place for referral to medical team. This is limiting teams development and increasing the risk of a delay in response for patients who are critically unwell.
  This could result in patient care being impacted without clinical lead to guide teams required development. (16)

- Clinical proformas being developed to guide patient triage, assessment and escalation in line with National Guidelines.
- Organisational Change has commenced to improve current structure and purpose of team

- **4554 (Digital)** There is a risk that the trust is not sufficiently protected against the current and evolving cyber threats. Vulnerabilities in protection increase the risk of significant service disruption due to unavailability of business critical systems. Vulnerabilities in protection could also increase the risk of data loss or breaches due to cyber attacks. (15)

    - Cyber Personnel – A dedicated Cyber assurance and advisory expert, alongside named cyber operational staff. Recently onboarded a cyber apprentice to act in a supporting role
    - Firewalls – a first layer of defence and protection for anything on our network.

- **4575 (Digital)** The trust performance against the mandatory 20 day turnaround (as per the Freedom of Information Act) for Freedom of Information requests is repeatedly below tolerance of 90%. Increasing the likelihood of complaints/reports to the ICO from requestors. The ICO can investigate these complaints resulting in regulatory fines where it feels the organisation is not supporting the requirements of FoIs, resulting in potential financial and reputational damage and complaints (16)

    - FoI Policy and Procedures
    - FoI central coordination and reporting

- **4576 (Digital)** The trust is repeatedly performing below tolerance of 95% for responses to Subject Access Requests within the mandated calendar month turnaround time. Lower performance levels could result in increased complaints to the ICO about the trust from requestors. The ICO may choose to investigate these complaints and as a result impose significant financial penalties on the organisation causing financial and reputational damage and complaints. (15)

    - Trust policy and procedure in place

Risks increased:
0 No risks have escalated in score**.**

Risks removed and closed in period:

2 risks reduced and closed:

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

    - The schedule of works has been amended and the down time for the existing scanner has been reduced to two weeks, this means scanning can continue as now with the additional provision of the mobile unit.
    - Risk reduced from 16 to its target score (TRR 8) and closed

- **2272 CEO** There is a potential for people to lose trust and confidence in our services as a result of recent reports and incidents.

    - Inquest has concluded without further comment from public. NHSE have moved us out of enhanced surveillance for quality
    - Risk reduced from 12 to its target score (TRR 4) and closed.

Top 3 Risks:

The following 3 risks were agreed as the top organisational risks at the last ERMG meeting:

1- Finance- Cost Reduction Plan – 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- Medical staffing Workforce and function – systems not functional to deliver the expectation of the organisation. Risk 4559

3- QEF – Estates risk- lack of Business Continuity Plans to support service provision in some critical areas of the estate. Risk aggregation in relation to estates infrastructure has demonstrated a number of significant risks, both for the ORR and locally managed.

Current compliance with Risk reviews:

Risk review compliance is currently at 58%. This is a decline on last reporting period. (81%). Action review compliance is 77%. This is a decline from last reporting period. (81%) Support with reviews continue to be offered by Corporate and Clinical Risk Lead where able.

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

ERMG Risk Report ORR

Total Risks (Current/Managed)

19

People

2

Risk Sub Type	Business Unit	Risk Id	Risk Title	Rating
Resources	People & OD	4559	There is a risk that the appropriate support is not available to our medical staff to support good rota management and strategic medical workforce modelling	20
Resources	People & OD	4525	risk of Lack of a strategic workforce planning	12
Staff Safety	People & OD	3132	Exposure to incidents of violence and aggression in ECC	15
Wellbeing	People & OD	4417	Increase in incivility and disrespectful behaviours being reported	12

Quality

6

Risk Sub Type	Business Unit	Risk Id	Risk Title	Rating
Safety	Chief Operating Officer	4564	DART- Risk of clinical safety for patients out-of-hours due to junior workforce currently in deteriorating patient service.	16
Safety	People & OD	2432	Risk of Significant, unprecidented service disruption due to industrial action	16
Safety	Digital	4554	Cyber Threats and Vulnerabilities	15
Safety	Surgical Services	3107	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
Effectiveness	Medical Services	2545	Risk of delayed transfers of care and increased hospital lengths of stay	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

5

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	Digital	4575	Non compliance with FoI response turnaround time could result in ICO imposed penalties.	16
Compliance	Digital	4576	Non compliance with SARs response turnaround time could result in ICO imposed penalties.	15
Compliance	Nursing, Midwifery & Quality	4541	Risk of governance failure as we transition to new governance arrangements	16

This report does not contain any data

Reputation

Current/Managed Organisational Risk Register (all levels)

19

Risk Id	Report Inclusion Summary	Risk Description	Risk Owner	Business Unit	Service	Existing Controls	Which Strategic Objectives are threatened by this risk? Summary	Initial Risk Rating	Rating	Target Rating	Date moved to current risk	Next review Date	Stage	Open Form
4559	BU Dir. Governance Meeting Organisational Risk People and OD Committee Quality Governance Committee Finance & Performance Committee	There is a risk that the appropriate support is not available to our medical staff to support good rota management and strategic medical workforce modelling. This could result in errors and non compliance with contractual obligations as well as a lack of engagement and morale. As such a negative impact on the Trust's reputation as a training provider and employer.	Amanda Venner	People & OD	Workforce Development	-	SA 1.2 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. SA 2.2 Growing and developing our people in order to improve patient outcomes, reduce reliance on temporary staff and deliver the 24-25 workforce plan SA 3.1 Improve the quality of care delivery and accessibility for patients by meeting the locally agreed stretch standards by March 2025. SA 3.2 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.	20	20	12	11 Jun 2024	06 Jul 2024	Current Risk	
2341	BU Dir. Governance Meeting Organisational Risk Finance & Performance Committee Health and Safety Committee BAF COO Operations Oversight Group	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	SA 3.1 Improve the quality of care delivery and accessibility for patients by meeting the locally agreed stretch standards by March 2025. SA 3.2 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. SA 1.4 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	16	16	4	20 Feb 2023	07 Aug 2024	Current Risk	

Risk Id	Report Inclusion Summary	Risk Description	Risk Owner	Business Unit	Service	Existing Controls	Which Strategic Objectives are threatened by this risk? Summary	Initial Risk Rating	Rating	Target Rating	Date moved to current risk	Next review Date	Stage	Open Form
4564	BU Dir. Governance Meeting Organisational Risk COO Operations Oversight Group Quality Governance Committee	Risk of clinical safety for patients out-of-hours due to junior workforce currently in deteriorating patient service. Limited governance structure in place and future development of the team requires clinical lead and clinical manager to improve clinical supervision and oversight to the team. No clear escalation process in place for referral to medical team. Junior workforce currently responsible for clinical triage of all Out-of-hours clinical tasks. Team are currently providing unnecessary clinical tasks that could be covered by other existing services. This is limiting teams development and increasing the risk of a delay in response for patients who are critically unwell. This could result in patient care being impacted without clinical lead to guide teams required development.	Jo Halliwell	Chief Operating Officer	Site Resilience	Organisational Change has commenced to improve current structure and purpose of team within the organisation. Clinical proformas being developed to guide patient triage, assessment and escalation in line with National Guidelines. Learning and development plans as per a ratified skills and competency matrix completed for all team members. Clinical workload being offloaded with organisation - education and training to staff being arranged and provided. Clinical supervision for all team members with trust PNA service on a monthly basis arranged.	SA 1.2 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. SA 2.2 Growing and developing our people in order to improve patient outcomes, reduce reliance on temporary staff and deliver the 24-25 workforce plan	20	16	8	21 Jun 2024	21 Jul 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.	SA 1.2 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. SA 4.2 Work collaboratively as part of the Gateshead system to improve health and care outcomes to the Gateshead population SA 5.1 Contribute effectively as part of the Great North Healthcare Alliance to maximise the opportunities presented through the regional workforce programme	20	16	4	01 Jul 2024	01 Aug 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 Transformati and Assuranc	Trust Policies, procedures, guides, materials and tools. Staff training, awareness and communication programmes Internal and external auditing and IG spot check programme	SA 1.3 Evidence an agreed strategic approach to the development of an EPR supported by a documented and timed implementation plan. SA 3.1 Improve the quality of care delivery and accessibility for patients by meeting the locally agreed stretch standards by March 2025.	20	16	4	24 Nov 2023	01 Aug 2024	Current Risk	
4575	BU Dir. Governance Meeting Digital Committee Organisational Risk	The trust performance against the mandatory 20 day turnaround (as per the Freedom of Information Act) for Freedom of Information requests is repeatedly below tolerance of 90%. Increasing the likelihood of complaints/reports to the ICO from requestors. The ICO can investigate these complaints resulting in regulatory fines where it feels the organisation is not supporting the requirements of FoIs, resulting in potential financial and reputational damage and complaints	Kris Mackenzie	Digital	Digital Transformati and Assuranc	FoI Policy and Procedures FoI central coordination and reporting	SA 1.3 Evidence an agreed strategic approach to the development of an EPR supported by a documented and timed implementation plan.	20	16	8	16 Jul 2024	16 Aug 2024	Current Risk	
4402	BU Dir. Governance Meeting Digital Committee Organisational Risk BAF	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 Transformati and Assuranc	Action to scope and procure an EPR to support robust record management requirements [Record Lifecycle - creation to destruction]	SA 1.3 Evidence an agreed strategic approach to the development of an EPR supported by a documented and timed implementation plan.	20	16	8	24 Nov 2023	17 Aug 2024	Current Risk	

Risk Id	Report Inclusion Summary	Risk Description	Risk Owner	Business Unit	Service	Existing Controls	Which Strategic Objectives are threatened by this risk? Summary	Initial Risk Rating	Rating	Target Rating	Date moved to current risk	Next review Date	Stage	Open Form
2432	BAF BU Dir. Governance Meeting Organisational Risk Quality Governance Committee People and OD 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.	SA 1.2 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. SA 2.1 Caring for our people in order to achieve the sickness absence and turnover standards by March 2025 SA 2.2 Growing and developing our people in order to improve patient outcomes, reduce reliance on temporary staff and deliver the 24-25 workforce plan	20	16	8	07 Nov 2022	17 Jul 2024	Current Risk	
2425	BU Dir. Governance Meeting Finance & Performance Committee Organisational Risk BAF	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.	SA 3.2 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. SA 5.2 Evidenced business growth by March 2025 with a specific focus on Diagnostics, Women's health and commercial opportunities SA 1.2 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.	20	16	4	22 Aug 2022	17 May 2024	Current Risk	
2424	BU Dir. Governance Meeting COO Finance & Performance Committee Organisational Risk BAF	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.	SA 3.2 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. SA 5.2 Evidenced business growth by March 2025 with a specific focus on Diagnostics, Women's health and commercial opportunities	20	16	8	22 Aug 2022	17 May 2024	Current Risk	
3107	BAF BU Dir. Governance Meeting COO Organisational Risk Quality Governance Committee Operations Oversight Group	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	SA 1.1 Evidence full compliance with the Maternity Incentive Scheme (MIS) and the Ockenden actions SA 1.2 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.	20	15	5	28 Dec 2018	01 Aug 2024	Current Risk	

Risk Id	Report Inclusion Summary	Risk Description	Risk Owner	Business Unit	Service	Existing Controls	Which Strategic Objectives are threatened by this risk? Summary	Initial Risk Rating	Rating	Target Rating	Date moved to current risk	Next review Date	Stage	Open Form
3132	BU Dir. Governance Meeting Organisational Risk Quality Governance Committee People and OD Committee Health and Safety Committee BAF	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	SA 2.1 Caring for our people in order to achieve the sickness absence and turnover standards by March 2025	20	15	6	27 Oct 2021	26 Jun 2024	Current Risk	
4554	BU Dir. Governance Meeting Organisational Risk Digital Committee	There is a risk that the trust is not sufficiently protected against the current and evolving cyber threats. Vulnerabilities in protection increase the risk of significant service disruption due to unavailability of business critical systems. Vulnerabilities in protection could also increase the risk of data loss or breaches due to cyber attacks (ransomware etc).	Kris Mackenzie	Digital	IT		SA 1.3 Evidence an agreed strategic approach to the development of an EPR supported by a documented and timed implementation plan.	20	15	10	05 Jun 2024	05 Jul 2024	Current Risk	

								Initial Risk Rating	Rating	Target Rating			Stage	
						HSCN – National data network with enhanced and robust network security which benefits from the Network Analytics Service (NAS) which monitors all network traffic on HSCN for anomalous behaviour. Secure Boundary Service (SBS) – Perimeter network security solution offering additional protection against security threats, with increased network traffic visibility and content identification within encrypted traffic as well as enriched threat intelligence. Enhanced Domain Name System (DNS) - integration into the NCSC protective DNS to help disrupt the use of DNS for malware distribution and operation Network Management – All networking equipment is within manufacturer support for maintenance and security updates. Network segmentation in place to allow for compartmentalisation of sub networks to allow for additional security protection and controls Community of Interest Network (CoIN) – Private secure health network to allow for secure access to data and applications Resilient Data Centre – 2 on site data centres to allow for continuous replicated services for critical systems, with 2 off site disaster recovery environments Enhanced backup solution – continuous data backup allowing for swift restoration of services in the event of a cyber infiltration Active Directory – Secure method of allowing users to connect with network resources, and manages and controls what users and computers are permitted to access and how they can function Device Certificates – Trust issued device certificates to ensure secure authentication between network resources as well as ensuring effective device identification and authorisation Microsoft Defender for endpoint – Endpoint management which scans our endpoints continuously to check for vulnerabilities as well as provide anti-virus protection on all user and server endpoints IT Health/ Lansweeper – Scans full estate for software and any installs on PC's, also shows end of life for windows versions, high priority vulnerabilities as well as OS compliance Group Policy – Sets rules and restrictions to users and computers to ensure consistent and nationally enforced application of device and security protocols. SCCM – Allows us to update and manage the patch and software delivery for all of our endpoints. Intune – Manages the central configuration of our mobile/ tablets and allows consistent restriction of applications and internet access. National CSOC – National service providing continuous monitoring of our internet traffic and end user estate, with proactive alerting for suspicious activity and resolution support Windows Patch management – Routine patch delivery for our devices to ensure up to date security protection Driver/ BIOS updates – Updates from Dell, Lenovo to make sure devices have the most up to date driver packages Bit locker – All laptops have BitLocker installed to enforce security encryption in case of theft or loss. SpecOps – Password management policy, ensuring all users have secure password, Any inactive user accounts or users who haven't logged in for 90 will be monitored and appropriately actioned in line with our account management policy. Firewalls – a first layer of defence and protection for anything on our network. Cyber Personnel – A dedicated Cyber assurance and advisory expert, alongside named cyber operational staff. Recently onboarded a cyber apprentice to act in a supporting role.						

Risk Id	Report Inclusion Summary	Risk Description	Risk Owner	Business Unit	Service	Existing Controls	Which Strategic Objectives are threatened by this risk? Summary	Initial Risk Rating	Rating	Target Rating	Date moved to current risk	Next review Date	Stage	Open Form
4576	BU Dir. Governance Meeting Digital Committee	The trust is repeatedly performing below tolerance of 95% for responses to Subject Access Requests within the mandated calendar month turnaround time. Lower performance levels could result in increased complaints to the ICO about the trust from requestors. The ICO may choose to investigate these complaints and as a result impose significant financial penalties on the organisation - causing financial and reputational damage and complaints.	Kris Mackenzie	Digital	Digital Transformati and Assuranc	Trust policy and procedure in place		20	15	5	16 Jul 2024	16 Aug 2024	Current Risk	
4417	BU Dir. Governance Meeting Organisational Risk People and OD Committee BAF	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 Developmen	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.	SA 2.1 Caring for our people in order to achieve the sickness absence and turnover standards by March 2025	15	12	6	26 Oct 2023	17 Jul 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	SA 1.2 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. SA 2.2 Growing and developing our people in order to improve patient outcomes, reduce reliance on temporary staff and deliver the 24-25 workforce plan	16	12	8	26 Mar 2024	17 Aug 2024	Current Risk	
2582	BU Dir. Governance Meeting Finance & Performance Committee Organisational Risk BAF	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		SA 3.1 Improve the quality of care delivery and accessibility for patients by meeting the locally agreed stretch standards by March 2025.	15	12	3	13 Oct 2021	23 May 2024	Current Risk	

								Initial Risk Rating	Rating	Target Rating			Stage	
						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							
2545	BAF BU Dir. Governance Meeting COO Finance & Performance Committee Organisational Risk Operations Oversight Group	Risk of delay in transfer to community for patients who are on pathway 3 or who live in a non Gateshead area. Due to lack of complex care provision and difficulties in accessing social care teams from other locations. This delay adds significant pressure to acute bed availability and significant risk of problems with flow through the hospital impacting national standard achievement. There is a risk of falls, nosocomial infection and deconditioning to patients experiencing delays. This leads to poor patient and staff experience and adversely impacts quality of care delivery.	Joanna Clark	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.	SA 3.1 Improve the quality of care delivery and accessibility for patients by meeting the locally agreed stretch standards by March 2025. SA 4.2 Work collaboratively as part of the Gateshead system to improve health and care outcomes to the Gateshead population	20	8	4	07 Dec 2021	16 Aug 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	SA 1.2 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.	15	8	4	16 Aug 2022	01 Aug 2024	Current Risk	

Risks Closed in Period (all levels)

This report does not contain any data

Risks Added to ORR in Period (all levels)

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Risk Id	Report Inclusion Summary	Risk Description	Risk Owner	Business Unit	Service	Existing Controls	Which Strategic Objectives are threatened by this risk? Summary	Initial Risk Rating	Rating	Target Rating	Date added to ORR	Next review Date	Stage	Open Form
4575	BU Dir. Governance Meeting Digital Committee Organisational Risk	The trust performance against the mandatory 20 day turnaround (as per the Freedom of Information Act) for Freedom of Information requests is repeatedly below tolerance of 90%. Increasing the likelihood of complaints/reports to the ICO from requestors. The ICO can investigate these complaints resulting in regulatory fines where it feels the organisation is not supporting the requirements of FoIs, resulting in potential financial and reputational damage and complaints	Kris Mackenzie	Digital	Digital Transformation and Assurance	FoI Policy and Procedures FoI central coordination and reporting	SA 1.3 Evidence an agreed strategic approach to the development of an EPR supported by a documented and timed implementation plan.	20	16	8	16 Jul 2024	16 Aug 2024	Current Risk	
4576	BU Dir. Governance Meeting Digital Committee	The trust is repeatedly performing below tolerance of 95% for responses to Subject Access Requests within the mandated calendar month turnaround time. Lower performance levels could result in increased complaints to the ICO about the trust from requestors. The ICO may choose to investigate these complaints and as a result impose significant financial penalties on the organisation - causing financial and reputational damage and complaints.	Kris Mackenzie	Digital	Digital Transformation and Assurance	Trust policy and procedure in place		20	15	5	16 Jul 2024	16 Aug 2024	Current Risk	

ORR Risks Overdue Review (all levels)

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Risk Id	Report Inclusion Summary	Risk Description	Risk Owner	Business Unit	Service	Existing Controls	Which Strategic Objectives are threatened by this risk? Summary	Initial Risk Rating	Rating	Target Rating	Date moved to current risk	Next review Date	Stage
4559	BU Dir. Governance Meeting Organisational Risk People and OD Committee Quality Governance Committee Finance & Performance Committee	There is a risk that the appropriate support is not available to our medical staff to support good rota management and strategic medical workforce modelling. This could result in errors and non compliance with contractual obligations as well as a lack of engagement and morale. As such a negative impact on the Trust's reputation as a training provider and employer.	Amanda Venner	People & OD	Workforce Development	-	SA 1.2 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. SA 2.2 Growing and developing our people in order to improve patient outcomes, reduce reliance on temporary staff and deliver the 24-25 workforce plan SA 3.1 Improve the quality of care delivery and accessibility for patients by meeting the locally agreed stretch standards by March 2025. SA 3.2 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.	20	20	12	11 Jun 2024	06 Jul 2024	Current Risk
2424	BU Dir. Governance Meeting COO Finance & Performance Committee Organisational Risk BAF	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.	SA 3.2 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. SA 5.2 Evidenced business growth by March 2025 with a specific focus on Diagnostics, Women's health and commercial opportunities	20	16	8	22 Aug 2022	17 May 2024	Current Risk
2425	BU Dir. Governance Meeting Finance & Performance Committee Organisational Risk BAF	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.	SA 3.2 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. SA 5.2 Evidenced business growth by March 2025 with a specific focus on Diagnostics, Women's health and commercial opportunities SA 1.2 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.	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	Which Strategic Objectives are threatened by this risk? Summary	Initial Risk Rating	Rating	Target Rating	Date moved to current risk	Next review Date	Stage
2432	BAF BU Dir. Governance Meeting Organisational Risk Quality Governance Committee People and OD 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.	SA 1.2 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. SA 2.1 Caring for our people in order to achieve the sickness absence and turnover standards by March 2025 SA 2.2 Growing and developing our people in order to improve patient outcomes, reduce reliance on temporary staff and deliver the 24-25 workforce plan	20	16	8	07 Nov 2022	17 Jul 2024	Current Risk
3132	BU Dir. Governance Meeting Organisational Risk Quality Governance Committee People and OD Committee Health and Safety Committee BAF	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	SA 2.1 Caring for our people in order to achieve the sickness absence and turnover standards by March 2025	20	15	6	27 Oct 2021	26 Jun 2024	Current Risk
4554	BU Dir. Governance Meeting Organisational Risk Digital Committee	There is a risk that the trust is not sufficiently protected against the current and evolving cyber threats. Vulnerabilities in protection increase the risk of significant service disruption due to unavailability of business critical systems. Vulnerabilities in protection could also increase the risk of data loss or breaches due to cyber attacks (ransomware etc).	Kris Mackenzie	Digital	IT		SA 1.3 Evidence an agreed strategic approach to the development of an EPR supported by a documented and timed implementation plan.	20	15	10	05 Jun 2024	05 Jul 2024	Current Risk

Risk Id	Report Inclusion Summary	Risk Description	Risk Owner	Business Unit	Service	Existing Controls	Which Strategic Objectives are threatened by this risk? Summary	Initial Risk Rating	Rating	Target Rating	Date moved to current risk	Next review Date	Stage
						HSCN – National data network with enhanced and robust network security which benefits from the Network Analytics Service (NAS) which monitors all network traffic on HSCN for anomalous behaviour. Secure Boundary Service (SBS) – Perimeter network security solution offering additional protection against security threats, with increased network traffic visibility and content identification within encrypted traffic as well as enriched threat intelligence. Enhanced Domain Name System (DNS) - integration into the NCSC protective DNS to help disrupt the use of DNS for malware distribution and operation Network Management – All networking equipment is within manufacturer support for maintenance and security updates. Network segmentation in place to allow for compartmentalisation of sub networks to allow for additional security protection and controls Community of Interest Network (CoIN) – Private secure health network to allow for secure access to data and applications Resilient Data Centre – 2 on site data centres to allow for continuous replicated services for critical systems, with 2 off site disaster recovery environments Enhanced backup solution – continuous data backup allowing for swift restoration of services in the event of a cyber infiltration Active Directory – Secure method of allowing users to connect with network resources, and manages and controls what users and computers are permitted to access and how they can function Device Certificates – Trust issued device certificates to ensure secure authentication between network resources as well as ensuring effective device identification and authorisation Microsoft Defender for endpoint – Endpoint management which scans our endpoints continuously to check for vulnerabilities as well as provide anti-virus protection on all user and server endpoints IT Health/ Lansweeper – Scans full estate for software and any installs on PC's, also shows end of life for windows versions, high priority vulnerabilities as well as OS compliance Group Policy – Sets rules and restrictions to users and computers to ensure consistent and nationally enforced application of device and security protocols. SCCM – Allows us to update and manage the patch and software delivery for all of our endpoints. Intune – Manages the central configuration of our mobile/ tablets and allows consistent restriction of applications and internet access. National CSOC – National service providing continuous monitoring of our internet traffic and end user estate, with proactive alerting for suspicious activity and resolution support Windows Patch management – Routine patch delivery for our devices to ensure up to date security protection Driver/ BIOS updates – Updates from Dell, Lenovo to make sure devices have the most up to date driver packages Bit locker – All laptops have BitLocker installed to enforce security encryption in case of theft or loss. SpecOps – Password management policy, ensuring all users have secure password, Any inactive user accounts or users who haven't logged in for 90 will be monitored and appropriately actioned in line with our account management policy. Firewalls – a first layer of defence and protection for anything on our network. Cyber Personnel – A dedicated Cyber assurance and advisory expert, alongside named cyber operational staff. Recently onboarded a cyber apprentice to act in a supporting role.						

Risk Id	Report Inclusion Summary	Risk Description	Risk Owner	Business Unit	Service	Existing Controls	Which Strategic Objectives are threatened by this risk? Summary	Initial Risk Rating	Rating	Target Rating	Date moved to current risk	Next review Date	Stage
2582	BU Dir. Governance Meeting Finance & Performance Committee Organisational Risk BAF	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	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	SA 3.1 Improve the quality of care delivery and accessibility for patients by meeting the locally agreed stretch standards by March 2025.	15	12	3	13 Oct 2021	23 May 2024	Current Risk
4417	BU Dir. Governance Meeting Organisational Risk People and OD Committee BAF	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.	SA 2.1 Caring for our people in order to achieve the sickness absence and turnover standards by March 2025	15	12	6	26 Oct 2023	17 Jul 2024	Current Risk

Changes in CRR (Current/Emerging) (select filters below for this table)

Business Unit: All 12 selected | Service Line: All 48 selected | Organisational Risk: Organisational | Report Inclusion: All 18 selected | Risk ID: All 280 selected | Current Rating: 0 to 25

Risk ID	Risk Stage	Open	Risk Title	Owner	Business Unit	Service	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024
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	16	16
4541	Current Risk		Risk of governance failure as we transition to new governance arrangements	Gill Findley	Nursing, Midwifery & Quality	Corporate Nursing				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	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	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	16	
2424	Current Risk		Risk that efficiency requirements are not met.	Kris Mackenzie	Finance	Finance	16	16	16	16	16	
2432	Current Risk		Risk of Significant, unprecidented service disruption due to industrial action	Amanda Venner	People & OD	Workforce Development	16	16	16	16	16	
3107	Current Risk		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	15	15
3132	Current Risk		Exposure to incidents of violence and aggression in ECC	Laura Farrington	People & OD	Workforce Development	15	15	15	15	15	
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 & OD	Workforce Development	12	12	12	12	12	
4525	Current Risk		risk of Lack of a strategic workforce planning	Sophia Grainger	People & OD	Human Resources			9	12	12	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	8	
2545	Current Risk		Risk of delayed transfers of care and increased hospital lengths of stay	Joanna Clark	Medical Services	Medical Services - Divisional Management	16	8	8	8	8	8
4575	Current Risk		Non compliance with FoI response turnaround time could result in ICO imposed penalties.	Kris Mackenzie	Digital	Digital Transformation and Assurance						16
4554	Current Risk		Cyber Threats and Vulnerabilities	Kris Mackenzie	Digital	IT					15	15
4559	Current Risk		There is a risk that the appropriate support is not available to our medical staff to support good rota management and strategic medical workforce modelling	Amanda Venner	People & OD	Workforce Development					20	
4564	Current Risk		DART- Risk of clinical safety for patients out-of-hours due to junior workforce currently in deteriorating patient service.	Jo Halliwell	Chief Operating Officer						16	16
4576	Current Risk		Non compliance with SARs response turnaround time could result in ICO imposed penalties.	Kris Mackenzie	Digital	Digital Transformation and Assurance						15

No slicers

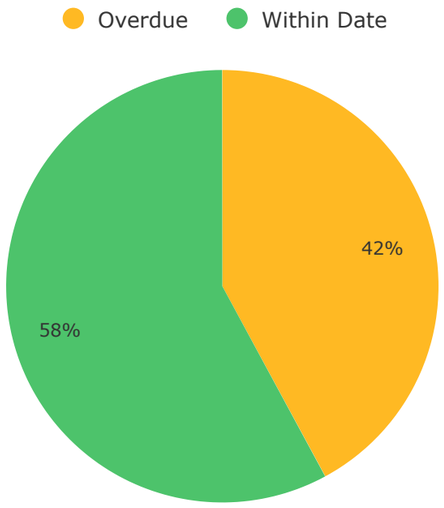
Open Risk Actions (select filters below for this table and graph)

Business Unit: All 12 selected | Service Line: All 44 selected | Organisational Risk: Organisational | Report Inclusion: All 16 selected | Risk ID: All 187 selected | Current Rating: 0 to 25

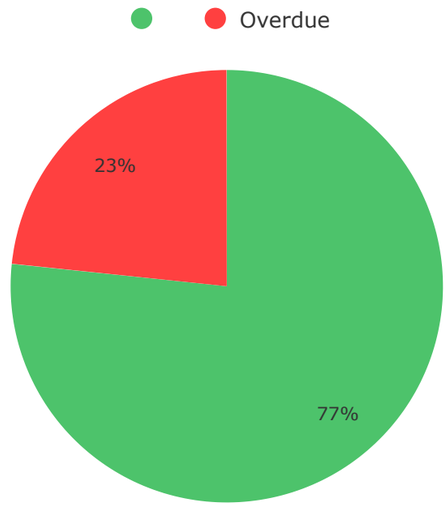
Risk ID	Risk Description	Priority	Total Actions	Action Description	Action Stage	Details	Owner	Owner Dept	Overdue	% Complete	Start Date	Due Date
Risk 00002341	There is a risk to maintaining business continuity of services and recovery plans due to the estate infrastructure, age and backlog maintenance 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		20%	31/03/2023	31/07/2024
Risk 00002424	Efficiency requirements are not achieved.	Normal	1	delivery oversight group and finance focus sessions	In Progress		Kris Mackenzie	Finance	Overdue	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		60%	18/10/2022	31/07/2024
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	▪ 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	Overdue	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	31/07/2024
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		25%	05/06/2023	31/12/2024
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	3	Development of role of IAO/IAA	In Progress		Catherine Bright	Digital		75%	01/02/2024	26/07/2024
				Esablish IAO network with link to SIRO	In Progress		Catherine Bright	Digital		45%	02/02/2024	26/07/2024
				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	3	Create a zero-tolerance campaign	In Progress		Laura Farrington	People and OD		50%	26/10/2023	31/10/2024
				Embed FTSU Champions within the Organisation	In Progress		Tracy Healy	People and OD	Overdue	10%	31/10/2023	30/06/2024
				Review existing Bullying & Harassment policy	In Progress		Laura Farrington	People and OD		50%	26/10/2023	30/08/2024
Risk 00004525		Normal	8	1. Workforce planning	Not Started		Amanda Venner	People and OD		0%	22/05/2024	31/10/2024

				Action Description	Action Stage	Details	Owner	Owner Dept	Overdue	% Complete	Start Date	Due Date
	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.			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	31/08/2024
				Education, learning and Workforce development group to continue work on the implications of the LTWF	In Progress		Sarah Neilson	People and OD		50%	26/03/2024	30/10/2024
				Focus on absence management	Not Started		Carol O'Flaherty	People and OD	Overdue	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		25%	26/03/2024	31/07/2024
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		20%	01/06/2024	31/07/2024
Risk 00004564	▪ Risk of clinical safety for patients out-of-hours due to junior workforce currently in deteriorating patient service. ▪ Limited governance structure in place and future development of the team requires clinical lead and clinical manager to improve clinical supervision and oversight to the team. ▪ No clear escalation process in place for referral to medical team. ▪ Junior workforce currently responsible for clinical triage of all Out-of-hours clinical tasks. ▪ Team are currently providing unnecessary clinical tasks that could be covered by other existing services. This is limiting teams development and increasing the risk of a delay in response for patients who are critically unwell. ▪ This could result in patient care being impacted without clinical lead to guide teams required development. ▪	Normal	1	Task and finish group to be configured to assist with integration of team across organisation, clini	Not Started		Rebecca Railton	COO		0%	24/06/2024	31/07/2024
Risk 00004575	The trust performance against the mandatory 20 day turnaround (as per the Freedom of Information Act) for Freedom of Information requests is repeatedly below tolerance of 90%. Increasing the likelihood of complaints/reports to the ICO from requestors. The ICO can investigate these complaints resulting in regulatory fines where it feels the organisation is not supporting the requirements of FoIs, resulting in potential financial and reputational damage and complaints	Normal	2	FoI Status Reporting	Not Started		Catherine Bright	Finance		0%	16/07/2024	16/08/2024
				FoI training schedule	In Progress		Dianne Ridsdale	Finance		0%	16/07/2024	02/08/2024
Risk 00004576	The trust is repeatedly performing below tolerance of 95% for responses to Subject Access Requests within the mandated calendar month turnaround time. Lower performance levels could result in increased complaints to the ICO about the trust from requestors. The ICO may choose to investigate these complaints and as a result impose significant financial penalties on the organisation - causing financial and reputational damage and complaints.	Normal	2	Link in with Transformation - possibility of RPIW	In Progress		Catherine Bright	Finance		0%	16/07/2024	30/08/2024
				Task and Finish Group to be established to review processes	In Progress		Mark Smith	Finance		0%	16/07/2024	30/08/2024

Risk Review Compliance



Risk Action Compliance



Gateshead Health
NHS Foundation Trust

Committee Escalation and Assurance Report

Name of Board Committee	Finance and Performance Committee
Date of Board Committee:	25 June 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 requiring escalation 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)

Financial Position - The Committee received a report setting out the overall challenging financial position with particular issues in relation to medical staffing, medical education and overall staffing. There is a plan to address the issues and immediate actions have been put in place to reduce spend. The Committee will receive a highlight report at the next meeting with a full report and action plan to the following meeting in August.

Financial Plan and CRP – there is a gap in assurance in relation to the details of the CRP. The allocation of CRP targets are currently being agreed.

Paediatric Autism Pathway Validation – the Committee received an update on progress – work is in place but needs to be implemented.

GP Shared Care – work is underway to reach an agreement, but if this cannot be achieved this could have an impact on a large number of patients.

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

Community Services Contract – the Committee was presented with a programme of work and timetable and will receive monthly updates.

CDC – the capital programme is on track. The opening has been confirmed for 1 October with the first patient scheduled for 24 October, with full occupation to follow at a later date.

Strategic Objectives and leading indicators – The Committee was assured about the content and style of the new report. In relation to indicators, the Committee noted a strong performance in relation to cancer. The Committee was also assured that improvements are embedded with a quick recovery to an issue with ambulance handovers in May.

Gateshead Health
NHS Foundation Trust

Risks (any new risks / proposed changes to risk scores)
A new risk had been added – 4559 (POD) in relation to appropriate support not being available to medical staff. The Committee suggested that the wording of this risk may need to be reviewed to reflect the wider risk to the organisation. Risk 2250 (CSS) – risk of losing MRI provision – had been reduced from 16 to 12. Risk 2424 (finance) –pressures from COVID – to consider whether this is still appropriate. It was noted that the Audit Committee had added a new risk relating to verifying compliance with SFIs in relation to procurement processes for 0 - £10k spend.

Gateshead Health
NHS Foundation Trust

Committee Escalation and Assurance Report

Name of Board Committee	Quality Governance Committee
Date of Board Committee:	25 June 2024
Chair of Board Committee:	Mrs A Stabler

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

Items to be escalated to the Board:

- Shared Care Contracts – The Committee was advised of an issue in relation to primary care and shared care contracts. This relates to GPs in the outer west area who have handed back patients in relation to concerns about the shared care contracts. This is impacting on 174 rheumatology patients at the moment, but could potentially increase to around 3000 patients which would be difficult to manage and would have a significant impact on patient care. A meeting is being held with GPs to try and manage the issue through collaboration. The Committee was advised that an options paper is being developed for the ICB in order to be clear on the Trust's position. The Trust is not prepared to compromise its values to put patients at the centre of a dispute but is also not prepared to pick up additional costs at the detriment to other services.

  Issue to be escalated via the ICB.

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)

- Paediatric audiology – the Committee was provided with an update on progress with the agreed action plan with the ICB to address concerns raised following the national review of paediatric audiology services. Feedback is awaited from the initial extended cohort review by the subject matter expert to find out if it will be necessary to move into full incident mode management which would potentially require a full 5-year look back exercise. The ICB are working closely with the Trust and would provide support if there was a need to go to intervention.

- InPhase Low or no harm incidents - The Committee was advised of an issue that had come to light with InPhase where some low or no harm incidents were not reporting through the app correctly and therefore not flowing through to 'to-do' lists. This was an issue relating to implementation in September and is believed to have involved

1500 cases. This issue was rectified by February and there has been no further issue since February.

- Falls with harm – The Committee was advised on action being taken to reinvigorate the Falls Prevention Steering Group in the light of concerns about the number of falls with harm that have occurred within the first 6 months of this year.

- Complaints Action – the Committee was provided with an update on the management of complaints. The Committee had concerns about the lack of traction/pace of progressing with complaints and will be looking at progress against the Quality Strategy.

- Junior doctors – the Committee was provided with information on plans in place to manage disruption due to the junior doctors strike.

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

- The Committee was advised of the outcome of the recent Mental Health Act (MHA) monitoring visit which was included in the papers for this item. It was noted that this was one of the most positive reports seen from the CQC and had only highlighted two small issues. The Committee congratulated the team on the outcome of the visit.

- Positive assurances were agreed in relation to:

  Maternity Oversight Report
  Combined Leading Indicators and Elective Recovery Report
  Implementation of Martha's Rule/Call for Concern pilot
  IPC Annual Report
  Palliative Care
  Equality and Quality Impact Assessment
  Nursing Strategy Update
  Fuller Inquiry Report
  Letter re Infected Blood Inquiry
  Serious Incidents Report
  Pharmacy and Medicines Assurance Report

Referrals to POD Committee:

- Mr A Crampsie to pick up with POD:
- Nursing Workforce –how POD has oversight of the nursing workforce.
- Level 1 Oliver McGowan Training – to ensure a target is set for staff to complete the training.
- Sickness – Dr G Findley is meeting with the Director of POD to discuss support for ward managers on sickness.

Gateshead Health
NHS Foundation Trust

Risks (any new risks / proposed changes to risk scores)
• There were no changes to risks on the ORR • In relation to the BAF – Quality Improvement Plan – Committee agreed to move the likelihood score up to 5 from 4 for now, to be reduced once the Committee has more assurance.

Gateshead Health
NHS Foundation Trust

Escalation and Assurance Report

Name of Committee / Group:	Digital Committee
Date of Committee / Group:	10 July 2024
Chair of Committee / Group:	Mr A Moffat

Alert
(matters of significant concern requiring escalation for further action or to bring to the attention of the full Board / Committee / Group)

The Committee agreed to again escalate the following items to the Board as they continue to be recorded as red rated KPIs:

- Information Asset Owners (IAOs) ~~—~~ Despite a number of initiatives being implemented, t~~T~~he Committee ~~i~~remains ~~s~~ concerned about the slow pace of improvement in this area.

- Freedom of Information (FoI) and Subject Access Requests (SARs) – response rates are continuing to be significantly below the statutory deadlines and the Committee was of the view that the organisation needs to decide how these areas are resourced and whether working towards the target response rate is a priority. It was suggested this should be taken forward via the executive team.

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

- There were no advisory issues.

Assure
(key assurances received and any highlights of note)

- The Committee received an update on the EPR project and received assurance that progress is being made towards preparing a draft Outline Business Case by September 2024.

The Committee also received assurance in relation to:

- Internal Audit actions
- Digital Nursing Team
- Strategic Objectives
- Digital Maturity Assessment

Gateshead Health
NHS Foundation Trust

Risks (any new risks / proposed changes to risk scores)
• There were no changes to risks, although the Committee noted that there is a draft risk on the register which has not yet been published to the ORR relating to the management of cyber vulnerabilities.
Cross-referrals to Tier 1 Board Committees
• None

Gateshead Health
NHS Foundation Trust

Escalation and Assurance Report

Name of Committee / Group:	People and OD Committee
Date of Committee / Group:	Tuesday 9 July 2024
Chair of Committee / Group:	Mrs Maggie Pavlou

Alert
(matters of significant concern requiring escalation for further action or to bring to the attention of the full Board / Committee / Group)

- There were no issues requiring escalation to the Board.

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

- External Audit Findings - Contracts – The Committee was advised about an issue in relation to contracts not being consistently maintained on an employee's personal record. This presented a risk that the Trust is unable to confirm that employees are being paid in line with contracts. The audit highlighted further work that is needed on local records management and to ensure that documents are all held in one place. A plan is in place to rectify the issue and mitigate the risk. A further report will be brought to the Committee in September.

- Sickness Absence – there has been an in month deterioration in sickness rates from 5.2% to 5.7% since the last Committee. Service improvement work in Occupational Health and a dedicated focus on sickness should have an impact on this in the coming months. The Committee is seeking further assurances around this and an update will be provided in September.

- EDI – The Committee was not fully assured over the overall vision and direction of travel of work on EDI. It was noted that an HR EDI Group time out session is planned to focus on this.

- Medical Vacancies – The Committee was advised that a safe staffing type report is being considered for medicine and this will report in to either the POD or Quality Governance Committee in future.

- Historic Pre-Employment ID Checks – the Committee noted progress since the last meeting with 29 full or partial ID checks now outstanding with 11 staff to escalate to a formal disciplinary process. There is a reduction in the risk score from 12 to 8 however, a further update will be provided to the Committee in September due to this previously being identified as an 'alert' item and the potential reputational risk to the Trust.

Gateshead Health
NHS Foundation Trust

Assure ***(key assurances received and any highlights of note)***
• Freedom to Speak Up Guardian (FTSU) – Good assurance was received through a comprehensive report which provided the Committee with information and data triangulated to the plan and demonstrated a good use of the Committee. As a result, the Committee felt they had oversight of activity, what the themes/issues are and the actions that are being taken.
Risks (any new risks / proposed changes to risk scores)
• There were no changes to risks.
Cross-referrals to Tier 1 Board Committees
• None

Gateshead Health
NHS Foundation Trust

Committee Escalation and Assurance Report

Name of Board Committee	Group Audit Committee
Date of Board Committee:	24 June 2024
Chair of Board Committee:	Mr A Moffat

Alert
(matters of significant concern requiring escalation to the Board for further action or to bring to the attention of the full Board)

- 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)

- Head of Internal Audit's opinion - this was 'good', but in order to improve there needs to be a continued focus on management responses.
- Internal Audit Charter – it was agreed that this should be shared widely via CEO and executive colleagues.
- Conflicts of Interest Policy - the level of returns is low for conflicts of interest and gifts and hospitality declarations. This was also the case last year. Further promotional and education work is needed to increase compliance during 2024/25.
- Contracts of Employment – it was noted that work is ongoing – the Audit Committee requested that the Director of POD provide a report to the next meeting in September to allow the Committee to fully understand the issues and the timescales for completion.

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

- Accounts and Annual Report – the Audit Committee recommended the sign off of the accounts and Annual Report, and this was supported by Internal and External Audit colleagues.
- Internal Audit Progress report – The Committee noted that actions to escalate and increase visibility have been working and the trends are positive as a result.
- Schedule of Losses and Special Payments – The Committee authorised the Chief Executive and Group Director of Finance and Digital to sign the register as

acknowledgement that the Board has formally approved the writing off of the losses and special payments made in Quarter 4 2023-24.
Risks (any new risks / proposed changes to risk scores)
• To add a new risk to the risk register in relation to the acceptance by the Committee that there is no auditable process in place to evidence compliance with SFIs for electronic supplier quotes under £10K, but mitigations will be put in place around staff training. • Employment Files – this has been taken to EMT and the risk may have been reduced, but this may need to be reviewed in the light of additional issues raised relating to contracts of employment.
Cross-referrals to Tier 1 Board Committees
• No cross-referrals made.

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 18

Report Title:	**Board Walkabout Feedback**			
Name of Meeting:	Board of Directors			
Date of Meeting:	31 July 2024			
Author:	Board Members			
Executive Sponsor:	Chief Nurse			
Report presented by:	Chief Nurse			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☒	**Assurance:** ☐	**Information:** ☐
	To provide Board Members with an overview of observations and reflections from Board walkabouts, supporting triangulation with other sources of information and assurance			
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*	-			

Key issues:
Briefly outline what the top 3-5 key points are from the paper in bullet point format
 	
Consider key implications e.g.
• *Finance*
• *Patient outcomes / experience*
• *Quality and safety*
• *People and organisational development*
• *Governance and legal*
• *Equality, diversity and inclusion*
	• This is a new report to formally share the feedback from Board Member walkabouts at public Board.
	• This supports Board Members in their triangulation of information from different sources and will feature on every Board agenda.
	• Over time this will enable key themes and trends to be identified, as well as any material actions from visits.
	• This report covers two visits:
	  • Domestic services, Ward 8, Ward 1 and Ward 2 (EAU) – 2 April 2024; and
	  • Breast screening – 16 July 2024.
	• Both feedback reports include positive observations about the teams and the cleanliness of the areas.
	• Further visits to the areas where the full capacity protocol could be enacted have informed the separate paper on today's agenda (Item 14).			

<table>
<tr><td></td><td colspan="6">• Board reflections on the use of artificial intelligence (AI) are a suggested area for discussion through Digital Committee.</td></tr>
<tr><td>Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper</td><td colspan="6">Board Members are requested to review the feedback from the walkabout process and consider this in the context of other items on the Board's agenda for consistency and triangulation.</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:</td><td>Aim 1
☒</td><td colspan="5">We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>Aim 2
☒</td><td colspan="5">We will be a great organisation with a highly engaged workforce</td></tr>
<tr><td>Aim 3
☐</td><td colspan="5">We will enhance our productivity and efficiency to make the best use of resources</td></tr>
<tr><td>Aim 4
☐</td><td colspan="5">We will be an effective partner and be ambitious in our commitment to improving health outcomes</td></tr>
<tr><td>Aim 5
☐</td><td colspan="5">We will develop and expand our services within and beyond Gateshead</td></tr>
<tr><td>Trust strategic objectives that the report relates to:</td><td colspan="6">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.

Evidence an improvement in the staff survey outcomes and increase staff engagement score to 7.3 in the 2025 survey</td></tr>
<tr><td>Links to CQC Key Lines of Enquiry (KLOE):</td><td>Caring
☒</td><td>Responsive
☒</td><td>Well-led
☒</td><td>Effective
☒</td><td>Safe
☒</td><td></td></tr>
<tr><td colspan="7">Risks / implications from this report (positive or negative):</td></tr>
<tr><td>Links to risks (identify significant risks – new risks, or those already recognised on our risk management system with risk reference number):</td><td colspan="6">None</td></tr>
<tr><td>Has a Quality and Equality Impact Assessment (QEIA) been completed?</td><td colspan="2">Yes
☐</td><td colspan="2">No
☐</td><td colspan="2">Not applicable
☒</td></tr>
</table>

Board of Directors' Walkabout Feedback

Board Members in attendance:	Martin Hedley NED Gill Findley Chief Nurse
Area visited:	Domestics services, Ward 8, Ward 1 and Ward 2 (EAU)
Date of visit:	2.4.24
Observations about the environment visited if applicable (e.g. clean, tidy, welcoming, health and safety considerations, colleague wellbeing or patient wellbeing considerations)	Domestic supervisors area and changing facilities were being decorated at the time of our visit Ward 8 was rather cluttered and the kitchen fire door was propped open, but this was addressed by staff at the time of the visit. The area was clean and the domestic was in the process of cleaning after the meals. On ward 2 the full capacity protocol was enacted with 2 patients on the corridor. One patient was due to go home and was sitting in a wheelchair, he expressed that he was embarrassed sitting there and that he had wet himself a number of times whilst waiting to go home.
What were you impressed by?	All staff were friendly and welcoming. Wards were clean and there was active cleaning going on in all areas We saw the "think yellow" campaign in action Meal prep and delivery/clean up seemed efficient and it was noted how the domestic staff and the clinical staff work alongside each other well. A new domestic employee mentioned how well his induction training had prepared him for Health & Safety matters at the Trust.
Any areas of concern / things to follow up?	Staff felt that the Cardea system was cumbersome and difficult to use for ordering products
Overall summary	Overall staff were welcoming and happy to talk about their areas. The new domestic services manager accompanied us on the ward visit and said that she had been impressed with the standards since she started at Gateshead.

Board Members in attendance:	Alison Marshall, Chair Martin Hedley, Non Executive Director Amanda Venner, Executive Director of People & OD
Area visited:	Breast Screening
Date of visit:	Tuesday 16 July 2024
Observations about the environment visited if applicable (e.g. clean, tidy, welcoming, health and safety considerations, colleague wellbeing or patient wellbeing considerations)	Clean, neat and tidy. No patient or staff complaints during construction - role model attitude. POD is excellent, a great use of space and calm relaxing environment. Aware of community and need to reach under served population (with plans and ideas) Good efforts to prioritize patients based on need (last scan date) rather than geographic convenience.
What were you impressed by?	Team exuded confidence and capability with an understanding of their achievements and challenges. Clear leadership across the MDT, with a highly engaged team
Any areas of concern / things to follow up?	Idea for Board – Could the Board take a position on how we will use AI. Focus on freeing staff up and better patient outcomes - to counter negative stories of mass job losses Suggest take through Digital Committee.
Overall summary	High performing team with strong clinical leadership in evidence, building a strong team. They know their aspirations as well as their operational numbers.

NHS
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Report Cover Sheet Agenda Item: 19

Report Title:	**Consolidated Finance Report**			
Name of Meeting:	Trust Board			
Date of Meeting:	31st July 2024			
Author:	Mrs Jane Fay, Deputy Director of Finance			
Executive Sponsor:	Mrs Kris Mackenzie, Group Director of Finance & Digital			
Report presented by:	Mrs Kris Mackenzie, Group Director of Finance & Digital			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
	The purpose of this paper is to provide assurance against corporate objectives and address financial risks			
Proposed level of assurance – to be completed by paper sponsor:	**Fully assured** ☐ **No gaps in assurance**	**Partially assured** ☒ **Some gaps identified**	**Not assured** ☐ **Significant assurance gaps**	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	Not applicable			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity, and inclusion*	The Trust has an approved 2024-25 planned deficit of **£12.650m** before adjustments for donated asset depreciation, and **£12.405m** after. As of June 24, the Trust has reported an actual deficit of **£7.431m** after adjustments for donated asset depreciation. This is an adverse variance of **£0.009m** from its year-to-date target for reasons detailed in the body of this report. The Board recently approved the 2024-25 capital plan totalling **£16.553m**. As of June 24, the Trust has reported net capital spend totalling **£4.999m**, which is **£0.304m** less than planned.			
Recommended actions for this meeting:	The recommendation to Board is to receive the report, discuss the potential implications and record partial			

Outline what the meeting is expected to do with this paper.	assurance for the achievement of the 2024-2025 planned deficit as a direct consequence of the reported year to date position and financial risks. To note the summary of performance as of June 2024 (Month 3) for the Group (inclusive of Trust and QE Facilities, excluding Charitable Funds).				
Trust Strategic Aims that the report relates to:	**Aim 1** ☒	We will continuously improve the quality and safety of our services for our patients			
	Aim 2 ☐	We will be a great organisation with a highly engaged workforce			
	Aim 3 ☒	We will enhance our productivity and efficiency to make the best use of resources			
	Aim 4 ☐	We will be an effective partner and be ambitious in our commitment to improving health outcomes			
	Aim 5 ☐	We will develop and expand our services within and beyond Gateshead			
Trust corporate objectives that the report relates to:	Ensuring robust governance structures to enhance our productivity and efficiency to make the best use of resources				
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)	Financial Risks				
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒		

1 Introduction

1.1 The purpose of this report is to provide a summary of financial performance for April 2024 to June 2024 for the Group (inclusive of the Trust and QE Facilities, excluding Charitable Funds).

1.2 The Trust is planning to achieve an annual deficit of **£12.405m** in 2024-25 financial year inclusive of an annual cost reduction target of **£22.806m** and **£2.721m** elective recovery fund income.

2 Key Financial Performance Indicators

2.1 Performance against key performance indicators is detailed in Table 1

Finance KPIs	Jun-24			RAG	Apr-24 to Jun-24			RAG
	Plan	Actual	Variance		Plan	Actual	Variance	
I&E (Surplus) / Deficit (after adjustments for donated asset depreciation) £m	1.4	1.4	(0.0)		7.4	7.4	0.0	
Income £m	(32.5)	(31.8)	0.7		(95.3)	(95.2)	0.1	
Pay Expenditure £m	22.0	21.7	(0.3)		66.0	67.1	1.0	
Non Pay Expenditure £m	11.4	11.0	(0.4)		35.5	34.5	(0.9)	
Non-Operating Income £m	(0.1)	(0.2)	(0.1)		(0.3)	(0.5)	(0.2)	
Non-Operating Expenditure £m	0.5	0.5	0.0		1.6	1.6	0.0	
Agency Expenditure £m	0.4	0.2	(0.2)		1.1	0.8	(0.4)	
CRP Delivery £m	(1.3)	(1.1)	0.2		(2.4)	(2.3)	0.1	
Capital Expenditure £m	1.6	2.0	0.4		5.3	5.0	(0.3)	
Cash position £m	(4.7)	(4.1)	(0.4)		19.6	25.8	(6.2)	
Liquidity days	(10.73)	(11.95)	1.22		(10.73)	(11.95)	1.22	

Table 1: Finance KPIs

2.2 For the period of June 24 only the Trust has reported a deficit of **£1.360m** after the adjustment for donated asset depreciation which is a **£0.018m** favourable variance against plan.

2.2.1 Year-to-date the Trust has reported a deficit of **£7.431m** which an adverse variance of **£0.009m** against plan.

2.2.3 The key drivers of this adverse variance are use of escalation beds in response to norovirus outbreak, and high numbers of patients not meeting the medical criteria to reside, in addition management of operational pressures and elective recovery performance means higher than planned medical workforce costs across medicine **£1.328m** and surgical business units **£0.240m** driven by premium rate payments on bank, agency and

WLI; with additional pressures on clinical supplies within the surgery **£0.469m** and pathology **£0.239m**.

2.2.4 Variable income performance (£0.751m), pathology testing income (£0.415m) and interest receivable (£0.235m) mitigate the cost pressures.

2.5 A detailed analysis of performance against all income and expenditure categories is detailed in Table 2.

STATEMENT OF COMPREHENSIVE INCOME

June 24-25	NHSE APRIL - MARCH 25 FINAL PLAN							
	Annual Plan £000's	Plan In Month £000's	Actual In Month £000's	Plan to Date £000's	Actual to Date £000's	Variance (Actual - Plan) £000's	Previous Month Variance £000's	Movement in Month £000's
Operating								
Operating Income from Patient Care activities								
Income From NHS Care Contracts	(344,635)	(29,458)	(28,841)	(86,839)	(85,880)	958	343	616
Income From Local Authority Care Contracts	(90)	(26)	(14)	(41)	(45)	(4)	(15)	11
Private Patient Revenue	(684)	(57)	(68)	(171)	(245)	(74)	(63)	(11)
Injury Cost Recovery	(504)	(42)	7	(125)	(132)	(6)	(55)	48
Other non-NHS clinical revenue	(1,700)	(22)	(29)	(56)	(64)	(8)	(1)	(7)
Total Operating Income From Patient Care activities	**(347,613)**	**(29,605)**	**(28,944)**	**(87,232)**	**(86,366)**	**866**	**208**	**657**
Other Operating Income								
Education and Training Income	(11,257)	(976)	(1,002)	(2,852)	(2,964)	(112)	(85)	**(27)**
R&D Income	(564)	(47)	(90)	(141)	(275)	(135)	(91)	**(44)**
Other Income	(21,790)	(1,832)	(1,727)	(5,047)	(5,577)	(530)	(620)	**90**
Donations & Grants Received	0	(8)	0	(25)	0	25	0	**25**
Total Other Operating Income	**(33,611)**	**(2,863)**	**(2,820)**	**(8,064)**	**(8,816)**	**(752)**	**(796)**	**44**
Total Operating Income	**(381,224)**	**(31,606)**	**(31,764)**	**(94,437)**	**(95,183)**	**113**	**(588)**	**701**
Operating Expenses								
Employee Expenses - Substantive	242,176	20,811	20,609	62,375	63,240	865	1,048	**(183)**
Employee Expenses - Bank	7,502	723	799	2,252	2,717	465	386	**80**
Employee Expenses - Agency	3,993	372	206	1,130	761	(370)	(203)	**(167)**
Employee Expenses - Other	1,104	92	112	276	349	73	53	**20**
Total Employee Expenses	**254,775**	**21,997**	**21,725**	**66,033**	**67,067**	**1,034**	**1,284**	**(250)**
Purchase of Healthcare - NHS bodies	8,172	678	713	2,034	2,335	301	260	**41**
Purchase of Healthcare - Non NHS bodies	3,300	292	373	875	1,118	243	195	**48**
Purchase of Social Care	0	0	0	0	0	0	0	**-**
NED's	192	16	15	47	45	(2)	(2)	**0**
Supplies & Services - Clinical	37,782	3,241	4,081	9,652	10,958	1,306	84	**1,222**
Supplies & Services - General	2,943	251	253	758	765	7	(46)	**53**
Drugs	24,772	2,120	1,735	6,411	5,831	(580)	(200)	**(380)**
Research & Development expenses	0	0	3	1	3	2	1	**2**
Education & Training expenses	1,488	144	167	478	470	(7)	(29)	**21**
Consultancy costs	276	45	136	91	189	98	7	**91**
Establishment expenses	4,344	378	319	1,102	1,026	(76)	(16)	**(60)**
Premises	19,123	1,667	1,558	5,062	4,965	(97)	(6)	**(91)**
Transport	1,545	155	116	479	342	(137)	(98)	**(39)**
Clinical Negligence	9,120	760	454	2,279	1,973	(306)	(1)	**(305)**
Operating Leases	1,212	101	(31)	304	72	(232)	(98)	**(134)**
Other Operating expenses	5,513	423	123	2,384	1,569	(815)	(310)	**(505)**
Reserves	0		0		0	0	0	**-**
Operating Expenses included in EBITDA	**119,782**	**10,273**	**10,015**	**31,959**	**31,663**	**(297)**	**(261)**	**(285)**
Depreciation & Amortisation - Purchased / Constructed	10,287	844	633	2,533	1,905	(629)	(174)	**(455)**
Depreciation & Amortisation - Donated / Granted	245	19	24	58	71	13	6	**7**
Depreciation & Amortisation - Finance Leases	3,540	295	266	885	794	(91)	(62)	**(29)**
Impairment & Revaluation	96	8	98	25	109	84	(5)	**89**
Operating Expenses excluded from EBITDA	**14,168**	**1,167**	**1,020**	**3,502**	**2,879**	**(623)**	**(235)**	**(388)**
Total Operating Expenses	**388,725**	**33,437**	**32,760**	**101,494**	**101,609**	**115**	**788**	**(673)**
(Profit)/Loss from Operations	**7,501**	**967**	**996**	**6,197**	**6,426**	**228**	**200**	**28**
Non Operating								
Non-Operating Income								
Finance Income	(1,220)	(102)	(161)	(306)	(541)	(235)	(175)	**(59)**
Total Non-Operating Income	**(1,220)**	**(101)**	**(161)**	**(305)**	**(541)**	**(235)**	**(175)**	**(59)**
Non-Operating Expenses								
Finance Costs	824	69	49	206	147	(59)	(39)	**(20)**
Gains / (Losses) on Disposal of Assets	0	0	0	0	0	0	0	**0**
PDC dividend expense	4,420	368	368	1,105	1,105	(0)	1	**(1)**
Total Finance Costs (for non-financial activities)	**5,244**	**439**	**418**	**1,311**	**1,252**	**(59)**	**(38)**	**(21)**
Other Non-Operating Expenses								
Misc. Other Non-Operating expenses	0	0	0	0	0	0	0	
Total Non-Operating Expenses	**5,244**	**439**	**418**	**1,311**	**1,252**	**(59)**	**(38)**	**(21)**
(Surplus) / Deficit Before Tax	**11,525**	**1,305**	**1,253**	**7,203**	**7,138**	**(66)**	**(13)**	**(52)**
Corporation Tax	1,125	94	132	281	365	84	45	**38**
(Surplus) / Deficit After Tax	**12,650**	**1,399**	**1,384**	**7,485**	**7,503**	**18**	**32**	**(14)**
(Surplus) / Deficit After Tax from Continuing Operations	**12,650**	**1,399**	**1,384**	**7,485**	**7,503**	**18**	**32**	**(14)**
Remove capital donations / grants I&E impact	(245)	(21)	(24)	(63)	(71)	(8)	(6)	(3)
Adjusted Financial Performance (Surplus) / Deficit	**12,405**	**1,378**	**1,360**	**7,422**	**7,431**	**9**	**27**	**(17)**

Table 2: Statement of Comprehensive Income

3 Cost Reduction Programme

3.1 Included in the Trusts 2024-25 financial plans is an annual CRP requirement of £22.800m. As of June £15.845m potential CRP schemes have been identified, including £2.317m vacancy factor estimated based on April to June, which is a shortfall of £6.955m against target. Table 3 provides detail be business unit.

Business Unit	Indicative CRP Target £000	Potential CRP Schemes £000	Variance £000
Clinical Support & Screening BU	£5,209	£2,822	2,387
Surgical BU	£1,832	£3,053	(1,221)
Medicine BU	£2,062	£2,371	(309)
Community BU	£1,615	£660	955
Trust Financing - QEF	£3,000	£2,820	180
Trust Financing - Corporate	£6,960	£2,713	4,247
Finance and Digital BU	£1,129	£460	669
Nursing and Midwifery BU	£426	£185	241
People and OD BU	£252	£337	(85)
Estates and Facilities BU	£90	£400	(310)
Chief Operating Officer BU	£157	£0	157
Chief Executive BU	£53	£0	53
Medical Director BU	£15	£26	(11)
Grand Total	**£22,800**	**£15,845**	**£6,955**

Table 3: Cost Reduction Plan

4 Capital

4.1 The Trusts 2024-25 approved capital programme totals £16.547m comprising of £9.810 CDEL limit and £6.737m of PDC awards relating to the Community Diagnostic Centre.

4.2 Capital expenditure totalled £4.999m at June 24, with the main area of spend being at the Community Diagnostic Centre £4.349m and 23/24 carried forward schemes.

4.3 Variations to the approved programme as at June 24 include an additional PDC award totalling £0.534m relating to Digital Diagnostics and charitable funded schemes totalling £0.046m, resulting in available capital funding of £17.127m as summarised in table 4 below.

Capital Funding	£'000s	£'000s
Net Depeciation*		9,324
Cash		486
PDC Funded Schemes		
- CDC	6,737	
- Digital Diagnostics	534	7,271
Chariatble Funds		46
Total		17,127

* After principal loan repayments

Table 4: Internal CDEL

5 Cash and Liquidity

5.1.1 Group cash as of 30th June totalled £25.752m, a reduction of £4.151m from May (£29.903m). This is the equivalent to an estimated 24.18 days operating costs (May 28.08 days) and is £6.152m above plan year-to-date.

5.1.2 The liquidity metric for June was -11.95 days; 1.22 days below plan.

5.1.3 The Statement of Financial Position is presented in table 5.

Statement of Position - June 2024

	2024/2025 May 2024 Group	2024/2025 June 2024 Group	Movement from Prior Month	2024/2025 June 2024 QEF	2024/2025 June 2024 FT
	£000's	£000's	£000's	£000's	£000's
Assets					
Non-Current Assets					
Investments	80	80	0	80	16,824
Property, Plant and Equipment, Net	164,084	165,420	1,336	1,145	164,275
Right of Use Assets	8,232	7,967	(266)	3,573	4,393
Trade and Other Receivables, Net	2,251	2,215	(36)	784	1,432
Finance Lease - Intragroup				40,579	0
Trade and Other Receivables - Intragroup Loan	0	0	0		2,988
Total Non Current Assets	174,647	175,682	1,035	46,162	189,912
Current Assets					
Inventories	4,899	5,344	445	3,009	2,335
Trade and Other Receivables - NHS	6,554	8,575	2,020	782	7,793
Trade and Other Receivables - Non NHS	7,925	7,788	(137)	3,678	4,109
Trade and Other Receivables - Intragroup				10,396	248
Trade and Other Receivables - Other	0	0	0		0
Prepayments	5,306	5,584	278	810	4,774
Cash and Cash Equivalents	29,903	25,753	(4,151)	2,368	23,385
Other Financial Assets - PDC Dividend	0	0	0		0
Accrued Income	1,167	1,692	525	1,125	567
Finance Lease - Intragroup				562	0
Trade and Other Receivables - Intragroup Loan					3,325
Total Current Assets	55,754	54,735	(1,019)	22,729	46,537
Liabilities					
Current Liabilites					
Deferred Income	8,430	8,328	(102)	113	8,215
Provisions	5,295	4,628	(668)	615	4,013
Current Tax Payables	4,997	4,881	(115)	403	4,478
Trade and Other Payables - NHS	5,745	7,025	1,279	1,266	5,758
Trade and Other Payables -Intragroup				248	10,396
Trade and Other Payables - Other	8,928	7,957	(971)	2,962	4,995
Lease Liabilities	3,212	2,966	(246)	490	2,476
Trade and Other Payables - Capital	2,522	2,908	386	0	2,908
Other Financial Liabilities - Accruals	23,802	24,750	948	6,738	18,012
Other Financial Liabilities - Borrowings FTFF	999	999	0	0	999
Other Financial Liabilities - PDC Dividend	0	889	889	0	889
Other Financial Liabilities - Intragroup Borrowings	0	0		3,325	0
Finance Lease - Intragroup	0	0		0	562
Total Current Liabilities	63,930	65,331	1,401	16,161	63,702
NET CURRENT ASSETS (LIABILITIES)	(8,176)	(10,596)	(2,419)	6,569	(17,164)
Non-Current Liabilities					
Deferred Income	2,011	2,011	(0)	1,719	292
Provisions	2,472	2,472	0	0	2,472
Trade and Other Payables - Other	-	0	0	0	0
Lease Liabilities	5,397	5,397	0	3,138	2,259
Other Financial Liabilities - Accruals	0	0	0	0	0
Other Financial Liabilities - Intragroup Borrowings	0	0	0	2,988	0
Other Financial Liabilities - Borrowings FTFF	11,013	11,013	0	0	11,013
Finance Lease - Intragroup				0	40,579
Total Non-Current Liabilities	20,893	20,893	(0)	7,845	56,616
TOTAL ASSETS EMPLOYED	**145,578**	**144,194**	**(1,384)**	**44,886**	**116,132**
Tax Payers' and Others' Equity					
PDC	164,535	164,535	0	0	164,535
Taxpayers Equity	0	0	0	0	0
Share Capital	0	0	0	16,824	0
Retained Earnings (Accumulated Losses)	(32,236)	(33,620)	(1,384)	28,061	(61,681)
Other Reserves	0	0	0	0	0
Revaluation Reserve	13,180	13,180	0	0	13,180
Misc Reserve	99	99	0	0	99
TOTAL TAXPAYERS EQUITY	145,578	144,194	(1,384)	44,886	116,132
TOTAL ASSETS EMPLOYED	**145,578**	**144,194**	**(1,384)**	**44,886**	**116,132**

Table 5: Statement of Financial Position

6 Conclusion

6.1 The Trust has a 2024-25 planned annual deficit totalling £12.405m.

6.2 The Trust has reported an adjusted deficit of **£7.431m** for the period up to 30th June 2024; which is an adverse variance of **£0.009m** from its year-to-date target.

6.3 Cost reduction programme planned to achieve £2.415m, including £1.702m vacancy factor, at 30th June 24; and delivered £2.317m.

6.4 The Trust is forecasting to achieve its planned deficit target of £12.405m by the achievement of mitigations to reduce spend, maximise income and development of CRP schemes. Delivery will be supported and monitored via work streams within the Trust's Financial Sustainability Group.

6.5 The Trust is forecasting to achieve it approved capital programme. Delivery will be supported and monitored via Capital Delivery and Capital Steering Group.

Kris Mackenzie, Group Director of Finance & Digital
July 2024

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 20

Report Title:	Strategic Objectives & Constitutional Standards			
Name of Meeting:	Tier 1 and Tier 2 Committees – Trust Board			
Date of Meeting:	31st July 2024			
Author:	Deborah Renwick			
Executive Sponsor:	Kris Mackenzie			
Report presented by:	Kris Mackenzie			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☒	**Assurance:** ☒	**Information:** ☒
	This report presents progress, risk and assurance in relation to our Strategic Objectives for M3 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*				
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*	**We will continuously improve the quality and safety of our services for our patients**. **Maternity** compliance with Ockenden recommendations has remained fairly static at 78%, compliance with Maternity Incentive Scheme (MIS) has improved to 83%. Delivery of the **Quality Improvement Plan** has deteriorated to 76% of actions on track. This is primarily driven by a recalibration of the improvement plan in-line with Trust objectives. PSIRP: Recent increases in the incidence of harm rates from falls are being reviewed by the recently renewed Trust wide Falls Group. A comprehensive plan to understand and prevent falls across the Trust is in place. QA: Increases in C. difficile cases have been reviewed; thematic analysis concluded inappropriate antimicrobial prescribing and an increased prevalence circulating in community. QA: Performance against learning disability and autism training is now at 33.4%. e-learning training went live 6th June.			

• *Equality, diversity and inclusion*	Medicines management indicators are still under review to support SMART and measurable KPI's. The Trust is on track with an **agreed strategic approach to EPR.** Project teams are established to support Outline Business Case OBS review and update. Work is ongoing to support procurement planning against in-scope best of breed systems and alignment to EPR plans. **Development & implementation of an Estates strategy** that provides a 3 year capital plan to address key critical infrastructure and estate functional risks across the organisation by March 2025. • A clinically prioritised capital plan is now in place. • Baseline risk assessments from Inphase has been undertaken; a full review of risks and incidents is planned to support an accurate reflection of risks and scoring. • Multi-disciplinary PLACE audits have not taken place as planned in June due to staffing pressures. • A reduction in the value of backlog maintenance score will be heavily influenced by the work to rationalise aging estate. **We will be a great organisation with a highly engaged workforce.** • Budget realignment has now corrected previously reported vacancy rates; which has improved the rate from 1.7% to 1.6% in month. Pockets of vacancy pressures are still evident in key service areas and workforce realignment is underway whereby over recruited areas are supporting workforce critical gaps. • Staff engagement score remains at 6.6, below target levels of 7.3. A refreshed approach to increasing participation in July's survey is planned. • Turnover rates have increased in month from 11.8% to 12.1%, and remain higher than our target of <9.7% • Sickness absence remains high at 5.8%. • Temporary staffing spend has reduced again and is now 0.9% of total pay bill, representing an overall improvement of 0.5% since April. **We will enhance our productivity and efficiency to make the best use of our resources.** **Improve the quality-of-care delivery and accessibility for patients by meeting locally agreed stretch targets.** Average NEL length of stay has reduced by half a day to 6.3 days in June, the current rate and trend is influenced by changes in SDEC

	counting & recording in May – which accounts for circa 2 days in the figures since the change. The ED 4-hr standard is improving at 76% in June, still below the national target level of 78% and planned improvement levels – both admitted and non-admitted are below their differential standards. A deep dive is underway to understand the daily variation in performance. Creating flow and discharging patients earlier in the day is impacting on our patients spending longer time in ED and waiting longer for bed. Patients who occupy a hospital bed and don't meet the criteria to reside has increased to 55 in June, mandated changes to the reasons for delay in June may have contributed to the increase as this appears to have settled in July. The stretch target of achieving zero > 52 week RTT waiters was not achieved by the end of Q1. Recruitment and transformation plans are in place to shore up capacity deficits, whilst shared pathways remain problematic and are supported by GNHCA discussions. Recovery trajectories in gynaecology and surgery are improving, and mutual aid to support urology. Risks remain in T&O for lower limb surgery. Plans to improve counting & coding and productivity in outpatients are underway. Clinical engagement in changing pathways to reduce follow-up outpatients is highlighted as a risk factor to this improvement work. **Evidence of reduction in cost base & an increase in patient care related income by the end of March 2025 to a balanced financial plan for 2025/26.** At the end of month 3 we are reporting a deficit of £ 7.4m, representing a £9k adverse variance from plan (post asset appreciated adjustments). Cost Reduction Plan (CRP) is £98k below planned for levels in M3. Key operational pressures include higher than planned medical workforce costs and premium rates for bank, agency and WLI. The Trust is planning to deliver a forecast outturn deficit position of £12.6m via the tighter grip and control in Sustainability Task and Finish Group and is on plan to achieve £5m cash forecast at the end of March. **We will be an effective partner and be ambitions in our commitment to improving health outcomes.** Our fragile services review will feed into the annual planning cycle and inform provider collaborative sustainability. Improvements in health

<table>
<tr><td></td><td colspan="6">inequalities will be driven by the Health Inequalities Group. Digital teams will continue to support efforts to reduce digital exclusion by repurposing hardware in 2024/25 and have achieved 84% of the target to date in Q1. Gynaecology transformation plans are supporting waiting times reducing in line with planned trajectory and are currently at 37 weeks. Improvement work supporting paediatric autism assessments and diagnosis have not yet delivered waiting time reductions, waits are currently at 81 weeks.

We will develop & expand our services within and beyond Gateshead.

Plans to increase QEF generated income by 0.5% are ahead of schedule with Month 3 performance at remaining at 0.2%.</td></tr>
<tr><td>Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper</td><td colspan="6">The recommendations to the Committee are to receive this report, 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 colspan="5">We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>Aim 2
☒</td><td colspan="5">We will be a great organisation with a highly engaged workforce</td></tr>
<tr><td>Aim 3
☒</td><td colspan="5">We will enhance our productivity and efficiency to make the best use of resources</td></tr>
<tr><td>Aim 4
☒</td><td colspan="5">We will be an effective partner and be ambitious in our commitment to improving health outcomes</td></tr>
<tr><td>Aim 5
☐</td><td colspan="5">We will develop and expand our services within and beyond Gateshead</td></tr>
<tr><td>Trust corporate objectives that the report relates to:</td><td colspan="6">All Strategic Objectives.</td></tr>
<tr><td>Links to CQC KLOE</td><td>Caring
☒</td><td>Responsive
☒</td><td>Well-led
☒</td><td>Effective
☒</td><td colspan="2">Safe
☒</td></tr>
<tr><td colspan="7">Risks / implications from this report (positive or negative):</td></tr>
<tr><td></td><td colspan="6">Key areas to establish reporting:
• PLACE audits
• SMART Medication metrics

No movements in key quality measures:
• Okenden
• Mental health act compliance training

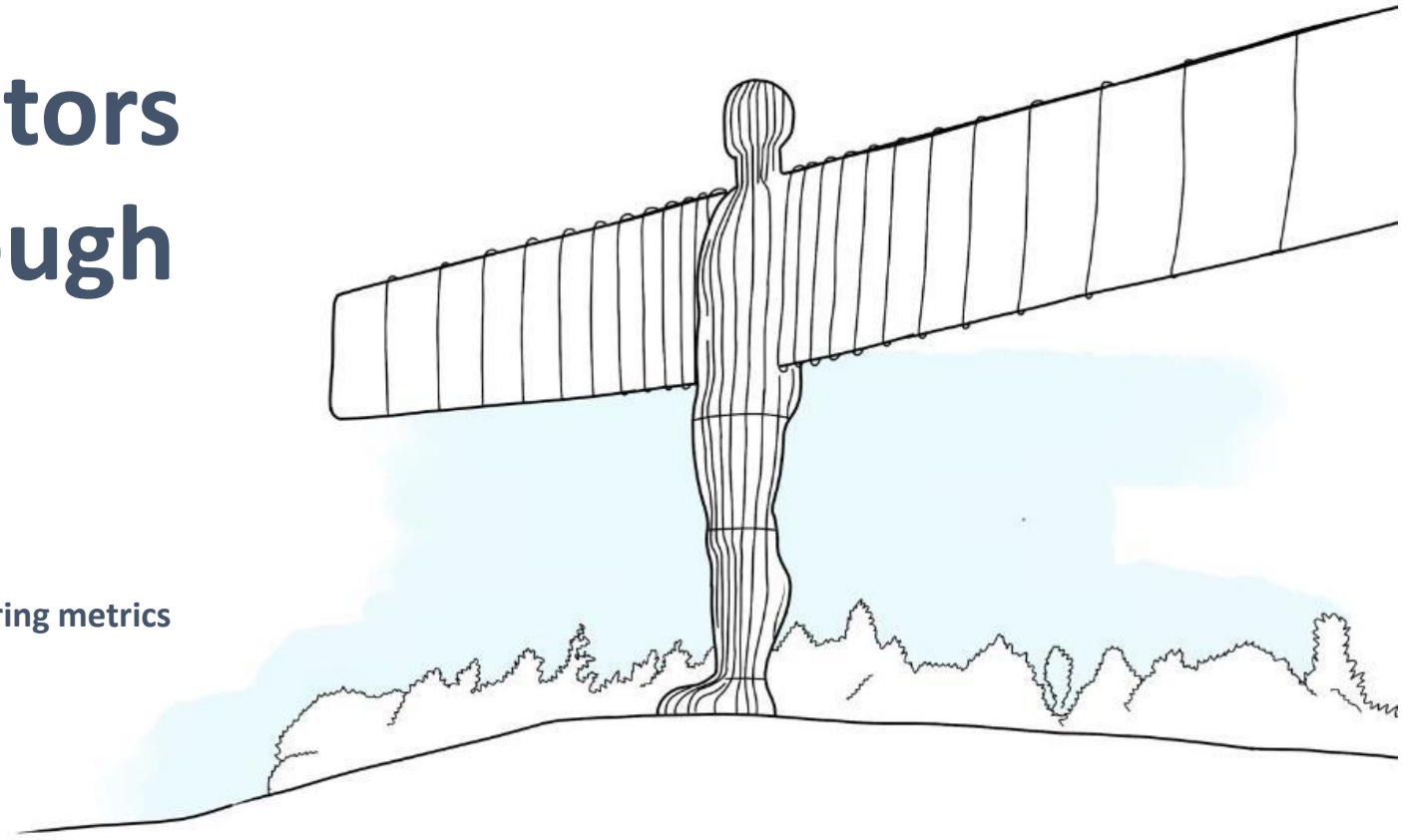
Areas Requiting attention:</td></tr>
</table>

	C.difficile cases at M3 at 50% higher than the same period last year – annual allowance is unknown. Raised incidence in falls with harm. Workforce: Staff engagement and staff turnover Discharge and flow issues impacting on Urgent and Emergency Care metrics and 4hr A&E target Risk in achieving financial plan. Waiting times reductions and ASD pathway improvements		
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒

NHS
Gateshead Health
NHS Foundation Trust

Strategic Objectives 2024/25

Leading Indicators and Breakthrough Objectives



Including Constitutional standards monitoring metrics

Reporting Period: June 2024

Strategic Objectives 2024/25 | **What are we aiming for**

NHS Gateshead Health NHS Foundation Trust

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**

Strategic Objectives 2024/25

Executive Summary

Gateshead Health NHS Foundation Trust

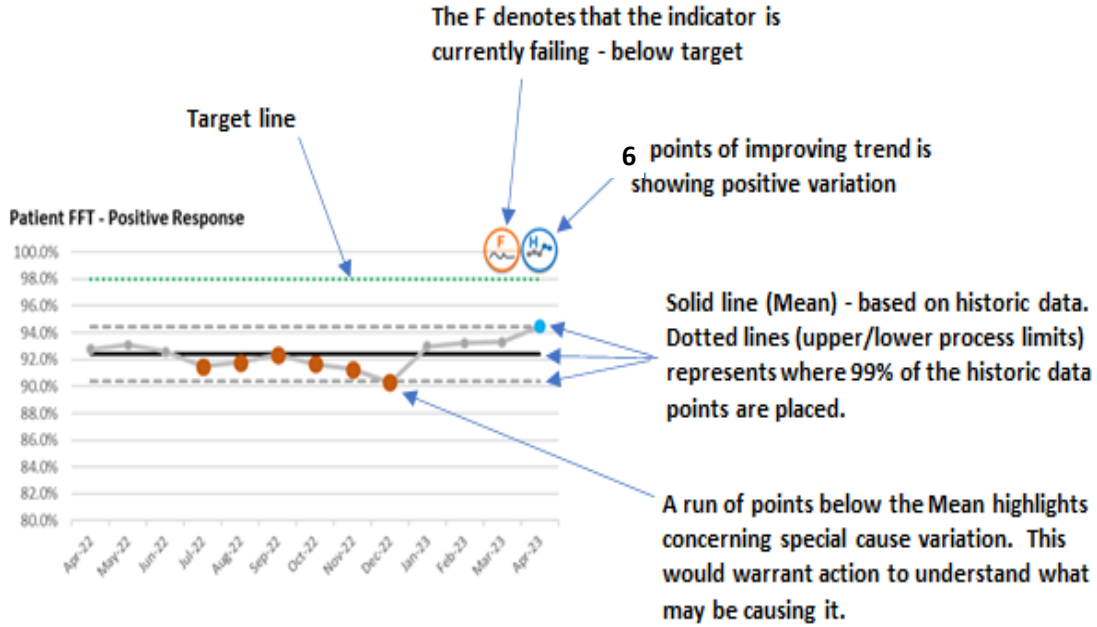
Improved	No Change	Needs further attention
We will continuously improve the quality and safety of our services for our patients		
Compliance with Level 1 training plans for learning Disability & Autism training improved to 33.72%	Mental Health Act Training requires a training package for all registered staff remains static at 87.9%	C.Difficile incidence is higher than the same period last year, thematic analysis indicates antimicrobial prescribing is an issue.
Strategic approach to development of EPR is on track	Reduction in patient safety incidents linked to estate issues: remains at 6	Raised incidence in falls: Review to follow, including thematic analysis.
Maternity Incentive Schemes Compliance improved to 83%		Okenden recommendations compliance decreased to 74%
		Quality Improvement Plans reduced to 76% compliance
We will be a great organisation with a highly engaged workforce		
Reduction in temporary staffing spend evidenced early month reduction to 0.9% of pay bill.	Maintain the vacancy rate at <=2.5%, currently at 1.6%	Achievement of the internal turnover standard of 9.7% (currently at 12.1%)
	Improve the staff engagement score to 7.3 (currently at 6.6)	
We will enhance our productivity and efficiency to make the best use of our resources		
Achievement of 4-hr A&E target (Below planned trajectory and target)	Review and revise 2022/25 Green Plans: Align governance to group structure - Meetings underway	Average non-elective length of Stay < 4 Days
Reduce >12 hour total time in Emergency Department	Achievement of the trajectory to achieve 60% RTA to Bed within 1 hour	Achievement of Zero 52 weeks at the end of Q1 (forecast > 100). Revised delivery in Q2.
Risk in achievement of financial plans at end of M3		Reduce the number of patients with no Criteria to Reside (Increased to 55)
		Increase in New & Follow up value added activity to 33% (reduced 29.2% in June)
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	Reduction in the waiting times for paediatric autism pathway referrals from over 52 weeks to <30 weeks by March 2025
Increase in the number of digital devices repurposed to the local community	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 wait for gynaecology outpatients to no more than 26 weeks by March 2025.
	Evidence in an improvement in health inequalities in the key focus areas linked to the determinants of Health for Gateshead	
We will develop and expand our services within and beyond Gateshead		
	0.5% increase in QEF externally generated turnover (June 0.2%)	

How to interpret the SPC icons and 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.



SPC Rules

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

Strategic Objectives 2024/25

Leading Indicator and Breakthrough Objectives Assurance Heatmap

Gateshead Health NHS Foundation Trust

	P	?	F	
Improvinng		•Maintain the vacancy rate at <=2.5%	•Achievement of the internal turnover standard of 9.7% •Achievement of the 52 week RTT standard by end Q1	H L
Neither improving or deteriorating		•Harm falls rate per 1000 bed days •Achievement of the % to reduce >12 hour total time in Emergency Department •Average Length of Stay Non-Elective (Emergency) <4 days •Cdiff Healthcare associated rate per 100,000 occupied bed days •Achievement of the internal sickness absence standard of 4.9% •Reduction in the wait for gynaecology outpatients to no more than 26 weeks	•Ockenden Recommendations % compliance with Total Recommendations •Achievement of the trajectory to reduce >12 hour total time in Emergency Department •Reduce the number of patients with no Criteria to Reside •Increase % of Outpatient % with procedures •Smoking status to be recorded in the clinical record at the immediate time of admission in 98% of all inpatients by March 2025	
Deteriorating			•Reduction in the waiting times for paediatric autism pathway referrals from over 52 weeks to <30 by March 2025 •Achievement of the trajectory to achieve RTA to Bed within 1 hour •Achievement of the 4 hours trajectory	H L
	Consistency in PASSING the target	**Inconsistency in HITTING, PASSING and FALLING SHORT of the target**	**Consistency in FAILING the target**	

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

Strategic Objectives 2024/25

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

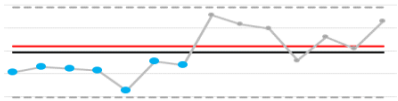
Gateshead Health NHS Foundation Trust

Full compliance with the Maternity Incentive Scheme (MIS) and the Ockenden actions

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.

An agreed strategic approach to the development of an EPR supported by a documented and timed implementation plan.

Development & 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

Metric	Target	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Ass/Var	Trend
LEADING INDICATORS																	
Ockenden Recommendations % compliance with Total Recommendations	100%	88.8%	88.8%	55.5%	55.5%	55.5%	88.8%	88.8%	88.8%	77.7%	77.7%	77.7%	78.0%	78.0%	78.0%		
Maternity Incentive Schemes % compliance with Total Recommendations	100%												68.0%	77.0%	83.0%		
Reduction in patient safety incidents linked to estate issues	<=4					2	2	3	9	3	5	6	4	6	6		
Compliance with the quality improvement plan indicated by the % of actions on track	100%				68.0%	76.0%	76.0%	84.0%	80.0%	84.0%	88.0%	88.0%	88.0%	88.0%	76.0%		
BREAKTHROUGH OBJECTIVES																	
Scoring in domains in areas of PLACE inspection composite score > 95%																	
Harm falls rate per 1000 bed days	12%	2.06	2.31	2.21	2.13	1.27	2.54	2.37	4.55	4.16	3.96	2.58	3.60	3.10	4.28		
Cdiff Healthcare associated rate per 100,000 occupied bed days	<=3.20	14.5	7.7	14.6	14.7	36.2	41.2	7.0	33.5	20.1	36.5	21.0	21.1	20.9	22.1		
90% of staff to complete Mental Health Act training.	90%									92.2%	92.2%	89.7%	89.7%	87.9%	87.9%		
85% of staff to complete GHFT Level 1 learning disability and autism training from April 2024. Develop plans for Level 1 Face to face interactive training as part of mandatory training offer.	85%														33.72%		

Strategic Objectives 2024/25

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

Gateshead Health NHS Foundation Trust

Full compliance with the Maternity Incentive Scheme (MIS) and the Ockenden actions

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.

An agreed strategic approach to the development of an EPR supported by a documented and timed implementation plan.

Development & 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

Measures Requiring focus this month are:

	Measure	Summary
1	**Ockenden Recommendations % compliance with Total Recommendations**	The Trust is reporting compliance at 74%. Areas non-compliant are: Managing complex pregnancy, Informed Consent & Workforce. MNVP 2024/25 workplan, CQC Survey Action plan and Equity and Equality plans have been submitted. Q1 documentation audit is underway and plans in place to ensure sustainability of QUIT smoking in pregnancy team.
	Maternity Incentive Schemes % compliance with Total Recommendations	The Trust is reporting compliance at 83%. Areas non-compliant are: Safety Action 4 (Clinical Workforce Planning) Safety Action 5 (Midwifery Workforce) Safety Action 6 (SBL Care Bundle) Safety Action 7 (MVP) and Safety Action 9 (Trust Board Oversight). Counter measures include: Update of maternity governance structure in line with Trust, ongoing work to review midwifery workforce establishments.
2	**Compliance with the quality improvement plan indicated by the % of actions on track.**	Latest reported data relates to June 2024 with 76% of the Improvement Plan actions on track to deliver. The newly developed Quality Improvement Plan still monitors 25 actions covering Patient Safety, Patient Experience and Quality; however some of these measures have changed to reflect Trust priorities. The first round of updates received in June demonstrates good progress is being made overall. However, compliance against daily resus trolley checks remains a concern, Chief Matrons are now leading on this improvement work and continue to engage with staff across the Trust.
	85% of staff to complete GHFT Level 1 learning disability and autism training from April 2024. Develop plans for Level 1 Face to face interactive training as part of mandatory training offer.	Training went live in June 2024, performance is at 33.72%. Regional challenges remain in (i) Completion rates reporting , and (ii) finding suitable face to face training locations. The Trust awaits a regional fix for the reporting issue with Face to face training in place. However short-term staffing issues and sickness absence within the training team is limiting capacity and availability to book into face to face training.
	Improve Mental Health Act Policy Training Compliance to 95% for all *registered* staff via training and audit.	The Trust is reporting performance at 87.9% for the 4th month in a row. Mental Health Act training for qualified staff has been limited due to sickness absence within the MHA team. However, additional training sessions have been offered in Sept/Oct to support compliance.
	Improve our IPC C.Difficile infection rates per 100 000 occupied bed days.	The Trust has not yet received the annual allocated threshold from NHSE, and rates per 100 000 bed days remain high at 22.1. High levels of C Diff are currently circulating in the community with a more virulent strain of C-diff identified by UKHSA and high levels of antibiotic prescribing in some areas with increased bed occupancy rates. A 10 point c-diff reduction plan is in place, with a drive to 'back to basics' for clinical areas particularly around hand hygiene, AMS and learning.
	Harm related falls will reduce by 5% by March 2025.	Falls remain the highest reported incident for our clinical areas. Recent increases in falls with harm may be explained by the change to a new incident reporting system (inphase). Incidents are managed in a timely manner and there is work planned to strengthen the management falls, including (i) visibility of the electronic falls risk assessments, (ii) medical post-falls assessments, (iii) clear escalation processes for senior nurses to follow. The absence of a inpatient falls team has been noted, but is being mitigated by the work of the falls group. The trust falls prevention group has reconvened and is functioning as a 'workstream' to provide incident oversight and specialist guidance regarding falls prevention across the trust via an action plan. The AFLOAT risk assessment tool is planned to be completed daily as the daily falls assessment as it has shown to be a good indicator of a patients falls risk. The 'Think Yellow Think Falls' campaign continues to be used within the emergency care departments and consideration is being given to widening this to the ward areas.
	Medication Measures	These metrics are still under development.
3	**Evidence an agreed strategic approach to the development of an EPR supported by a documented and timed implementation plan.**	Work is on track to support our Strategic approach, with the Project Team established to support delivery of this objective. The core focus of this group will be to refresh the 2023 Outline Business Case and localise to current position/ drivers and risks. Current drivers are due to the contractual limitations of the existing provision decision regarding strategic route will be required in Dec 2024 to allow sufficient time for procurement of a solution, including due diligence. There is an opportunity to explore wider collaboration with the alliance as part of this work however it is noted that the timescales for this may be prohibitive.
4	**Reduction in risks and severity of scores linked to estate issues**	Baseline assessment status: 20 Risks with combined critical infrastructure risk score of 252. Current High scoring risks include: Theatre ventilation UPS (20), Maternity (20) Bensham Retraction (16) Audiology ventilation (16) Audiology clinical diagnosis (16) Endoscopy washers (16) Records management (16). A full review of these risks is planned in Q1/Q2.
	Reduction in patient safety incidents linked to estate issues	There are 6 estates related incidents reported in June, higher than the average volume of incidents reported in 2023/24. There are no consistent themes with the current incidents.
	Scoring in domains in areas of PLACE inspection composite score > 95%	In the month of June 2024 PLACE lite was stood down to prioritise the implementation of my audit/my domestic and due to staff absences. PLACE lite has now resumed and a assessment was carried out on the 02.07.2024 trialling the dedicated NHS paperwork which is a more robust approach to the assessment being carried out. The paperwork is a bank of set questions set up by NHS England. An NHS PLACE specific app is available , this is currently being reviewing to assess the effectiveness of the app with the hope of being able to start and utilise the app moving forward, the app has a designated bank of questions which have been created to allow for a % score to be produced at the end of each assessment. This will result in no % score being available until the app is used which may take several months. However using the dedicated NHS paperwork will offer an increased level of assurance as an interim measure.
	Reduction in value of backlog maintenance score as reported via the ERIC return	There is now a clinically prioritised plan to review and deliver the backlog maintenance programme. The challenges are limitations on capital available to support the plan & CDEL allocation. Rationalisation of our existing aging estate is required to meet the 25% reduction target (equating to £3.5m reduction). The Trust's annual ERIC submission is due for submission in August.

Strategic Objectives 2024/25 — We will be a great organisation with a highly engaged workforce

NHS Gateshead Health NHS Foundation Trust

Caring for our people in order to achieve the sickness absence and turnover standards by March 2025

Growing and developing our people in order to improve patient outcomes, reduce reliance on temporary staff and deliver the 24-25 workforce plan

Improvement in the staff survey outcomes and increase staff engagement score to 7.3 in the 2025 survey

Metric	Target	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Ass/Var	Trend
LEADING INDICATORS																	
Maintain the vacancy rate at <=2.5%	<=2.5%	2.6%	3.4%	3.7%	3.1%	2.3%	1.8%	2.5%	2.5%	2.3%	2.2%	2.4%	1.7%	1.7%	1.6%		
Improve the staff engagement score to 7.3	>=7.3			5.92			7.00			6.60			6.60				
BREAKTHROUGH OBJECTIVES																	
Achievement of the internal turnover standard of 9.7%	<=9.7%	15.2%	14.8%	14.2%	13.1%	13.0%	13.1%	13.2%	13.2%	12.8%	12.9%	12.5%	12.0%	11.8%	12.1%		
Achievement of the internal sickness absence standard of 4.9%	4.90%	4.9%	5.0%	5.3%	5.7%	6.0%	6.2%	5.9%	6.0%	6.3%	5.6%	5.2%	5.7%	5.7%	5.8%		
Reduction in temporary staffing spend of pay bill evidenced month on month	<=2.3%												1.4%	1.0%	0.9%		

Measures Requiring focus this month are:

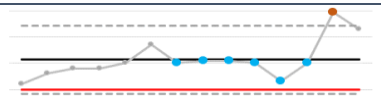
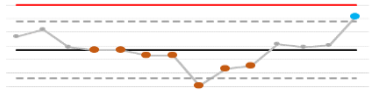
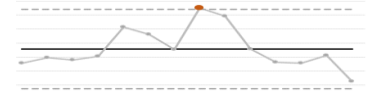
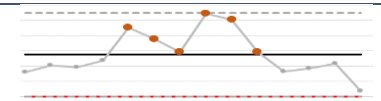
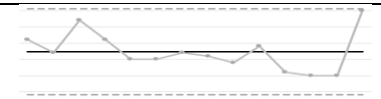
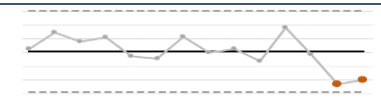
Measure	Summary
Maintain the vacancy rate at <=2.5%	Current vacancy rate of 1.6% is less than target due to successful overseas recruitment drives. The overall percentage masks critical vacancies that are causing operational pressure and additional pay spend. A review of the VCF process is in progress to scrutinise all vacancies.
Improve the staff engagement score to 7.3	A refreshed approach to increasing completion rates will take place for the July quarterly people pulse, with an aim to increase completion which will better allow the Trust to measure engagement on a quarterly basis.
Achievement of the internal turnover standard of 9.7%	Turnover rate at 12.1% has increased by by 0.3%, and is 2.4% away from the 9.7% target. Staff are leaving the NHS across all providers given the significant work pressures and burnout. High staff turnover adds pressure in maintaining safe, high quality services. To provide a countermeasure The People Promise Exemplar programme is now underway, good feedback has been forthcoming from the ICB.
Achievement of the internal sickness absence standard of 4.9%	Sickness absence performance is 5.8% in June across the Group, which is 0.9% above target levels. The trust continues a monthly case management approach of all long-term sickness absences. Training, development and support against our new absence management policy commenced June 2024.
Reduction in temporary staffing spend evidenced month on month reduction and no higher than 2.3 % of pay bill.	Temporary staffing spend is at 0.9% of pay bill in June, representing a 0.5% reduction from April. The Trust aims to see a month-on-month reduction in spend (2024/25 Planning Guidance ask for this to be no more than 2.3% of total pay bill). Further controls have been instigated to support Bank and Agency spend reduction, supported by a Trust wide monitoring group.

Strategic Objectives 2024/25 — We will enhance our productivity and efficiency to make the best use of our resources

NHS Gateshead Health NHS Foundation Trust

Improve the quality of care delivery and accessibility for patients by meeting the locally agreed stretch standards by March 2025

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

Metric	Target	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Ass/Var	Trend
LEADING INDICATORS																	
Average Length of Stay Non-Elective (Emergency) <4 days	<=4	4.20	4.60	4.80	4.80	5.00	5.70	5.00	5.10	5.10	5.00	4.30	5.00	6.96	6.30	?	
Achievement of the 4 hours trajectory	≥78% (Local ≥80%)	73.4%	74.4%	71.8%	71.3%	71.4%	70.6%	70.5%	66.1%	68.6%	69.0%	72.2%	71.8%	72.0%	76.3%	F, H	
Achievement of the 52 week RTT standard by end Q1	Apr 24 - 58 May 24 - 42 Jun 24 - 18 Jul 24 - 0	145	196	236	237	293	273	263	143	113	112	76	72	109	88	F, L	
Achievement of 2024/25 financial Plan - Variance (£k)	Figure in brackets favourable												2,312	2,609	0.009		
Finance - Forecast Out-turn Deficit (Plan)	12,650												12,650	12,650	12,650		
BREAKTHROUGH OBJECTIVES																	
Achievement of the trajectory to reduce >12 hour total time in Emergency Department	0	355	395	380	404	614	562	453	750	692	458	362	358	413	225	F	
	2.0%	3.6%	4.0%	3.9%	4.4%	6.5%	5.7%	4.9%	7.4%	7.0%	4.9%	3.6%	3.8%	4.1%	2.3%	?	
Reduce the number of patients with no Criteria to Reside	<10	46	42	52	46	40	40	42	41	39	44	36	35	35	55	F	
Achievement of the trajectory to achieve RTA to Bed within 1 hour	60.0%	10.5%	12.9%	11.6%	12.2%	9.5%	9.1%	12.3%	10.0%	10.6%	8.8%	13.6%	9.7%	5.5%	6.1%	F, L	
Increase % of Outpatient % with procedures	>=33%	28.5%	28.7%	27.9%	28.3%	27.6%	29.0%	28.9%	28.5%	27.9%	28.4%	27.9%	31.3%	32.0%	29.2%	F	
2024-25 CRP Delivery Variance	Figure in brackets favourable												0	0	98		
No less than £5m cash as per forecast at March 2025	>=£5m												£5m	£5m	£5m		

Strategic Objectives 2024/25

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

Gateshead Health NHS Foundation Trust

Improve the quality of care delivery and accessibility for patients by meeting the locally agreed stretch standards by March 2025

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

Measures Requiring focus this month are:

Measure		Summary
1	**Average Length of Stay Non-Elective (Emergency) <4 days**	Length of stay is over > 5 days; barriers remain in prompt discharge processes, early discharge planning and capturing accurate EDD and out of hospital support. The revised discharge improvement workstream focuses on areas for improvement including a more efficient trusted assessment process, therapy handovers from acute to community, utilisation of Intermediate Care facilities as well as identifying and challenging daily blockages to discharge.
	Achievement of the 4 hours trajectory	Performance against the 4-hr target has improved from the same period last year but remains below planned for performance levels. Current risks include workforce issues, problems in maintaining flow, streaming at the front door and redirection to appropriate services. A deep dive underway to understand the drivers behind variability in performance.
	Achievement of the trajectory to reduce >12 hour total time in Emergency Department	Current performance at 2.3% is above <2% target. The discharge improvement workstream has a number of focused objectives including (1) Reviewing availability of EAU & back of house beds, (2) Ensuring flow earlier in the day, (3) Utilisation of the discharge lounge, (3) daily reviews of discharge plans and discharge dates. The combined programme will improve flow and ensure patients do not remain in ED for extended periods.
	Achievement of the trajectory to achieve 60% RTA to Bed within 1 hour	Performance is at 6.1% for June. This is driven by late bed availability in the day. Supporting work under the discharge workstream includes better streaming to SDEC and planning for tomorrows discharges today. The team have also implemented operational support frameworks such as Patient Flow team alerts to delays and transparency/visibility of long stay patients on EAU.
	Reduce the number of patients with no Criteria to Reside	Average number of patients per day who do not meet the criteria to reside has increased to 55. Availability of services in the Community to support patients who no longer need acute hospital care and ensuring that we are maximising our use of our own services is a key risk to achieving our stretch reduction. New nationally mandated discharge codes have been introduced in June, supporting increased transparency in patient delays. Ongoing work continues to support standardisation and embedding robust discharge processes across the Trust.
	Achievement of the 52 week RTT standard by end Q1 and delivery of the trajectory for 40 weeks	Achievement of our internal stretch target to eradicate 52 week waiters by the end of Q1 has not been achieved; delivery challenges remain in T&O, Gynaecology and Urology due to capacity and demand imbalances and challenged shared pathways in key service areas. Planned recruitments, service transformation and GNCA collaboration are counter measures to support improvements to get back on track in Q2. Work is also underway to maximise outpatient data collection/counting and coding in support of achieving 33% value added activity in outpatients and reduce unnecessary follow-up activity.
	Increase in New Outpatient activity	Current performance is at 29.2%, below 33% target. Plans to support robust counting and recording are underway across surgery and medicine. Modelling to support achievement of 33% is now required to quantify the planned additional work and understand variance from target levels. Risks include clinical engagement to support plans to reduce non-value added follow-up activity in outpatients and capacity conversion to support delivery of the elective care programme.
2	**Evidence achievement of the 24-25 financial plan**	In month improvements to plan of £2.5m leave the Trust with a negative variance against planned levels of £9k at the end of M3. Ongoing risks include an overspend against delegated budgets, achievement of variable income targets and achievement of cost reduction programme. The drivers of the overspend against delegated budgets includes , staffing overspends arising from sickness & maternity cover, escalation beds and enhanced care. Sustainability Task & Finish Group will focus on grip and control measures, workforce growth and deployment, cost reduction informed by benchmarking, continuous improvement and transformation.
3	**Review & revise the 2022/25 green plan & align with the group structure by the end of Q2.**	Q1 - Q2 plans to embed the Green plan governance structure and align with group governance. The first sustainability meeting is scheduled for the last week in June, where 10 workstreams will provide update reports aligned to our sustainability objectives. Work plan priorities include: waste, active travel, fleet, procurement, estates & facilities, workforce/communications, sustainable care, medicine, digital transformation and adaptation. Q4 plans include a survey of understanding across the Board/EMT and Senior Leadership Group members.

Strategic Objectives 2024/25

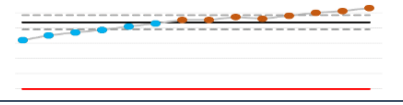
We will be an effective partner and be ambitious in our commitment to improving health outcomes

NHS Gateshead Health NHS Foundation Trust

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

Work collaboratively as part of the Gateshead system to improve health and care outcomes to the Gateshead population

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'

Metric	Target	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Ass/Var	Trend
LEADING INDICATORS																	
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																	
BREAKTHROUGH OBJECTIVES																	
Increase in the number of digital devices repurposed to the local community	>300												100	100	50		
Smoking status to be recorded in the clinical record at the immediate time of admission in 98% of all inpatients by March 2025	>=98%	84.9%	92.7%	91.8%	91.2%	90.2%	90.6%	92.6%	88.7%	92.2%	93.4%	91.1%	92.1%	91.6%	92.5%	F	
Reduction in the wait for gynaecology outpatients to no more than 26 weeks	<=26	21.1	23.1	23.2	23.6	26.7	26.8	27.9	25.9	28.1	28.0	39.7	35.9	27.0	37.0	?	
Reduction in the waiting times for paediatric autism pathway referrals from+B2 over 52 weeks to <30 by March 2025	<=30	62.0	65.0	67.0	68.5	71.0	73.0	75.0	75.0	77.0	76.0	78.0	80.0	81.0	83.0	F H	

Measures Requiring focus this month are:

Measure	Summary
Evidence a reduction in the number of 'fragile' and 'vulnerable' services as a direct outcome of Alliance working	This will be reviewed quarterly as part of the Provider Collaborative Sustainability review. Outputs and products from this work will be reviewed to inform the annual planning process and is contained in the Project Plan for 2024/25 to support planning for 2025/26.
Evidence in an improvement in health inequalities in the key focus areas linked to the determinants of Health for Gateshead	Key determinants of Health for Gateshead are to be defined through the Health Inequalities Group workstream. Evidence/measures and controls will be implemented as part of the focused work to progress in 2024/25.
Increase in the number of digital devices repurposed to the local community	Digital exclusion is where members of the population have inadequate access and capacity to use digital technologies that are essential to participate in society. The risk to this target is that the quantity of devices being made available for recycling and repurposed is dependant on Trust usage and need. This is therefore entirely variable throughout the course of the year. In Q1 250 devices have reached end of life as they are unable to take the latest windows OS update, which has driven improvement during the first quarter and the Trust will continue to recycle equipment as swiftly and efficiently as possible.

Smoking status to be recorded in the clinical record at the immediate time of admission in 98% of all inpatients by March 2025	In 2022 the Trust moved from recording smoking status at discharge to recording smoking status on admission (within 6 or 24 hours). This helps care workers understand and support patient needs in managing withdrawal from tobacco and identifying target cohorts of patients who require support from the tobacco dependency treatment service. The Trust is currently reporting performance at 92.5% against this measure in June. Historically all patients who are smokers are referred for support, on average 74% are seen by the tobacco dependency treatment service & 34% of those seen undertake a supportive quit attempt. On average 14% of those patients had quit or recoded a nonsmoking status by week 4.
Reduction in the wait for gynaecology outpatients to no more than 26 weeks by March 2025.	Gynaecology outpatient services have undertaken a full service redesign to reduce the first outpatient wait from 39+ weeks to < 26 weeks. Current data shows an increase of median wait from 27 weeks in May to 37 weeks in June.
Reduction in the waiting times for paediatric autism pathway referrals from over 52 weeks to <30 weeks by March 2025	Current waits are at 83 weeks for autism assessment pathways, which does not yet reflect the transformed pathways and revised clinical model. The modelled plan includes achieving this standard by March 2025. This will now require further review and mitigation to support the projected loss of capacity re: recent senior consultant appointment.

Strategic Objectives 2024/25 — We will develop and expand our services within and beyond Gateshead

NHS Gateshead Health NHS Foundation Trust

Contribute effectively as part of the Great North Healthcare Alliance to maximise the opportunities presented through the regional workforce programme

Evidenced business growth by March 2025 with a specific focus on Diagnostics and Women's health and commercial opportunities

Metric	Target	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Ass/Var	Trend
LEADING INDICATORS																	
0.5% increase in QEF externally generated turnover	>=0.5%													0.2%	0.2%		
Place holder - metric to be agreed / developed																	
BREAKTHROUGH OBJECTIVES																	
Place holder - metric to be agreed / developed																	

Measures requiring focus this month

Measure	Summary
0.5% increase in QEF externally generated turnover	Current cumulative performance is good at 0.2% which is slightly ahead of target plan. Performing well at engagement VAT consultancy, risk surrounding new business due to lack of Business Development resource and existing contracts without renewal dates.

NHS
Gateshead Health
NHS Foundation Trust

Constitutional Standards 2024/25

Reporting Period: June 2024

Constitutional Standards

Constitutional Standards Metrics Assurance Heatmap

Gateshead Health NHS Foundation Trust

	P	?	F	
Improvinng		•12 hour trolley waits (DTA to left department) •Ambulance handover delays 60 minutes +	•Achievement of the A&E 4 hours standard •Ambulance handover delays 30-60 minutes •Achievement of the 52 week RTT standard by end Q1	H L
Neither improving or deteriorating	•Achievement of the Cancer 31 day standard	•% of ED attendances > 12 hours in department •Achievement of the Cancer 28 day standard •Achievement of the Cancer 62 day standard	•Achievement of the RTT 18 week standard	
Deteriorating			•Achievement of the 6 week diagnostic standard	H L
	Consistency in PASSING the target	**Inconsistency in HITTING, PASSING and FALLING SHORT of the target**	**Consistency in FAILING the target**	

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

Constitutional Standards

Metrics

NHS Gateshead Health NHS Foundation Trust

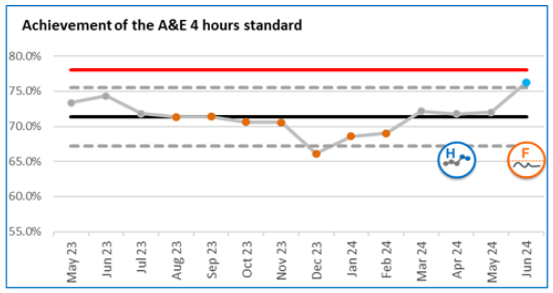
Metric	Target	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Ass/Var
Achievement of the A&E 4 hours standard	>78%	73.4%	74.4%	71.8%	71.3%	71.4%	70.6%	70.5%	66.1%	68.6%	69.0%	72.2%	71.8%	72.0%	76.3%	
12 hour trolley waits (DTA to left department)	0	5	0	11	0	50	24	0	7	1	0	0	1	4	0	
% of ED attendances > 12 hours in department	<2%	3.6%	4.0%	3.9%	4.4%	6.5%	5.7%	4.9%	7.4%	7.0%	4.9%	3.6%	3.8%	4.1%	2.3%	
Ambulance handover delays 30-60 minutes	0	93	96	59	77	123	99	80	110	25	1	0	0	2	1	
Ambulance handover delays 60 minutes +	0	77	52	62	16	122	100	51	50	2	0	0	0	0	0	
Achievement of the RTT 18 week standard	>92%	72.4%	70.7%	70.6%	68.9%	67.0%	66.9%	67.7%	67.2%	68.3%	67.8%	67.9%	68.9%	70.6%	70.6%	
Achievement of the 52 week RTT standard by end Q1	Apr 24 - 58 May 24 - 42 Jun 24 - 18 Jul 24 - 0	145	196	236	237	293	273	263	143	113	112	76	72	109	88	
Achievement of the 6 week diagnostic standard	>95%	89.5%	90.0%	91.9%	90.7%	88.6%	92.4%	94.1%	91.4%	90.0%	92.1%	91.2%	88.8%	86.0%	83.8%	
Achievement of the Cancer 28 day standard	>77%	69.2%	78.1%	77.4%	77.6%	76.0%	76.8%	78.5%	80.4%	75.9%	83.0%	81.1%	80.0%	82.7%	82.2%	
Achievement of the Cancer 31 day standard	>96%	99.5%	100.0%	100.0%	99.6%	99.5%	100.0%	99.4%	99.4%	99.6%	100.0%	97.9%	99.1%	100.0%		
Achievement of the Cancer 62 day standard	>70%	72.7%	69.6%	69.1%	73.5%	70.4%	68.6%	70.0%	64.6%	72.4%	71.2%	73.9%	75.7%	68.2%		

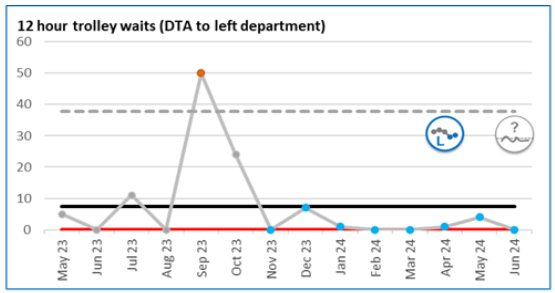
Validated data unavailable at time of report

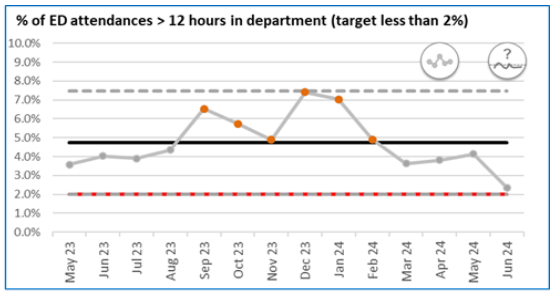
Constitutional Standards

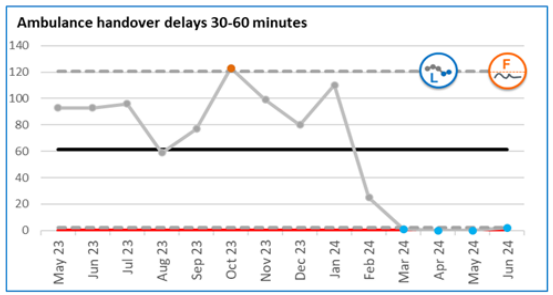
Metrics (SPC)

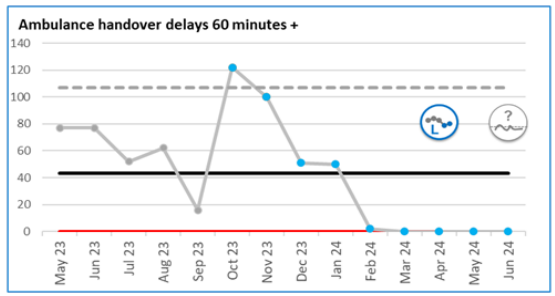
Gateshead Health NHS Foundation Trust

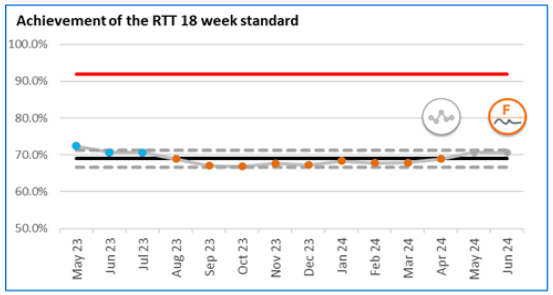


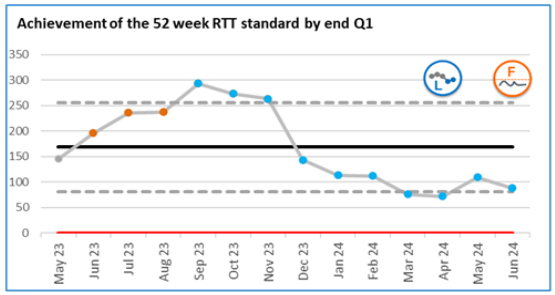


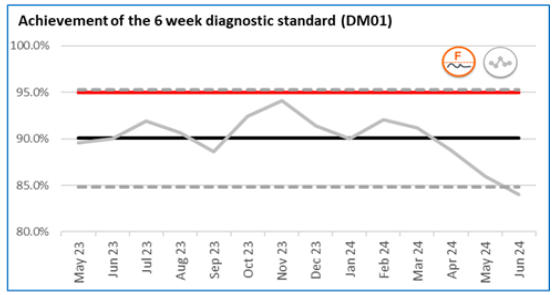


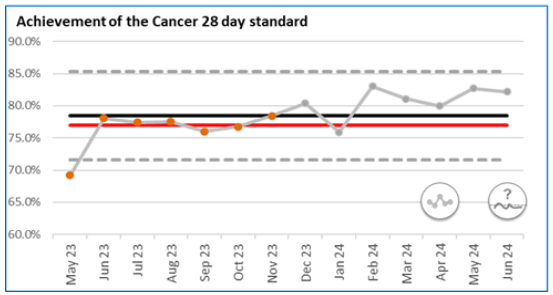


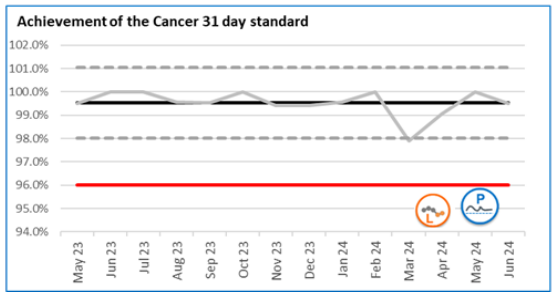


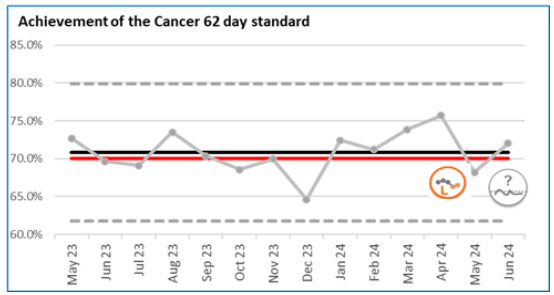












Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 21

Report Title:	**Maternity Integrated Oversight Report – June 2024**			
Name of Meeting:	Trust Board			
Date of Meeting:	31/7/2024			
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 11/7/2024 SBU operational board 31/7/2024 Safecare/Risk & safety Council 23/7/2024			
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 June 2024, there were 148 births, 0 MNSI case and 1 perinatal losses. • Exceptions reported – positive outlier for induction of labour **Mortality and morbidity rates:** • 1 perinatal loss during June 2024 • 0 MNSI cases • 0 learning events **Saving Babies Lives Care Bundle Q1:** • Agreed LMNS audits received • Q! LMNS meeting to review & agree targets 12/8/24 **Complaints summary Q4:** • 8 complaints • Themes – communication, patient information			

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** ☒

Gateshead Health NHS Foundation Trust

Maternity Integrated Oversight Report

Maternity data from June 2024

Maternity IOR contents

- Maternity Dashboard 2024/25:
  - June 2024 data

- Exception reports:
  - Positive highlights – digital inclusion/recruitment & retention

- Items for information:
  - Strategic Objectives (inc/ SBLCB update – due this month)
  - Perinatal Quality Surveillance minimum dataset
  - Incidents
    - 0 MNSI cases reported in June 2024
  - Perinatal Mortality and Morbidity
    - 1 perinatal losses in June 2024
  - Q4 Complaints

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Total Births	Jun 24	148	-			155	113	197
Spontaneous vaginal deliveries	Jun 24	72	-			75	50	100
Assited births	Jun 24	76	-			80	52	109
Induction of Labour	Jun 24	38	-			62	39	85
Maternity Readmissions	Jun 24	3	-			3	-2	8
Neonatal Readmissions	Jun 24	4	-			5	-3	14
Smoking at time of booking	Jun 24	7.28%	15.00%			8.90%	3.81%	13.99%
Smoking at time of delivery	Jun 24	6.16%	6.00%			7.70%	0.55%	14.85%
In area CO at booking	Jun 24	90.73%	90.00%			88.56%	77.83%	99.29%
In area CO at 36 weeks	Jun 24	76.87%	80.00%			83.03%	71.76%	94.31%
Admitted directly to NNU (SCBU) (>37 weeks)	Jun 24	8	4			8	-2	18
Percentage Admitted directly to NNU (SCBU) (>37 we	Jun 24	5.88%	6.00%			5.43%	-1.30%	12.16%
Preterm birth rate <=36+6 weeks at birth	Jun 24	6.80%	6.00%			6.43%	2.29%	10.57%
Continuity of Carer: Percentage placed on pathway (2	Jun 24	15.52%	-			16.93%	6.97%	26.88%
Continuity of Carer: Percentage from BAME backgrou	Jun 24	22.22%	-			27.68%	0.14%	55.23%
Spontaneous Vaginal Births (%)	Jun 24	48.98%	-			48.29%	35.75%	60.83%
Induction Rate	Jun 24	26.03%	-			40.80%	28.99%	52.61%
Instrumental Delivery Rate	Jun 24	10.27%	-			13.06%	5.53%	20.58%
Elective C Section Rate	Jun 24	19.73%	-			18.69%	7.54%	29.84%
Emergency C Section Rate	Jun 24	21.77%	-			20.09%	8.29%	31.90%
C Section Rate	Jun 24	41.50%	-			38.79%	23.62%	53.95%
3rd or 4th degree tear (Total) Precentage	Jun 24	1.37%	3.00%			1.19%	-1.28%	3.67%
Massive PPH >=1.5L (All births)	Jun 24	1	2			9	0	19
Breastfeeding: Percentage of Initiated Breasfeeding	Jun 24	84.14%	66.20%			73.80%	61.73%	85.87%
Breastfeeding: Breasfeeding at Discharge (Transfer to	Jun 24	66.43%	56.20%			54.75%	37.59%	71.91%

Safe

Responsive

Maternity

NHS Gateshead Health NHS Foundation Trust

Maternity Dashboard 2024/25

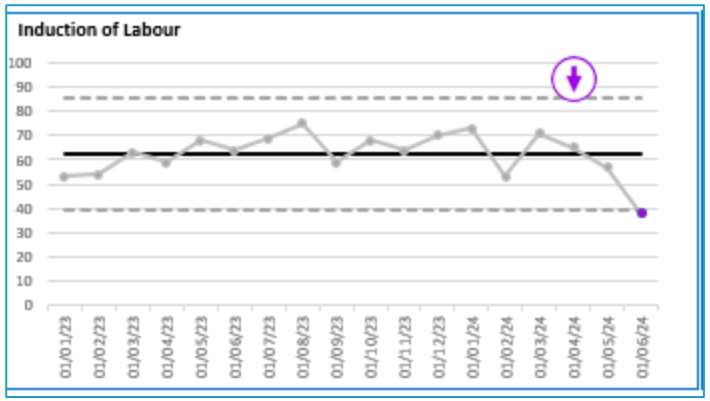
Maternity Dashboard 2024/25

Maternity

Gateshead Health NHS Foundation Trust

Responsive

Safe



- **Background**
  - There is no target for IOL rates however monitoring is a helpful adjunct to measure workload and acuity
  - Any delays >24 hours to IOL constitute a “red flag” event and are reported on daily SitRep to LMMS/NHSE
- **Assessment**
  - There is a reduction in IOL rates in June 2024
  - This is in line with overall reduced birth rate in June and increased caesarean section rate
  - No adverse outcomes related to IOL rate
- **Actions**
  - Continue to monitor to inform workforce plans
- **Recommendations**
  - None

Positive highlights

Maternity

NHS Gateshead Health NHS Foundation Trust

Responsive

Safe

- Digital inclusion:
  - Hope Foundation (hope-foundation.org.uk)
  - Devices, data, training to reduce digital exclusion
  - Direct referral from community midwives

- Retention data:
  - May 2022
    - 15 Band 5 RM in post on preceptorship programme
  - September 2022
    - 17 Band 5 RM recruited since edit of preceptorship programme
  - May 2024 -
    - 17 current Band 5 RM in post on preceptorship programme
    - 13 of the 32 B5 RM completed preceptorship programme to B6 RM
    - 31/32 remain in post at GHNT
    - 1 supported career break
    - 1 leaver
    - 1 Band 5 RM on preceptorship programme > 24 months

Maternity

Gateshead Health NHS Foundation Trust

Safe

Well Led

Strategic Objective 1:
Reporting Lead: Karen Parker
Executive: Gill Findley
Evidence full compliance (100%) with the Ockenden Recommendations

	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Total Areas	9	9	9									
Areas Not Applicable												
No. Compliant	7	7	5									
No. Non Compliant	2	2	4									
Percentage Compliance	78%	78%	56%									

Areas compliant: (List domains compliant) 1. Enhanced Safety, 2. Listening to families 3. Staff training & MDT working, 5. RA throughout pregnancy & Guidelines

Areas Non compliant: (List domains non-compliant) 4.Managing Complex Pregnancy, 6. Monitoring Guidelines, 7. Informed Consent & Workforce .

How are we performing or Progress Made? MNVP 2024/25 workplan submitted, CQC survey action plan submitted, Equity & Equality action plan submitted

What is driving performance or what are the challenges? Audit requirements approved from LMNS - review of audit planner to ensure new audits are captured for SBLCB (IEAs 4&6), workforce (Birthrate+ establishment review complete - ongoing work for approval of workforce action plan to acheive midwifery workforce BR+ compliance), new MNVP workplan submitted - website patient information review required, element 1 - smoking in pregnancy, challenges in capacity of QUIT team - additional support sought

What actions is being taken or future risks & planned developments? Q1 documentation audit underway, ensuring sustainability of QUIT smoking in pregnancy team

Strategic Objective 1:
Reporting Lead: Karen Parker
Executive: Gill Findley
Evidence full compliance (100%) with Maternity Incentive Scheme

	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Total Areas	88	88	88	88								
Areas not Applicable	6	6	6	6								
No. Compliant		56	63	68								
No. Non Compliant / Unassessed		35	26	17								
Percentage Compliance		68%	77%	83%								

Areas compliant: (List domains compliant) Safety Action 1 (PMRT) Safety Action 2 (MSMDS), Safety Action 3 (ATAIN), Safety Action 8 (Core Competency Framework) Safety Action 10 (HSIB & ENS)

Areas Non compliant/Not Assessed: (List domains compliant) Safety Action 4 (Clinical Workforce Planning) Safety Action 5 (Midwifery Workforce) Safety Action 6 (SBL Care Bundle) Safety Action 7 (MVP) Safety action 9

How are we performing or Progress Made? Ongoing monthly progress report towards standards demonstrating month-on-month increase, bi-monthly assessment of evidence repository via safety champions meeting

What is driving performance or what are the challenges? Audit requirements approved from LMNS, workforce (Birthrate+ establishment review, new leads in posts), Trust governance review - ensure oversight flows through correct processes

What actions is being taken or future risks & planned developments? Update of maternity governance structure in line with Trust, ongoing work to review midwifery workforce establishments

2024/25		April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
Number of perinatal losses		0	0*	1									
Number of HSIB cases		1	1	0									
Number of incidents logged as moderate harm or above		1	0	0									
Minimum obstetric safe staffing on labour ward		100%	100%	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	100%	90%										
	Complaints	2	1	1									
HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust		0	0	0									
Coroner Reg 28 made directly to Trust		0	0	0									

*CHPPD overall care hours per patient per day

Complaints: Q4 23/24 current position

North East and North Cumbria
Local Maternity and Neonatal System

Responsive

Final primary subject	Final sub-subject	Lessons learnt	Actions taken	Upheld, partially upheld or not upheld
Communication		Need to improve information on viability for women experiencing very early labour	Meeting held with family	Not upheld
Communication		Need to improve information for women having emergency surgery	Feedback to staff involved	Not upheld
Clinical Treatment	Inadequate midwifery care	Individual learning	Feedback to staff involved	Upheld
Communication		Need to improve information on viability for women experiencing pregnancy loss before date of viability	None	Not upheld
Communication		None	None	Not upheld
Incorrect Documentation		Maternal medication management plan for babies needed on Badger that doesn't mention substance abuse	Feedback to System C	Partially upheld
Communication		Need to improve system for actioning screening results	Review of system	Upheld
Inadequate medical care	Communication	As per action plan from case review		Upheld

NHS
Gateshead Health
NHS Foundation Trust

Report Cover Sheet Agenda Item: 22

Report Title:	**Nursing Staffing Exception Report**			
Name of Meeting:	Board of Directors (Part 1- Public)			
Date of Meeting:	31st July 2024			
Author:	Helen Larkin, Clinical Lead E-rostering			
Executive Sponsor:	Gillian Findley, Chief Nurse and Professional Lead for Midwifery and AHPs			
Report presented by:	Kate Clark, Deputy Chief Nurse			
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:				
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 June 2024. June has demonstrated some areas with staffing challenges relating to sickness absence and enhanced care requirements. During June, 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 assurance of this operating as expected, is provided by			

<table>
<tr><td></td><td colspan="5">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
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<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 20 staffing incidents raised via InPhase during the month of June, of which there was no physical harm and no/low psychological 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
June 2024

1. Introduction

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

Table 1: Whole Trust wards staffing June 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 (%)**
99.4%	**101.5%**	**97.4%**	**106.7%**

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 through the month of June have mitigated the risk of reduced Healthcare Assistants on nights by assignment of a third qualified nurse on duty with the exception of 2 nightshifts where the senior nurse reports the unit was safely staffed for the patient acuity.

Ward 28 have reduced Healthcare assistants throughout June, due to reduced occupancy and reduced elective activity during weekends.

Following discussion with the National Safer Staffing faculty, it was recommended CHPPD is an unsuitable metric for Paediatric services, therefore has been removed from this report. This is due to the model of care including Emergency department care and outpatient services. The CHPPD metric accounts for patients occupying a bed at midnight, therefore providing an unwarranted depiction of their current care delivery.
Incidents related to nurse staffing raised via Inphase and as a Red Flag are still demonstrated within the paper to highlight any identified concerns related to safer staffing within the department.

The exceptions to report for June are as below:

June 2024	
Registered Nurse Days	**%**
N/a	
Registered Nurse Nights	**%**
N/a	
Healthcare Support Worker Days	**%**
N/a	
Healthcare Support Worker Nights	**%**
SCBU	73.6%
Ward 28 Orthopaedic Elective Ward	72.9%

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

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

3. Care Hours Per Patient Day (CHPPD)

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

- Patient acuity and dependency

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

Ward level CHPPD is outlined in Appendix 1. For the month of June, the Trust total CHPPD was 8.4. 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.

There were 20 nurse staffing incidents raised via the incident reporting system. Fourteen were in relation to Paediatric Emergency Assessment and insufficient staffing, two of which were identified as causing Low Psychological Harm. Five incidents were reported by ward 25 highlighting insufficient staffing for the high acuity of the patients on the ward and number of patients requiring enhanced care, 2 of those incidents are highlighting Low Psychological Harm. One incident was reported by ward 14a reporting insufficient nurses for provision of 1-1 enhanced care resulting in an absconded patient. No physical Harm was reported for any of the incidents reported in the month of June.

Nursing Red Flags

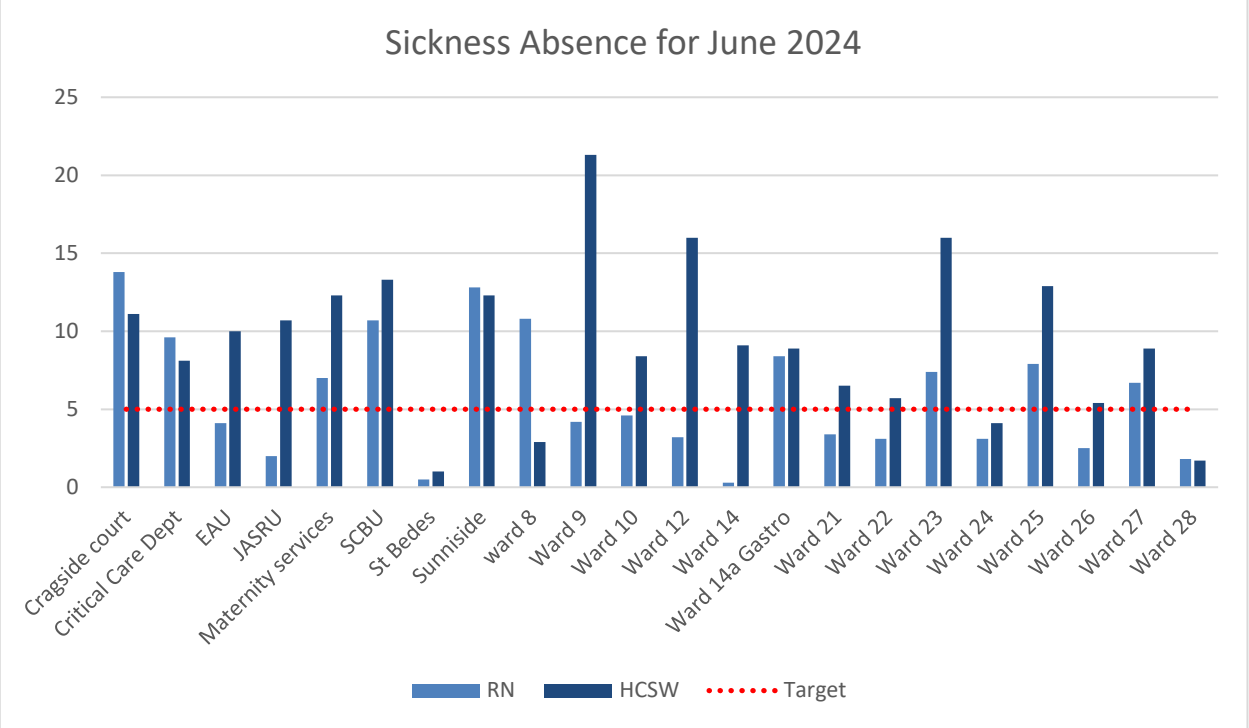
The National Institute for Health and Care Excellence (NICE) guideline for Safe Staffing for nursing in adult inpatient wards in acute hospitals (2014) recommend the use of nursing Red Flag reporting. A Nursing red flag can be raised directly as a result of rostering practice/shortfall in staffing or by the nurse in charge if they identify a shortfall in staffing requirements resulting in basic patient care not able to be delivered. Throughout the month of June there were 55 nursing red flags reported. This is compared to 23 red flags reported in May. Of those 56 Red flags raised, twenty seven of those were in Paediatrics, due to the increased volume and increased Inphase reports, these are listed below. There was one red flag raised by Ward 9, six by Ward 8, seventeen red flags raised by Ward 25, two by Ward 12, one by Ward 14, one by Ward 10 and one by Ward 14a. There was no red flags raised by SCBU or ward 28.

Date	Shift type	Ward	Narrative
1/6/24	Long Day	Paediatrics	X1 RN short for early shift and x2 RN short on late shift leaving critical staffing levels in afternoon. Message put out to nurse bank. Senior nurse informed APNP on duty.
3/6/24	Long Day	Paediatrics	Need a late qualified nurse 2/6/24
7/6/24	Long Day	Paediatrics	Need a long day qualified
8/6/24	Long Day	Paediatrics	Need a long day qualified

9/6/24	Long Day	Paediatrics	Need a long day qualified
9/6/24	Long Day	Paediatrics	Only 3 RNs on late shift instead of safe staffing level 4. Early staff stayed late to support due to increased acuity of department
10/6/24	Long Day	Paediatrics	1Q long day short today. Activity is high
11/6/24	Long Day	Paediatrics	Only 3 Q until 09.30am. No HCA in Peapod/SSU
12/6/24	Long Day	Paediatrics	Only x3 registered nurses on late shift instead of safe staffing levels of 4 nurses. Also no HCA on duty
12/6/24	Long Day	Paediatrics	Red flagged earlier today but further sickness
12/6/24	Long Day	Paediatrics	No HCA in SSU Peapod today
13/6/24	Long Day	Paediatrics	1 Qual Long Day shift outstanding TW also starting at 8pm and not 6pm
14/6/24	Long Day	Paediatrics	No HCA in SSU/PP today due to sickness and unfilled vacancy
14/6/24	Day	Paediatrics	No Q in Day unit today due to unfilled vacancy
16/6/24	Long Day	Paediatrics	Need a 12 hour qualified, messages gone out to staff and bank staff for cover
17/6/24	Long Day	Paediatrics	Need a 12hr shift for Peapod, messages gone out to staff for cover
17/6/24	Long Day	Paediatrics	X1 RN short. High acuity on department x6 patients on short stay minus 2 beds. Night Staff no breaks overnight, escalated to 1200 no help available twilight stayed extra to support
19/6/24	Long Day	Paediatrics	Only 3 RN on long day, should be 4. Last minute sickness and vacancy
19/6/24	Day	Paediatrics	No RN due to sickness. APNPs to cover where able
20/6/24	Long Day	Paediatrics	Only 3 Q in PP/ SS today. 1 Q allocated to allergy so should not be counted in this roster calculation
22/6/24	Long Day	Paediatrics	X1 RN short for early shift. No HCA on late. Twilight not starting until 8pm as has just finished night duty.
23/6/24	Long Day	Paediatrics	Only 2 RN until 10:00. Then only 3 nurses from 16:00-20:00
24/6/24	Long Day	Paediatrics	X2 RN until 09:30 then x3 for the rest of the shift. No HCA
27/6/24	Long Day	Paediatrics	3 qualified on duty on ppod, x1 LD outstanding
28/6/24	Long Day	Paediatrics	X1 qualified LD outstanding on ppod and TW outstanding
29/6/24	Long Day	Paediatrics	TW and qualified long day outstanding
29/6/24	Long Day	Paediatrics	Only 3 nurse on shift

5. Attendance of Nursing workforce

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



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 June 2024 and provides assurance of ongoing work to triangulate workforce metrics against staffing and care hours.

8. Recommendations

The Trust Board 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 June 2024

Decrease from previous month Increase form previous month

	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	93.5%	77.6%	85.0%	133.7%	146	13.0	13.0	26.0
Critical Care Dept	83.1%	112.4%	94.7%	84.8%	245	31.2	5.7	36.9
Emergency Care Centre - EAU	79.0%	105.4%	84.1%	120.4%	1302	6.3	4.2	10.5
JASRU	106.9%	90.9%	100.8%	84.9%	565	4.1	4.3	8.4
Maternity Unit	98.4%	109.1%	102.8%	91.5%	596	13.6	4.7	18.4
Special Care Baby Unit	83.7%	84.6%	107.8%	**73.6%**	105	16.2	4.7	21.0
St. Bedes	94.8%	102.3%	98.9%	104.0%	281	5.5	4.4	9.9
Sunniside Unit	79.1%	108.1%	109.9%	102.9%	269	5.7	4.4	10.1
Ward 08	132.7%	114.2%	94.3%	96.2%	586	4.4	3.4	7.8
Ward 09	95.5%	87.9%	112.1%	101.0%	807	2.7	2.1	4.9
Ward 10	92.0%	100.5%	108.5%	104.8%	712	3.0	2.7	5.7

	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%	105.9%	103.0%	113.4%	762	2.5	3.0	5.5
Ward 14 Medicine	119.8%	103.8%	97.3%	111.5%	730	3.3	2.9	6.2
Ward 14a Gastro	104.9%	138.3%	93.5%	123.8%	769	2.9	3.7	6.6
Ward 21 T&O	128.9%	120.8%	107.4%	166.7%	800	3.4	4.0	7.4
Ward 22	105.4%	86.0%	96.5%	86.8%	907	2.7	2.7	5.4
Ward 23	129.8%	88.7%	101.9%	101.7%	712	3.4	3.2	6.6
Ward 24	135.2%	80.8%	99.6%	104.9%	897	3.3	2.7	6.0
Ward 25	131.3%	95.5%	100.8%	90.3%	940	3.1	2.8	5.9
Ward 26	109.8%	99.7%	103.7%	143.3%	786	3.4	3.4	6.8
Ward 27	121.8%	118.3%	102.6%	100.0%	805	3.5	3.4	6.9
Ward 28	94.7%	97.7%	106.6%	**72.9%**	186	8.6	5.9	14.5
QUEEN ELIZABETH HOSPITAL - RR7EN	**99.4%** ↓	**101.5%** ↓	**97.3%** ↓	**106.7%** ↑	**13967**	4.8	3.5	8.4 ↓

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.~~ Now covered via the Leading Indicator reports rather than a separate report	~~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		√			√
Board Walkabout Feedback	Chief Nurse	Item for Assurance	Part 1	√	√	√	√	√
Great North Healthcare Alliance Progress Report	Director of Strategy and Planning	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					